

The COVID-19 vaccine- The need for a Risk vs. Reward calculation

By Dr. Alan Palmer- Updated May 1st, 2021 ([Jump to most recent updates](#))

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Disclaimer:

I am a chiropractic physician and never recommend that someone should or shouldn't consent to a medical procedure or a medication. Since vaccination is a medical procedure, I have always held to the same restraint. I am not recommending that anyone refrain from taking the COVID-19 vaccines. I am only providing information for individuals to compare to other information they are seeing and hearing, in the effort to help them make an educated decision. With this article I have acted as a journalist and have spent dozens of hours to investigate and assemble information from credible sources. While much of this information may not line up with the mainstream media's narrative, I have "fact checked" it for accuracy and provided the references.

Introduction

Before launching into the vaccine story, I feel it is appropriate to touch on something that may be on the minds of many of you. I know that to be true, because several people have brought these concerns and questions to me. In addition, these questions are relevant because of the situation we now face with the vaccines including the possibility of industry or governmental mandates. It really boils down to a person's freedom of choice and are we to remain sovereign over our own bodies, or will the government control that?

One question I have been getting is, "why would you write an article that would make people question vaccines?"

That is simple. After 2 ½ years and more than 2,500 hours of research and writing my eBook **1200 Studies- Truth Will Prevail** (<https://1200studies.com>), which contains excerpts from over 1,400 studies that contradict the narratives that we are told including, "the science is settled on vaccines" and "vaccines are safe and effective", I found out that there is good cause to be skeptical and question vaccines and the people that make and promote them. **1200 Studies** is the most comprehensive exposé on vaccines ever created.

Other than the massive amount of evidence in my eBook, there is a general distrust of the pharmaceutical industry. An August 2019 **Gallup** poll found that the pharmaceutical industry ranked 25th out of 25 industries in terms of public opinion. With 58% of people polled having a negative view and 15% being neutral, that means that only 27% of people view the industry in a positive light. This is an all-time low for pharma. And, close behind in 24th position is the federal government at only 4 points better.

<https://news.gallup.com/poll/266060/big-pharma-sinks-bottom-industry-rankings.aspx>.

Another issue is the behavior and quality control of pharma. Pfizer, the manufacturer of the first COVID-19 vaccine to make it to market in the U.S. has been fined and paid penalties to the tune of **4,747,652,947** (yes that's nearly 5 billion dollars), since the year 2000. The drug business is so profitable, the industry often looks at fines and penalties as part of the cost of doing business, never changing its behavior.

<https://violationtracker.goodjobsfirst.org/parent/pfizer> .

Case in point. Another concern now that we have witnessed the “*Operation Warp Speed*” production and rollout of these vaccines is, what kind of quality control has there been? An article in Vanity Fair brings serious questions to light about safety and health violations at the plants where vaccines and biologics are made. Apparently, the FDA has a team of only 14 inspectors that are responsible for inspecting 280 vaccine and biologics plants and manufacturing facilities. One of those inspectors has come forward with serious allegations of the lack of follow through on the part of the FDA after violations are brought to light.

The December 2nd, 2020 article by Katherine Eban is titled, **The COVID Vaccines Are Approaching. Is the FDA Ready to Inspect the Plants Where They’re Made?** Some of the revelations in this article are truly disgusting and shocking. <https://www.vanityfair.com/news/2020/12/fda-covid-vaccine-plant-inspectors>

Watch an interview with Katherine Eban regarding the FDA whistleblower and these issues here...
<https://video.kqed.org/video/whistleblower-says-fda-isn-t-properly-regulating-facilities-1607290063/>

You will see in my eBook on pages 133-139 (<http://1200studies.com>), that independent analysis of vaccines has found they often contain potentially dangerous contaminants and may not contain the very things we are told are in them that are supposed to give them their effectiveness. With the unprecedented rollout of billions of doses of vaccines in record time, quality control that was apparently sorely lacking before, is likely much worse now. If safety has been sacrificed for speed, it could certainly put people’s health and life at risk.

Unfortunately, history proves that we can’t trust our public health agencies and authorities to monitor safety in the vaccine industry

The ***National Childhood Vaccine Injury Act of 1986***,... granted economic immunity to pharmaceutical companies for the injuries caused by their vaccines. The responsibility for vaccine safety was therefore placed in the hands of the *United States Department of Health and Human Services (“HHS”)*..., which provided..., **that the Secretary of HHS “shall ... make or assure improvements in ... the licensing, manufacturing, ... adverse reaction reporting, ... and research on vaccines, in order to reduce the risks of adverse reactions to vaccines.”**

HHS was supposed to set up a task force to monitor the vaccine industry and report back to Congress-

“To assist the Secretary of HHS in performing these duties, Section 300aa-27(b) directs the Secretary to establish a task force responsible for making recommendations to the Secretary concerning implementation of the requirements of Section 300aa-27(a). **This task force is entitled the “*task force on safer childhood vaccines.*” ...The Director of the *National Institute of Health (NIH)* is the chair of the Task Force, which by statute also includes the *Commissioner of the FDA* and the *Director of the CDC.***

To track HHS’s fulfillment of these vaccine safety obligations, the following order was given... **“Within 2 years after December 22, 1987, and periodically thereafter, the Secretary [of HHS] shall prepare and transmit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report describing the actions taken pursuant to subsection (a) of this section during the preceding 2-year period.”**

In 2017, The ***Informed Consent Action Network (ICAN)*** and ***Robert F. Kennedy Jr.*** sued the United States government and won in an issue regarding vaccine safety. According to a legal document entitled, “Mandate for Safer Childhood Vaccines,” Health and Human Services (HHS) has openly admitted to not having filed any vaccine safety reports in over 30 years.”

The court filing, ICAN's summary of events and the HHS response revealing that they have no records can be found here: <http://icandecide.org/government/ICAN-HHS-Stipulated-Order-July-2018.pdf>

The meteoric rise since the 1980s in childhood chronic illness in virtually every category including neurodevelopmental conditions has tracked parallel with the dramatic increase in vaccines our children have been given. In 1987 the rate of chronic illness in children was 12%. Today it is 54%. In 1983, children got 11 doses by age 6. In 2021 they get 44 by age 6 (36 of those by 18 months!). By age 18 children now get 72 doses of vaccines. Our children deserve a robust vaccine safety system. It just simply does not exist.

Current CDC Schedule: <https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html#birth-15>

The other questions I have been getting relate to the effectiveness and collateral damage from the lockdowns and what could we have done differently, or what could we do now?

This is a topic that I could literally write a book about and have featured stories on many times in the **COVID-19 Update Newsletter** that I have been writing and sharing monthly for the last 7 months. (<https://www.wellnessdoc.com/science-and-news-monthly-newsletter/>).

So, what could we have done differently in our response to SARS-CoV-2 and what could we do now to get out of the tangled mess caused by the virus and the numerous problems that governments and their entities have created with the lockdowns and extreme measures they have imposed?

I could provide a massive amount of information and data on the damages of the lockdowns, the fact that they have not made any difference in deaths from COVID-19 and the long-term effects that will last for years beyond the pandemic, but it goes far beyond the scope of this article. This is just one such example...

An exhaustive study looking at 160 countries and effects of mitigation measures published in the journal *Frontiers in Public Health* titled, **Covid-19 Mortality: A Matter of Vulnerability Among Nations Facing Limited Margins of Adaptation**. <https://www.frontiersin.org/articles/10.3389/fpubh.2020.604339/full>

- A key quote from the study's authors- "**Stringency of the measures settled to fight pandemia, including lockdown, did not appear to be linked with death rate**".

An incredible resource containing 26 studies summaries and links, that all show that lockdowns have had no measurable effect on deaths from COVID-19. The article titled, **Lockdowns Do Not Control the Coronavirus: The Evidence**, can be found at the *American Institute for Economic Research* website here: <https://www.aier.org/article/lockdowns-do-not-control-the-coronavirus-the-evidence/>

It is now evident that the lockdowns have caused irreparable harm in so many ways, including increased deaths of despair and have had zero benefit in achieving the stated goals of reducing the spread of the virus and saving lives.

So, what should we have done and start doing differently now? *The Great Barrington Declaration* at <https://gbdeclaration.org/> provides the answers. Go there and if you agree, sign on to their declaration. And, be sure to read their FAQs page. <https://gbdeclaration.org/frequently-asked-questions/>

The three original authors of *The Great Barrington Declaration* are:

Dr. Martin Kulldorff, professor of medicine at Harvard University, a biostatistician, and epidemiologist with expertise in detecting and monitoring infectious disease outbreaks and vaccine safety evaluations.

Dr. Sunetra Gupta, professor at Oxford University, an epidemiologist with expertise in immunology, vaccine development, and mathematical modeling of infectious diseases.

This is the author's reason for creating it and the number of people that have endorsed these measures to date by signing on to the declaration.

Dr. Jay Bhattacharya, professor at Stanford University Medical School, a physician, epidemiologist, health economist, and public health policy expert focusing on infectious diseases and vulnerable populations.

This is their mission statement and the number of people that have signed on in support of the declaration as of February 25th, 2021.

As infectious disease epidemiologists and public health scientists we have grave concerns about the damaging physical and mental health impacts of the prevailing COVID-19 policies, and recommend an approach we call Focused Protection.

concerned citizens

754,399

medical & public health scientists

13,705

medical practitioners

41,455

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April 11th, 2021 update

- Associate Editor Peter Doshi of the British Medical Journal questions the "effectiveness" claims of the Pfizer and Moderna vaccines

- [Dr. Doshi had previously questioned the “end points” of the trials as not addressing the most important aspects for a successful vaccine, including protecting the elderly](#)
- [Now that the vaccines have been rolled out to elderly and long-term care facilities, unusually high rates of deaths are being reported in elderly nursing home residents after they receive the shots](#)
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- [Monthly *1200 Studies COVID-19 newsletter*](#)

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 attempts 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."*

Elderly people may be at even greater risk for danger from Pathogenic Priming or Adverse Immune Enhancement

According to a December 10th, 2020 article in the **Children's Health Defense** e-publication called ***the Defender*** titled, **Pfizer COVID Vaccine Trial Shows Alarming Evidence of Pathogenic Priming in Older Adults**, concerns are raised about pathogenic priming and how older adults may fare from these vaccines.

<https://childrenshealthdefense.org/defender/pfizer-covid-vaccine-trial-pathogenic-priming/>

From the article:

In the [development of vaccines against coronaviruses](#) like SARS-COV-1 and MERS in the early 2000's, researchers found evidence of a serious problem. Teams of U.S. and foreign scientists vaccinated animals with the four most promising vaccines. At first, the experiment seemed successful as all the animals developed a robust antibody response to coronavirus. However, when the scientists exposed the vaccinated animals to the

wild virus, the results were horrifying. Vaccinated animals [suffered hyper-immune responses](#) including inflammation throughout their bodies, especially in their lungs.

This issue is well known. Early in the COVID-19 scenario, Dr. Peter Hotez, of *Baylor College of Medicine*, testified before Congress about the dangers of accelerating coronavirus vaccine development, saying “(The unique safety problem of coronavirus vaccines” was discovered 50 years ago while developing the Respiratory Syncytial Virus (RSV) vaccine.”

He went to register that this “‘paradoxical immune enhancement phenomenon’ means vaccinated people may still develop the disease, get sicker and die.”

Researchers had seen this same “enhanced immune response” during human testing of the [failed RSV vaccine tests](#) in the 1950s. The vaccines not only failed to prevent infection; 80% of the children infected required hospitalization, and two children challenged with the RSV died (see [Openshaw, 2005](#)). In April of 2020, Hotez [told CNN](#), “If there is immune enhancement in animals, that’s a showstopper.”

[In this video footage](#), Offit, Hotez and even Fauci (in an unguarded moment), warn that any new coronavirus vaccine could trigger lethal immune reactions, “vaccine enhancement,” when vaccinated people come in contact with the wild virus. Instead of proceeding with caution, Fauci made the reckless choice to [fast track](#) vaccines, partially [funded by Gates](#), without critical [animal studies](#) before moving into human clinical trials that could provide early warning of runaway immune responses.

Gates (in [this video](#)) is so worried about the danger of adverse events that he says vaccines shouldn’t be distributed until governments [agree to indemnify](#) against lawsuits. On Feb. 4, according to the Centers for Disease Control and Prevention (CDC) [website](#), there were only [11 active CV cases](#) in the U.S., yet the U.S. quietly pushed through [federal regulations](#) giving coronavirus vaccine makers full immunity from liability.

My comment: Now that’s a problem. While as mentioned above, the AstraZeneca trials did incorporate some primate animal testing, the Moderna and Pfizer vaccines did not. In my opinion that was a mistake from a safety standpoint.

The article goes on to say: The Vaccines and Related Biological Products Advisory Committee [Briefing Document](#) on the Pfizer-BioNTech [COVID-19 vaccine](#) contains disturbing indications that might be a safety signal on pathogenic priming, **especially in older adults.** (**My comment:** this is consistent with previous failed attempts to develop a coronavirus vaccine, where the older animals were the ones most likely to suffer severe reactions from pathogenic priming).

The clinical trials found a 10-fold increase of serious adverse events in older adults after the second dose, compared to 3.6-fold for those under 55

Among the 18-55 year-old participants, there were 370 solicited **serious adverse events (SSAEs)** in the vaccinated group and 73 in the unvaccinated. **Of the vaccinated, 18% experienced SSAEs; in the placebo group, only 3% did, implying that SSAEs can be expected at a rate five times greater in the vaccinated compared to the unvaccinated.**

These included severe fatigue, headache, chills, vomiting, diarrhea, muscle and joint pain. Whether these conditions represent instances of pathogenic priming, identifying individuals who are now at higher risk of

serious morbidity and mortality if they become infected with SARS-CoV-2 is unknown, but given past studies, seems likely.

In the over 55 group, which was a smaller group, there were 60 SSAEs in the vaccinated group and 24 in the unvaccinated. **Of the vaccinated, 6.5% experienced SAEs, compared to 1.4% in the unvaccinated, implying a 4.46% increased risk overall of SSAEs due to vaccination.**

However, in the older group, the vaccinated group was 10 times more likely to have a SSAE upon receipt of the second vaccine dose than the first dose compared to the 1:1 ratio in the unvaccinated. In the younger group, the vaccinated were only 3.61 times more likely to have second-dose SSAEs than the age-matched placebo group, which had about as many SSAEs in the first and second dose.

End of excerpts:

Four big concerns I have are:

1. One very important thing to consider is that, while Phase 3 trials did include older individuals, they chose relatively healthy people. That is in no way representative of the general population of the elderly in the U.S.
2. We may not know what the extent of pathogenic priming reactions will be in the people getting the vaccine, until they are challenged by coming in contact with the wild virus in the future.
3. This “priming’ of the immune system by the vaccine may lead to development of autoimmune disease in the future. Because these vaccine trials have been so short lived in humans, around 90 days rather than 4 to 6 years or longer as is typically the case, we may not know for many months or even a few years what the fallout may be regarding autoimmune disease.
4. Currently 1 in 6 Americans has one or more autoimmune diseases. We know from many previous studies, that people with autoimmune disease and their offspring, are more likely to suffer adverse reactions from vaccines. How will individuals with current autoimmune disease do after exposure to the COVID-19 vaccines?

Shocking statements about vaccinating the elderly, by the associate director of the *Immunization Action Coalition*, a vaccine advocacy group

“Since they haven’t been studied in people in those populations, we don’t know how well the vaccine will work for them,” says Dr. Kelly Moore, associate director of the Immunization Action Coalition, a group that supports frontline workers who will be tasked with administering COVID-19 vaccines.

“We know that most vaccines don’t work nearly as well in a frail elderly person as they would in someone who is fit and vigorous, even if they happen to be the same age.”

Dr. Moore went on to admit that there is no way to truly know if COVID-19 vaccines will benefit the elderly in any way **because those at the highest risk were not included in the test groups.**

“There’s a question about the direct benefit of the vaccine, if given to people who live in those facilities, because we haven’t studied how well it works in that group yet.”

So much for science. At the same time, anyone who dies following vaccination for COVID-19 probably died from something else, according to Dr. Moore, especially if they were already nearing the end of their lives.

“One of the things we want to make sure people understand is that they should not be unnecessarily alarmed if there are reports, once we start vaccinating, of someone or multiple people dying within a day or two of their vaccination who are residents of a long-term care facility,” Dr. Moore contends.

“That would be something we would expect, as a normal occurrence, because people die frequently in nursing homes.”

<https://www.naturalnews.com/2020-12-11-cnn-reveals-vaccinating-elderly-covid19-kill-them.html>

My comments: If that’s the case Dr. Moore, why didn’t we hear these cautionary words from her or health officials when people in nursing homes started dying “from COVID-19”? In those cases, it was always COVID that killed them. But all that aside, her admission that they don’t know what will happen when they start mass immunization of the frail and most elderly is VERY concerning. Of course, we haven’t taken the time to test these vaccines on that population, so everyone’s grandmother and grandfather living in these facilities will become the test subjects. But of course, if they die shortly after, “it couldn’t have been from the vaccine” (I say sarcastically).

Keep this story in mind until you read this [STATUS UPDATE](#) story about deaths in elderly later in this document

A top expert in the field of respiratory diseases is an outspoken critic of the rush to the vaccines

Dr. Michael Yeadon, former VP and **Chief Scientific Officer with Pfizer** 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.

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.**

A large percentage of doctors and nurses are hesitant to take the vaccines

A Washington Post article titled, **Doctors and nurses want more data before championing vaccines to end the pandemic**, conveys the skepticism expressed by a large percentage of doctors and nurses, a group that typically buys in to the idea of vaccines.

From the article:

A report released November 19th by the University of California at Los Angeles researchers said that 66 percent of Los Angeles health-care workers who responded to an online questionnaire (not a randomized sample) said they would delay taking a vaccine. The American Nurses Association, a national professional organization, said one-third of its members do not intend to take the vaccine, and an additional third are undecided. <https://www.medrxiv.org/content/10.1101/2020.11.18.20234468v1>

“These mRNA vaccinations have never been approved before, so there is no reliable track record of safety. We should expect to set the bar higher for safety,” said Jeffrey A. Hirschfield, a pediatrician in St. Petersburg, Fla., who has discussed his reservations on Twitter. “It typically takes five to 10 years to successfully develop and vet vaccine candidates, especially those relying on new technologies.”

Marie Ritacco, a longtime nurse at St. Vincent Hospital in Worcester, Mass., and vice president of a state nurses union, said many nurses will continue to rely on personal protective equipment and strict anti-infection procedures rather than be in the first wave of health-care workers receiving coronavirus vaccine.

<https://www.msn.com/en-us/news/us/doctors-and-nurses-want-more-data-before-championing-vaccines-to-end-the-pandemic/ar-BB1becTK>

We now know that PCR Testing is a disaster

One of the biggest problems about the reports of success with the vaccines is the reliance on PCR testing for positivity, for which PCR testing is now shown to be highly inaccurate

Because the vaccine studies have used PCR testing to determine if someone is COVID-19 positive and as the next section will show you, it is estimated that the error rate in PCR testing may be as high as 50%, that makes their conclusions about effectiveness of their vaccines in the trials using this method null and void. A PCR test alone according to the experts I will present, cannot be used to diagnose COVID-19. In addition, the false positive rate at 30% and 70% of those testing positive being unable to transmit the virus to others makes this whole testing methodology a disaster.

Other reasons that this is so very important to understand is that we have shut down nations of the world, destroying lives, permanently closing tens of thousands of small businesses and potentially killing millions of people in the process over positive case numbers. Now we are facing mandated experimental vaccines, for a virus that for people under 60 years of age is no more serious than the seasonal respiratory viruses and pneumonia we have been encountering and dealing with successfully with minimal risk throughout our lifetimes.

This could be a very long section, because there is so much controversy now about the high false positive rate of PCR tests, so to keep it as simple as possible I will include a section out of my last newsletter, a couple other stories and some references and resources for those that want to dive deeper into this aspect.

To bypass this section on PCR testing and go to the next section click [HERE](#)

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! Read that again and let that sink in.

Think about this. As of December 14th, 16,545,000 people in the U.S. have been "confirmed" COVID positive by PCR testing. If 70% of those people are incapable of infecting anyone else, it means that 11,581,500

people have been quarantined for 14 days unnecessarily, unable to work or go to school and made to worry about any human contact with family or friends. As you will see, Dr. Mina has a better solution for testing.

As a side note, the CDC estimates that the number of Americans that have had COVID-19 is 8 times what have tested positive with PCR testing. That makes the total around 130 million. That is about 40% of the population! It is also estimated that around 50% of people have few if any symptoms. For the remaining 50%, the symptoms can range from mild-moderate to severe and even death in some cases.

THE LYNCHPIN OF WHAT IS WRONG WITH PCR TESTING AND THE RESULTING CALAMATIES IT IS CAUSING

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 a huge amount of 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 is that up to 70% of “positives” are people unable to transmit to others and are not infectious 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.

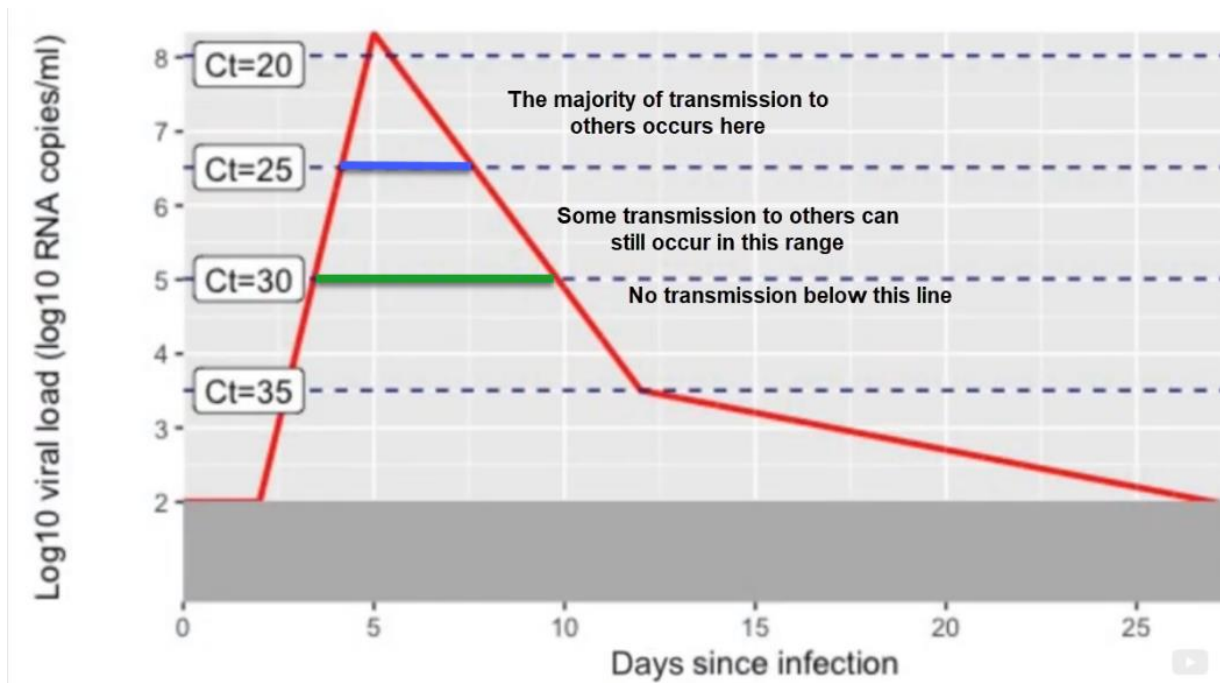
Story continued next page...

A visual representation of the viral explosion and decline

The red line represents the amount of viable virus in the body, sometimes called “viral load”. You can see that ability to transmit the virus to others occurs primarily between days 3 and 10. 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.



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. Imagine running Ct up to 40 or more, amplifying the sample exponentially in order to trigger a “positive” as most labs have done during the pandemic and you can understand why the rates of false positives are so high.

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](#).

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 at that point, 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 as you will see). **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 antibody 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



Yardley Yeadon
@MichaelYeadon3

COVID-19: Do We Have a Coronavirus Pandemic, or a PCR Test Pandemic? - AAPS | Association of American Physicians and Surgeons

I'm not alone is completely distrusting current PCR mass testing.
"Coronavirus is not a pseudo-epidemic..."



COVID-19: Do We Have a Coronavirus Pandemic, or a PCR Test Pandemic? - AAP...
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...
aapsonline.org



Yardley Yeadon
@MichaelYeadon3

[zerohedge.com/medical/covid-...](https://www.zerohedge.com/medical/covid-19-rt-pcr-test-how-to-mislead-all-humanity-into-accepting-social-media)

Wordy but worthwhile.

[#WhyAreTheyDoingThis](https://twitter.com/WhyAreTheyDoingThis)



The COVID-19 RT-PCR Test: How To Mislead All Humanity Into Accepting Soci...
zerohedge.com

5:46 PM · 11/7/20 · Twitter for iPad

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.

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.

The statement about the majority of people testing positive without symptoms is verified The Office of National Statistics in the UK which has found that only 22% are showing any symptoms of COVID-19 when the test says that they have it. <https://www.diabetes.co.uk/news/2020/jul/majority-of-people-with-a-positive-covid-19-test-are-symptom-free.html>

CEO of a major PCR testing company, also an esteemed pathologist calls what is going on “the greatest hoax ever perpetuated on an unsuspecting public”

Mercola.com published an article on December 9th, 2020 exposing the fallacies of PCR testing and the catastrophic consequences it has caused for the world.

According to Dr. Roger Hodkinson, one of Canada’s top pathologists and an expert in virology, the COVID-19 pandemic is the “greatest hoax ever perpetrated on an unsuspecting public.” Hodkinson made these blunt statements during a zoom conference with an Alberta Community and Public Services Committee (see video in link below).

Hodkinson is the CEO of Western Medical Assessments, a biotech company that manufactures COVID-19 PCR tests, so “I might know a little bit about all this,” he said, adding that the entire situation represents “politics playing medicine,” which is “a very dangerous game.”¹

He stressed that PCR tests simply cannot diagnose infection and mass testing should therefore cease immediately. He also pointed out that social distancing is useless as the virus “is spread by aerosols which travel 30 meters or so.”

<https://articles.mercola.com/sites/articles/archive/2020/12/09/coronavirus-hoax.aspx>

And one last criticism from one of the most highly respected and acclaimed researchers in the world, Tom Jefferson.

Tom Jefferson is a British epidemiologist, based in Rome, Italy, who works for the [Cochrane Collaboration](#). Jefferson is an author and editor of the Cochrane Collaboration's acute respiratory infections group, as well as part of four other Cochrane groups. He is also a founding member of the [Brighton Collaboration](#). He is also an advisor to the Italian National Agency for Regional Health Services.

The article published in the **Daily Mail** December 12th, 2020.

Some excerpts

The PCR verdict cannot tell these individuals whether they need to self-isolate or whether they might need treatment – the things that really matter to them and society.

In some cases, for example, viral RNA might be present in such very low quantities that an individual is not at all infectious and poses zero danger. In other cases, the swabs might pick up RNA which is so old it is completely dead, as people continue shedding material from the virus up to 80 days after the initial infection.

As Newcastle University’s Professor Allyson Pollock said recently, the PCR tests were never designed to be used across entire populations. The manufacturer’s instructions, she says, make it clear that they are no more than a tool to help with diagnosis and they are ‘not to be used on healthy people with no symptoms’.

All precision has been sacrificed and instead we are blundering through – imprisoning people in their homes, further crippling the economy long after the infection has vanished.

This is why we must treat the Government's daily tally of cases – often in five figures – with a huge dose of salt. And why we must restrict the reporting of positive coronavirus diagnoses to those who are infectious to others. These are the people who matter in a pandemic.

We must reach agreed laboratory standards for how swabs are processed so that one result can be meaningfully compared with another. And we must bring this indiscriminate regime of mass tests to a halt, concentrating instead on those who have good reason to believe they have the virus.

The alternative is yet more agonising muddle and delay. More needless damage to lives and livelihoods, more pointless suffering.

<https://www.dailymail.co.uk/health/article-9046363/DR-TOM-JEFFERSON-fear-mania-mass-Covid-testing-hugely-expensive-blunder.html>

A better way to ensure PCR accuracy

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.

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

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>

Based on a lie?

On November 27th, 2020, **twenty-two renowned international scientists** petitioned for the retraction of the original study showing PCR testing to be a credible source of identifying infection from SARS-CoV-2. They contend that there are 10 fatal flaws in the study leading to extreme false positives and the results and reliance on this study **according to the authors have led to “worldwide misdiagnosis of infections attributed to SARS-CoV-2 and associated with the disease COVID-19. We are confronted with stringent lockdowns which have destroyed many people’s lives and livelihoods, limited access to education and these imposed restrictions by governments around the world are a direct attack on people’s basic rights and their personal freedoms, resulting in collateral damage for entire economies on a global scale”**.

Some of them included the former head of research of Pfizer Dr. Michael Yeadon, the geneticist Kevin McKernan (the main initiator of the Human Genome Project), who holds several patents in the field of PCR diagnostics, the molecular geneticist Dr. Pieter Borger, PhD, the specialist for infectious diseases and preventive medicine Dr. Fabio Franchi, the microbiologist and immunologist Prof. emerit. Dr. Makoto Ohashi and the cell biologist Prof. Dr. Ulrike Kämmerer.

<https://cormandrostenreview.com/report/>

The paper goes on to detail the flaws and serious errors in the study that invalidate the results. The study that has raised these criticisms is titled **“Detection of 2019 novel coronavirus (2019-nCoV) by real-time RT-PCR.”**

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. That approach would prevent unnecessary quarantine, allow life, business and society to resume and allow us to focus on safeguarding the elderly and those with serious comorbidities, the only people really threatened by COVID-19.

Here are other examples of the problems with 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>

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

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**". <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 human 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!

The mRNA technology uses a lipid nanoparticle (LNP) incorporating PEG and is suspected in severe anaphylactic reactions in two UK healthcare workers

An ingredient called **Polyethylene Glycol (PEG)** is suspected as the culprit. PEG is used in the envelope that encloses the mRNA and is highly reactogenic in people that are sensitive to the chemical.

When Robert F. Kennedy found out about the controversial ingredient three months prior, he warned the FDA in a letter about the potential dangers of putting it in the experimental COVID-19 vaccines. In a December 12th article by Lyn Redwood of *Children's Health Defense*, an ingredient in the Moderna and Pfizer vaccines can lead to life-threatening reactions.

According to the article:

A mass vaccination campaign that targeted frontline workers to receive the vaccine began on Dec. 8. Within 24 hours of launching the campaign, [MHRA acknowledged](#) two reports of anaphylaxis and one report of a possible allergic reaction.

[Reuters](#) reported late yesterday afternoon that an investigation into the [anaphylactic reactions](#) by MHRA has identified [polyethylene glycol](#), or PEG, as the likely culprit.

[Moderna](#), Pfizer/BioNTech and Arcturus Therapeutics COVID vaccines all utilize a never-before-approved messenger RNA (mRNA) technology, an experimental approach designed to turn the body's cells into viral protein-making [factories](#). This technology involves the use of lipid nanoparticles (LNPs) that [encapsulate](#) the mRNA to protect them from degradation and promote cellular uptake.

The LNP formulations in the three COVID-19 mRNA vaccines are "PEGylated," meaning that the vaccine nanoparticles are coated with a synthetic, non-degradable and [increasingly controversial](#) PEG.

[COVID mRNA vaccines](#) are not the only vehicle for PEG involvement in COVID-19 vaccine production. Researchers at Germany's Max Planck Institute report developing a process for COVID-19 vaccine production to purify virus particles at "high yield." The process involves [adding PEG](#) to a virus-containing liquid and passing the liquid through membranes.

On Sept. 25, Robert F. Kennedy, Jr., chairman and chief legal counsel for Children's Health Defense (CHD), [notified](#) the Steven Hahn, director of the U.S. Food and Drug Administration (FDA), Dr. Peter Marks director of FDA's Center for Biologics Evaluation and Research and Anthony Fauci, director of the National Institute for Allergy and Infectious Diseases, of the serious and possibly life-threatening anaphylactic potential of PEG.

You can see the letter by going to the link to the article below.

An extensive [review of PEG](#) therapeutics, published in 2013, documented adverse effects of PEGylation and questioned the wisdom behind the continued use of PEG in drug development. The authors concluded that "the accumulating evidence documenting the detrimental effects of PEG on drug delivery make it imperative that scientists in this field break their dependence on PEGylation."

More evidence and links to studies about these concerns can be found in the article on CHD's web site.

<https://childrenshealthdefense.org/defender/pfizer-covid-vaccine-reaction-fda-peg/>

A major concern is that the public is unwittingly becoming part of the clinical trials and the largest human experiment in history

Is there proof of that? Yes! When are the clinical trials set to be completed? See below.

The Moderna Trial is due to complete October 27, 2022. WHAT? Nearly 2 years from now? Yes. See the screen captures 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 by informed consent, or just proceed without notification and consent?






<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>






For the Pfizer/ BionTech vaccine, 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 Other: Placebo	Phase 3

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>

So as you can see, the public rollout comes about 2 years BEFORE the completion of the clinical trials! You are part of the experiment. Yet, the odd thing is that they only plan on following the vaccinated group a very brief period of time (see next section).

Go back and read the first paragraph of this paper again for emphasis regarding the Nuremberg violations of experimenting on an unknowing person without their consent. After you do and then read this, realize that if you are injured now or later from the vaccine, you have NO RECOURSE. The government and drug companies have been given complete immunity (pun intended) from legal action. So, all that to say, unless you get full informed consent of all the possible risks including autoimmune disease, cancer and a litany of other serious complications including death and then sign off on the fact that you understand that you are a willing participant in an experiment with an experimental product (vaccine), your rights have been violated under the Nuremberg Code. In addition, if you are not informed of all the possible risks associated with receiving the vaccine, accepting and signing off on those risks you have not been given the right to full informed consent that is required legally and ethically for every medical procedure, even the ones that are low risk or benign.

Follow-up periods for Phase 3 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? Well with emergency use authorization being given after only 3 months of Phase 3 trial data, do you feel comfortable becoming part of the experiment?

You may be interested to know that if you are vaccinated in the trial and don't drop out, they only follow you for adverse effects for the following period.

- **Pfizer/BionTech**- 1 month after second dose and 6 months for serious adverse events.
- **Moderna**- with **Solicited Local and Systemic Adverse Reactions (ARs)** [Time Frame: Up to Day 8 (7 days after first dose) and up to Day 36 (7 days after second dose)
Unsolicited AEs [Time Frame: Up to Day 57 (28 days after each dose)
- **AstraZeneca/Oxford**- 1 month after second dose and 6 months for serious adverse events.

Another caveat is, that the FDA doesn't consider certain side effects serious, so they will only be tracked for 1 month. 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. The ironic thing is that many of these take months or years to even show up.

In both the case of Pfizer and AstraZeneca, they plan on tracking effectiveness for 2 years, so why not track adverse health effects for the same period also?

Thanks to the **Informed Consent Action Network** <https://icandecide.org> for providing this information.

According to Clinicaltrials.gov, if someone withdraws from the studies due to "Adverse Events (AEs) or Medically Attended AEs (MAAEs) Leading to Withdrawal [Time Frame: Up to Day 759 (2 years after second dose)]".

<https://www.clinicaltrials.gov/ct2/show/NCT04470427>

In other words, then they will track them for 2 years if they drop out. Why not if they stay in?

What are the vaccines designed to do? And, what does "effective" really mean in the percentage of effectiveness rates touted by the press releases and repeated ad nauseum by the media?

An October 22nd article titled, **Coronavirus Vaccine Trials Underway May Not Tell if the Shots Save Lives of COVID-19 Patients: British Medical Journal Expert**, highlights shortcomings of the COVID-19 vaccines, as expressed by one of the world's foremost medical experts.

From the article:

What most people do not realize is that the vaccines are not even designed to prevent COVID-19. What? None of the vaccines are designed to actually prevent infection. The primary measure of success is whether or not

the vaccine results in fewer symptoms when you're infected with SARS-CoV-2. And the bar is set so low, that the proforma for the vaccines consider a 50% rate in decreasing symptoms a success.

Writing in the *British Medical Journal (BMJ)*, Associate Editor Peter Doshi, said that several COVID-19 vaccine trials are now in their most advanced (phase 3) stage, but expressed reservations about what will it mean exactly when a vaccine is declared "effective"?

From the letter:

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.

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.

Follow-up:

Dr. Doshi released another opinion letter January 4th, 2021 highly critical of how the Pfizer and Moderna trials determined their rates of "effectiveness". The letter titled **Peter Doshi: Pfizer and Moderna's "95% effective" vaccines—we need more details and the raw data**, reported that because of exclusionary data the actual effectiveness (and remember that only means reduction of COVID-19 symptoms), should have been reported as between 19% and 29%! In other words, the numbers had to be manipulated to get to the approximately 95% effectiveness that was reported. Remember Peter Doshi is the *Associate Editor of the British Medical Journal (BMJ)* and is a highly credible scientifically qualified source to analyze the data and comment on it.

From his letter:

"Suspected covid-19"

All attention has focused on the dramatic efficacy results: Pfizer reported 170 PCR confirmed covid-19 cases, split 8 to 162 between vaccine and placebo groups. But these numbers were dwarfed by a category of disease called "suspected covid-19"—those with symptomatic covid-19 that were not PCR confirmed. According to [FDA's report on Pfizer's vaccine](#), there were "3410 total cases of suspected, but unconfirmed covid-19 in the overall study population, 1594 occurred in the vaccine group vs. 1816 in the placebo group."

With 20 times more suspected than confirmed cases, this category of disease cannot be ignored simply because there was no positive PCR test result. Indeed this makes it all the more urgent to understand. A rough estimate of vaccine efficacy against developing covid-19 symptoms, with or without a positive PCR test result, would be a relative risk reduction of 19% (see footnote)—far below the 50% effectiveness threshold for

authorization set [by](#) regulators. Even after removing cases occurring within 7 days of vaccination (409 on Pfizer’s vaccine vs. 287 on placebo), which should include the majority of symptoms due to short-term vaccine reactivity, vaccine efficacy remains low: 29% (see footnote).

However, if confirmed covid-19 is on average more severe than suspected covid-19, we must still keep in mind that at the end of the day, it is not average clinical severity that matters, it’s the incidence of severe disease that affects hospital admissions. With 20 times more suspected covid-19 than confirmed covid-19, and trials [not designed to assess](#) whether the vaccines can interrupt viral transmission, an analysis of severe disease irrespective of etiologic agent—namely, rates of hospitalizations, ICU cases, and deaths amongst trial participants—seems warranted, and is the only way to assess the vaccines’ real ability to take the edge off the pandemic.

There is a clear need for data to answer these questions, but Pfizer’s 92-page report didn’t mention the 3410 “suspected covid-19” cases. Nor did its [publication](#) in the *New England Journal of Medicine*. Nor did any of the reports on Moderna’s vaccine. The only source that appears to have reported it is FDA’s review of Pfizer’s vaccine.

The 371 individuals excluded from Pfizer vaccine efficacy analysis

Another reason we need more data is to analyse an unexplained detail found in a table of [FDA’s review](#) of Pfizer’s vaccine: 371 individuals excluded from the efficacy analysis for “important protocol deviations on or prior to 7 days after Dose 2.” What is concerning is the imbalance between randomized groups in the number of these excluded individuals: 311 from the vaccine group vs 60 on placebo. (In contrast, in Moderna’s trial, there were just 36 participants excluded from the efficacy analysis for “major protocol deviation”—12 vaccine group vs 24 placebo group.)

What were these protocol deviations in Pfizer’s study, and why were there five times more participants excluded in the vaccine group? The [FDA report](#) doesn’t say, and these exclusions are difficult to even spot in Pfizer’s report and journal publication.

We need the raw data

Addressing the many open questions about these trials [requires access to the raw trial data](#). But no company seems to have shared data with any third party at this point.

Pfizer says it is making data available “upon request, and subject to review.” This stops far short of making data publicly available, but at least leaves the door open. How open is unclear, since the [study protocol](#) says Pfizer will only start making data available **24 months after study completion. (My emphasis and comment: and the study isn’t scheduled to be completed until January 29th, 2023. That makes the release of the raw data January 29th, 2025! This is absurd with an experimental rushed to market product).**

Moderna’s data sharing statement states data “may be available upon request once the trial is complete.” This translates to sometime in mid-to-late 2022, as follow-up is planned for 2 years.

Things may be no different for the [Oxford/AstraZeneca vaccine which has pledged patient-level data](#) “when the trial is complete.” And the [ClinicalTrials.gov entry](#) for the Russian Sputnik V vaccine says there are no plans to share individual participant data.

Footnote: Calculations in this article are as follows: $19\% = 1 - (8+1594)/(162+1816)$; $29\% = 1 - (8 + 1594 - 409)/(162 + 1816 - 287)$. I ignored denominators as they are similar between groups.

End of excerpts: Follow the link below to read the rest of the article

<https://blogs.bmj.com/bmj/2021/01/04/peter-doshi-pfizer-and-modernas-95-effective-vaccines-we-need-more-details-and-the-raw-data/>

On 5 February 2021 he published a clarification to this piece. [It is available here.](#) It basically addressed some criticisms of his calculations which he defended aptly.

For those that want to see more evidence of the “fuzzy math” used to determine the “effectiveness” and the risks of the mRNA vaccines you can read this excellent article...

<https://everlyreport.com/what-you-need-to-know-about-the-covid-vaccine/>

“Significantly noticeable” side effects in the trials

A December 1st **CNBC** article cited a 10-15% rate of “significantly noticeable” side effects from the Pfizer and Moderna vaccines in their Phase 3 trials. <https://www.cnbc.com/2020/12/01/trump-covid-vaccine-czar-says-side-effects-significantly-noticeable-in-10percent-to-15percent-of-recipients.html>

Some key points:

- President Trump’s coronavirus vaccine czar said Pfizer’s and Moderna’s Covid-19 vaccines are safe, with only 10% to 15% of volunteers reporting “significantly noticeable” side effects.
- The side effects can last up to a day and a half, said Dr. Moncef Slaoui, who is leading the Trump administration’s Covid-19 vaccine program Operation Warp Speed.

The obvious and immediate side effects from the vaccine include (and sound very similar to what mild to moderate COVID patients are experiencing):

- Fever (and typically higher in the vaccinated group vs. people with COVID-19)
- Severe headache (both fever and severe headache are related to brain swelling after vaccination)
- Muscle aches
- Chills
- Day long exhaustion

Dr. Moncef Slaoui, who is leading the Trump administration’s Covid-19 vaccine program Operation Warp Speed also said...

“The longer, more important kind of adverse events such as some autoimmune disease or others have not been reported in a different way between the placebo group and the vaccine group in these two trials, which is very reassuring,” he told The Washington Post. “I always make sure we say that [while] we know the short term and I’m going to call it midterm effects of the vaccine is now well understood, the very long-term safety is not yet understood by definition.”

End of excerpts

The vaccine's immediate side effects can be worse than people suffer from mild to moderate COVID-19

Well, that quote from Dr. Slaoui is a real smoke screen. Autoimmune disease, cancer or other chronic metabolic diseases take much longer to rear their ugly head, typically months or even years, not just the short 2 to 3 months since participants were injected. And, I would have to assume that someone like Dr. Slaoui should know that. So, the comment must just be window dressing meant to make the public more “comfortable” with the vaccines.

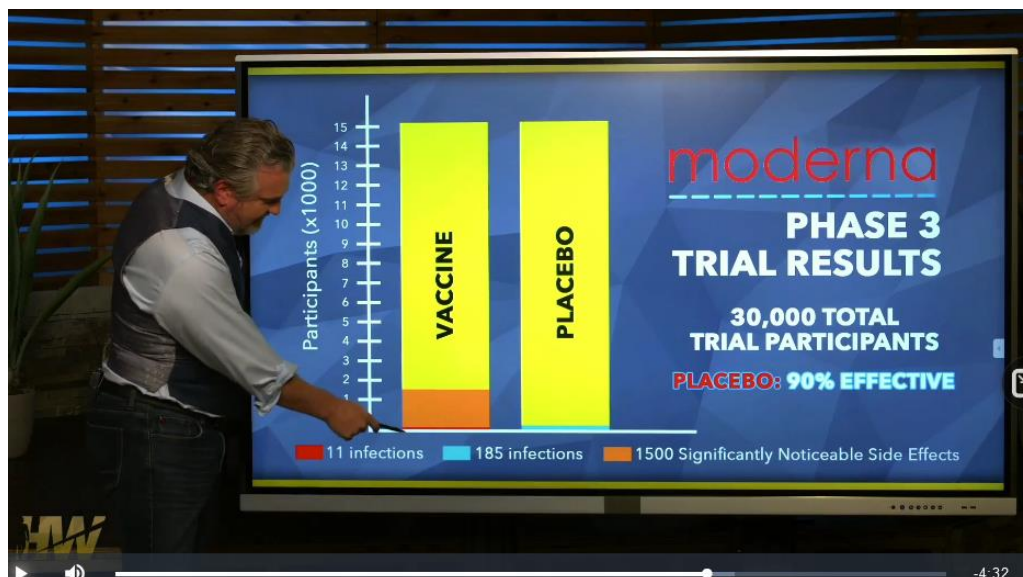
People need to ask themselves if that is worth taking the risk of serious adverse vaccine reactions and potential long-term health consequences. On a recent episode of the *Highwire*, Del Bigtree showed a graphic example of how the people in the vaccine trials suffered more symptoms from the vaccines than symptoms suffered by the placebo group. Later in this document, you will see excerpts from a *New York Post* article showcasing examples from vaccine trial participants describing how severe the side effects can become.

In the graphic below looking at the Moderna vaccine and using the 10-15% range of people experiencing significant side effects, Del shows that if just 10% (1,500 of 15,000 getting the shots) experienced those types of symptoms, the number of people experiencing those significant side effects from the vaccine would far exceed the 185 out of the 15,000 in the placebo group that did not get the vaccine and developed symptoms of COVID-19. Also, as we now know from the experts on PCT testing, the tests are false positives 30% of the time, so out of the 185 positives, there may have been only 125 true COVID-19 positives. Also consider that in the total population, it is estimated that approximately, 50% of people have zero to minimal symptoms from COVID-19. That could mean that out of the approximately 125 that truly had the infection, around 60 would most likely have little or no symptoms.

To make the differences even greater, we could use the higher range (15%) of the estimated number experiencing significant side effects from the vaccine which would be 2,250 people. That would be around 60 or so people having significant symptoms from COVID-19 and 2,250 people in the vaccinated group. Which odds would you take? And considering the risk factors for COVID-19, advanced age and if you have significant co-morbidities would need to be considered.

This is a screen capture from the episode “How Effective is the COVID-19 vaccine”.

<https://thehighwire.com/videos/how-effective-is-the-covid-19-vaccine/>



So, in looking at the graphic above and considering the percentage of vaccinated subjects experiencing side effects, the unvaccinated group (placebo) fared much better than the vaccinated group, with at least 90% fewer people having symptoms. Why don't all these people with symptoms show up in the data? Because as Del points out so brilliantly in this same video clip as above, they don't start monitoring for symptoms (including adverse effects from the vaccine), until 14 days AFTER the second shot. See what I've circled and underlined in the screenshot below.

ClinicalTrials.gov

Home > Search Results > Study Record Detail Save this study

A Study to Evaluate Efficacy, Safety, and Immunogenicity of mRNA-1273 Vaccine in Adults Aged 18 Years and Older to Prevent COVID-19

Sponsor: ModernaTX, Inc.

Current Primary Outcome Measures ICMJE (submitted: July 11, 2020)

- Number of Participants with a First Occurrence of COVID-19 Starting 14 Days after Second Dose of mRNA-1273 [Time Frame: Day 29 (second dose) up to Day 759 (2 years after second dose)]

First Submitted Date ICMJE July 11, 2020
First Posted Date ICMJE July 14, 2020
Last Update Posted Date October 28, 2020

<https://thehighwire.com/videos/how-effective-is-the-covid-19-vaccine/>

And, as you will see in this next section, reducing symptoms was the primary endpoint and expectation for the vaccine in the first place. So with that being the case, the vaccine is actually a miserable failure with regard to its stated purpose and the expectations! Don't believe me? Listen to what Anthony Fauci has recently said in this next segment.

Lowering the bar for expectations for the vaccines

In an article posted on *the Blaze.com* October 27th, titled, **Fauci says early COVID vaccines will prevent symptoms, not block disease — and may be only 50% to 60% effective**, the bar for the definition of success is definitely being set extremely low.

From the article:

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.

"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."

My comment: It is shocking to me that preventing infection with SARS-CoV-2 is not a criterion for success in these vaccine trials. The vaccine trials are not even designed to see if the vaccine will reduce hospitalizations or death. If the vaccine cannot reduce infection, hospitalization or death, then it cannot end the pandemic, which means everyone who takes the vaccine thinking it will help to "save grandma" or to "do their part" to protect others, will be doing so in vain.

My questions are:

Safe with limited short-term trials? Trials that never tested subjects that are at high risk for COVID-19. Elderly people and those with serious comorbidities have not been tested. What happens when millions of those people become that arm of the trial? Will the cure be worse than the disease?

What is the point? The vaccines WON'T or aren't designed to prevent transmission, reduce cases, reduce hospitalizations, reduce ICU bed utilization, ventilators or deaths. So really what is the point? For a person to assume short and long-term risk of adverse health consequences from an experimental "Warp Speed" vaccine, for a 50% chance it may reduce their symptoms to some degree, is ludicrous. After all, it is estimated that 50% or more of people that contract COVID-19 experience very mild or no symptoms at all. Therefore, why would younger healthy people who have extremely low risk from COVID-19 need a vaccine at all?

Not only that, but I have more than 2 dozen studies that show good Vitamin D status is protective from respiratory viral infections, including COVID-19. They show that symptoms are much milder, and it reduces the chances of severe or fatal cases. In addition, other studies since the start of the pandemic have found similar results in people with adequate Zinc levels. By being proactive with these and other immune supporting nutrients a person can achieve results similar to what the vaccines are reported to do, without the risk of short or long-term adverse reactions.

You can go to my website and see an article I wrote about Vitamin D and respiratory infectious diseases including COVID-19 with over two dozen references and links to the published research. Read that [HERE](#)

A look at some of the top COVID-19 vaccine candidates

Moderna's mRNA 1273 Vaccine

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.

Phase 1 trial

A report in the *New England Journal of Medicine* released July 14th, 2020 titled, **An mRNA Vaccine against SARS-CoV-2 – Preliminary Report**, reveals a high percentage of side effects in Moderna’s Phase 1 Vaccine Trial, although the authors and the media did their best to sugar coat it.

Symptom	Vaccination	Dose group	N	Maximum Severity		
				% Mild	% Moderate	% Severe
Any Systemic Symptom	1	25 mcg	15	20.0	13.3	-
		100 mcg	15	53.3	13.3	-
		250 mcg	15	26.7	26.7	-
	2	25 mcg	13	30.8	23.1	-
		100 mcg	15	20.0	80.0	-
		250 mcg	14	14.3	64.3	21.4

As you can see, 100% of recipients had adverse effects from the 100-mcg dose, with 80% of those being moderate symptoms. **And 100% of the recipients of the 25- mcg dose had adverse effects with 64.3% being moderate and 21.4% experiencing severe reactions.**

As expected, the announcement came shortly afterward that the trial **was successful**, and they were ready to move on to the next phase...Warp speed ahead Scotty!

Pfizer/BionTech

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.

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 undoubtedly 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 and potential dangers or consequences 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. 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 confirmation that the people they say contracted COVID-19 in the study, it invalidates the results. Nothing in the media about this though. Crickets...

If you read Pfizer’s and Moderna’s press releases and other clinical trial information, you’ll see that they have left out some really crucial information. For example:⁵

- They don’t say how many cycles they used for the PCR tests they gave to count COVID-19 cases, which is crucial for determining the accuracy of those tests (amplifying and running cycles over 30 to 33 only catches fragments of the virus after infection)
- They don’t say whether the “cases” had symptoms or not

- They don't mention anything about hospitalizations or deaths, meaning there is no indication it prevents either
- There is no indication about how long the vaccine lasts if it truly is effective and protective. Some indications suggest you might need to take this vaccine every three to six months in order for it to be effective

Moderna and Pfizer/BionTech vaccines turn cells in the human body into vaccine making machines- It is risky and untested in long-term trials

mRNA technology has NEVER been used in vaccines. Is a rushed to market, abbreviated safety process vaccine pushed on the public as the long-term phase of the trials a good idea? Here is more on the nature of what they will do to your cells.

According to a **Bloomberg Report**, "The coronavirus vaccines from Moderna Inc., in Cambridge, Mass., and its German rival BioNTech SE propose to immunize people in a radically different way: by harnessing human cells to become miniature vaccine factories in their own right. Instead of virus proteins, the vaccines contain genetic instructions that prompt the body to produce them. Those instructions are carried via messenger RNA, or [mRNA](#)."

"Moderna's mRNA-1273 consists of a strand of mRNA that tells the body to produce the spike protein the coronavirus uses to latch onto human cells. The strand is like one side of a zipper; the "teeth" are a sequence of chemical letters that cells read to produce the 1,273 amino acids that make up the spike protein. If the vaccine works as intended, the body will start producing the proteins soon after injection, prompting the immune system to react and build up protective antibodies against them."

According to some experts looking into this technology, if this genetic material recombines with our DNA, in essence we will become Genetically Modified Organisms (GMOs). I'm not 100% convinced of this yet, but if that were the case, just like you can never get the toothpaste back in the tube, how will you undo the splicing of this foreign genetic material from your own unique DNA code?

End of Bloomberg report-

Another leading vaccine candidate the AstraZeneca/Oxford vaccine 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.

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.

Adverse reactions

At least two cases of transverse myelitis (severe inflammation of the spinal cord) has been documented in AstraZeneca's trial, and the company temporarily halted its trial in September 2020.

Concerns over the genetically modified virus technology

The AstraZeneca Vaccine has the same recombinant technology as the Johnson & Johnson Vaccine described below. Recombinant in this case means that DNA is combined in a lab from two different viruses into a hybrid organism (genetically modified organism- GMO), that would not normally be found in nature. Read on about the Johnson & Johnson Vaccine to see why that is such a concern by many scientists.

Concerns over the Johnson & Johnson vaccine

This vaccine is similar to the AstraZeneca/Oxford vaccine. They are referred by some scientists as a "Frankenstein" vaccine. The reason is that it uses another virus, a chimpanzee adenovirus as the carrier for the

section of the SARS-CoV-2 virus spike protein DNA, which is “spliced” into the adenovirus. It is a hybrid of sorts, part this and part that (hence the Frankenstein label). J & J’s and AstraZeneca are both called recombinant Adenovirus vector vaccines. Adenoviruses are viruses that are part of the common cold spectrum of viruses, just like coronaviruses are. Like the Pfizer and Moderna mRNA vaccines, these vaccines are a departure from the traditional vaccine platform.

Johnson & Johnson’s vaccine consists of a **replication-incompetent (genetically modified) recombinant adenovirus type 26 virus**, with the section of the SARS-CoV-2 spike protein spliced in. It also contains the following ingredients: citric acid monohydrate, trisodium citrate dihydrate, ethanol, 2-hydroxypropyl- β -cyclodextrin (HBCD), **polysorbate 80**, sodium chloride, sodium hydroxide, and hydrochloric acid. The adenovirus is also grown in the **PER.C6® aborted fetal cell line**.

The reason I have highlighted those 3 ingredients, is because they have proven to be problematic in other vaccines.

1. **A replication-incompetent (genetically modified) recombinant adenovirus type 26 virus** is concerning because it uses the prior mentioned technology where a virus is made incapable of replicating (Adenovirus) and the gene sequences from another virus (in this case the SARS-CoV-2 spike protein are inserted into the modified Adenovirus. There is historical context to make this a major concern. In 2015 a vaccine against Dengue Fever was developed by Sanofi Pasteur and rolled out on children in the Philippines. In that case it was a Yellow Fever Virus that had gene sequences of the Dengue Virus spliced into it. This experiment on children in the Philippines went horribly wrong resulting in criminal charges brought against researchers, health officials and Sanofi Pasteur.

The following excerpt is from an April 24th, 2019 article published in *ScienceMag* titled **Dengue vaccine fiasco leads to criminal charges for researcher in the Philippines.**

<https://www.sciencemag.org/news/2019/04/dengue-vaccine-fiasco-leads-criminal-charges-researcher-philippines>

Dengvaxia consists of an attenuated yellow fever virus that expresses genes of each of the four types of dengue virus. The Philippine FDA greenlighted the vaccine in December 2015, based on research funded by Sanofi Pasteur in which Capeding played an important role. For example, she was the first author on a 2014 paper in *The Lancet* detailing a study among more than 10,000 children in five Asian countries that showed Dengvaxia worked and had a good safety profile. In April 2016, the Philippine government launched a \$67 million public school–based immunization program for Dengvaxia.

That alarmed some scientists, because the dengue virus is peculiar: A first infection is rarely fatal, but a second one with a different virus type can lead to much more serious disease, because of what is called antibody-dependent enhancement (ADE), in which the immune response to the first virus amplifies the effect of the second type. Scott Halstead, a retired dengue expert formerly at the Uniformed Services University of the Health Sciences in Bethesda, Maryland, argued that dengue vaccines could have the same effect, and warned that Dengvaxia should not be given to children never infected with dengue. But a vaccine panel at the World Health Organization (WHO) concluded in 2016 that Dengvaxia was safe for children aged 9 and older.

Halstead's concerns proved valid. In November 2017, Sanofi Pasteur announced that the vaccine could indeed exacerbate cases of dengue in children never previously infected, and the Philippines halted the

campaign immediately. (WHO now recommends the vaccine be used only after a test to be sure children have had at least one brush with dengue.)

End of excerpts

Many in the science world are concerned that the ADE or sometimes called Pathogenic Priming may not have been solely a result of the vaccine being given to children that had not had a prior infection, but that the vaccine platform (ie. The genetically modified organism created by recombinant virus splicing) may be what triggers this reaction in certain susceptible individuals. Couple that with the history of the failed prior attempts to create a coronavirus vaccine leading to termination of the trials after animal studies as a result of the numbers of animals that developed ADE and became severely ill and many dying.

2. **The PER.C6 cell line** is derived from human embryonic retinal cells, originally from the retinal tissue of an 18-week-old fetus aborted in 1985. Notoriously, DNA from the aborted fetus is present in vaccines and biologics where the viruses were grown on these cells. The FDA allows for 100,000,000 bits and strands of human DNA per dose. That is problematic, because as Dr. Theresa Deisher has warned can cause insertion into the recipient's DNA of this other human DNA (called homologous recombination) and lead to development of autoimmunity and other chronic health issues. Not to mention that it is abhorrent for many persons of faith to have human DNA from a fetus that was aborted for this purpose to be injected into their own body and potentially become part of their own DNA.

You can read about more about aborted fetal cell lines, Dr. Deisher's work in this area as well as the many problems with Polysorbate 80 in my eBook available at <https://1200studies.com>.

3. **Polysorbate 80** has been shown to cause allergic and even anaphylactic reactions in some people. It also has been shown to disrupt the blood-brain-barrier and aid in transport of drugs, chemicals and nanoparticles, even mercury and aluminum into the brain.

As a footnote, in October 2020 Johnson & Johnson paused its trial due to an undisclosed "unexplained illness" in one of its participants. This illness has not been disclosed publicly.

The phase 3 trial recipients have commonly experienced side effects very similar to the Pfizer and Moderna vaccine recipients. Those include fever, chills, headaches, body aches, joint pain, fatigue, basically the same symptoms as many people in the low risk category experience from COVID-19 itself.

See more in the next section on the J & J vaccine.

Major issues with all of them

A September 23rd article in Forbes did a good job of comparing the 4 top vaccine candidates and discussing some of the shortcomings.

The article is titled, [Covid-19 Vaccine Protocols Reveal That Trials Are Designed To Succeed.](#)

Here are some highlights from that article:

Moderna, Pfizer, AstraZeneca, and Johnson & Johnson are leading candidates for the completion of a Covid-19 vaccine likely to be released in the coming months. These companies have published their vaccine trial protocols. This unusually transparent action during a major drug trial deserves praise, close inspection of the protocols raises surprising concerns. These trials seem designed to prove their vaccines work, even if the measured effects are minimal.

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. Measuring differences amongst only those infected by SARS-CoV-2 underscores the implicit conclusion that the vaccines are not expected to prevent infection, only modify symptoms of those infected.

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.

Vaccine efficacy is typically proved by large clinical trials over several years. The pharmaceutical companies intend to do trials ranging from thirty thousand to sixty thousand participants. This scale of study would be sufficient for testing vaccine efficacy. The first surprise found upon a closer reading of the protocols reveals that each study intends to complete interim and primary analyses that at most include 164 (Infected- *my addition*) participants.

These companies likely intend to apply for an emergency use authorization (EUA) from the Food and Drug Administration (FDA) with just their limited preliminary results.

Interim analysis success requires a seventy percent efficacy. The vaccine or placebo will be given to thousands of people in each trial. For Moderna, the initial interim analysis will be based on the results of infection of only 53 people. The judgment reached in interim analysis is dependent upon the difference in the number of people with symptoms, which may be mild, in the vaccinated group versus the unvaccinated group.

Moderna's success margin is for 13 or less of those 53 to develop symptoms compared to 40 or more in their control group. For Johnson & Johnson, their interim analysis includes 77 vaccine recipients, with a success margin of 18 or less developing symptoms compared to 59 in the control group. For AstraZeneca, their interim analysis includes 50 vaccine recipients, with a success margin of 12 or less developing symptoms compared to 19 in the 25 person control group. Pfizer is even smaller in its success requirements. Their initial group includes 32 vaccine recipients, with a success margin of 7 or less developing symptoms compared to 25 in the control group.

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.

End of excerpts

<https://www.forbes.com/sites/williamhaseltine/2020/09/23/covid-19-vaccine-protocols-reveal-that-trials-are-designed-to-succeed>

***My comment: There will be Phase 4 testing. That is the phase where the vaccines are given to millions of people and then we see what happens over the next few years.**

Trials were designed to use chemical cocktails instead of inert saline placebos in the control (placebo) groups

The majority of the 100 or so vaccine candidates being produced around the world have decided to use other vaccines or injections with an aluminum adjuvant along with different chemicals for their “placebo” injections that controls would get. This summer after learning that Moderna was planning on using another vaccine as the “placebo”, once again ICAN filed a petition to the FDA demanding that the plan be modified to include a true saline placebo. As a result of ICAN’s efforts, Moderna agreed to use a saline placebo.

And, as the previous section reported, the AstraZeneca vaccine trial in Great Britain called for using a meningococcal vaccine as the “placebo” instead of an inert substance like saline. Why would that be? For previous vaccines, there has never been a saline placebo used in safety studies. The obvious reason why that would be is to hide the differences between the adverse symptoms developed in the vaccine group and the “placebo” group. If they both develop similar adverse events, it can be said that there were no significant differences between the two groups. Anyone doubting what I am saying can view the package inserts for the CDC vaccine schedule and check it out for themselves.

Clinical trials fraught with even more problems and adverse reactions

As Robert F. Kennedy has said on many occasions, we are finally getting to see how the sausage is made, referring to the very public process that the COVID-19 vaccines trials are being subjected to. Seeing and hearing reports along the way is a unique opportunity. Normally vaccine trials are done under a veil of secrecy, outside of public scrutiny and the results are reported in the package inserts after approval and release to market. In the trials so far, there have been multiple instances in adverse reactions and injuries from the vaccines.

According to a **New York Post** article on October 6th, 2020, some participants in the vaccine trials have had significant side effects.

From the article:

“If this proves to work, people are going to have to toughen up,” one of the Moderna participants, a North Carolina woman in her 50s who declined to be identified, told the outlet.

“The first dose is no big deal. And then the second dose will definitely put you down for the day for sure. ... You will need to take a day off after the second dose.”

She said she didn’t experience a fever but had a bad migraine that left her exhausted and struggling to focus, the outlet reported. But the next day, she woke up feeling better after taking Excedrin.

While she was uncomfortable, the side effects outweigh the risks of becoming infected with the virus, she said.

“My hope is that this works but also that the communication [on side effects] is good,” she said, adding that Moderna may need to tell people to take a day off after a second dose.

Meanwhile, a Maryland participant in his 20s said he came down with a high fever after receiving the shot. “I wasn’t sure if I needed to go to the hospital or not because 104 is pretty high,” he told CNBC. “But other than that, it’s been fine.”

Luke Hutchison, a 44-year-old from Utah, also participated in the Moderna trials and felt out of sorts for a couple of days after being administered his first shot on Aug. 18, the outlet reported. But just hours after receiving the second dose on Sept. 15, he became bedridden with shakes, chills, a terrible headache and shortness of breath, the outlet reported. For five hours, his temperature was above 100 degrees.

Hutchinson compared the ordeal — which lasted for 12 hours — to “full-on Covid-like symptoms” on Twitter. “I’m obviously an isolated case, but since all indications point to this vaccine being approved, I feel like people should know that the side effects may be severe, especially after the second shot,” he [wrote](#).

Pfizer trial participants have reported similar symptoms.

One of the participants said he suffered intense flu-like symptoms after his second injection that left him shaking so hard, he cracked part of his tooth.

“It hurt to even just lay in my bedsheet,” he told CNBC.

<https://nypost.com/2020/10/06/covid-19-vaccine-trial-participants-report-aches-fevers-and-chills/>

Other vaccine adverse reactions and long-term concerns

In addition to all the concerns expressed earlier in this article, what other concerns are there?

How many will become casualties of the vaccine? Bill Gates expects 700,000 victims will suffer adverse side effects from COVID-19 Vaccines

In an article published online in Germany reveals what Bill Gates is anticipating with regards to collateral damage from the COVID-19 vaccines. The truth is, based on other attempts at developing coronavirus vaccines and the clinical trials so far, it may be far worse than that.

<https://kenfm.de/bill-gates-predicts-700000-victims-from-corona-vaccination/>

From the article:

In an interview with **CNBC**, Gates says that for one out of every 10,000 people, permanent vaccination damage would occur, and he expects 700,000 victims.

Towards the end of the short CNBC interview Bill Gates says:

“We have ... you know ... one in ten thousand ... ah ... side effects. That’s ... you know ... way more. Seven hundred thousand ... ah ... you know ... people who will suffer from that. So, really understanding the safety at gigantic scale across all age ranges – you know – pregnant, male, female, undernourished and existing comorbidities. It’s very, very hard and that actual decision of ,OK, let’s go and give this vaccine to the entire world’ ... ah ... governments will have to be involved because there will be some risk and indemnification needed before that ... ah ... can be decided on.”

You can see that Gates interview here: https://d33wjekvz3zs1a.cloudfront.net/wp-content/uploads/2020/05/Gates-700000-Dead.mp4?_=1

That is a real problem, because there most certainly will be long-term health consequences to certain people from the vaccine

Autoimmune diseases

A May 2020 publication in the journal *Clinical Immunology* titled, **Potential antigenic cross-reactivity between SARS-CoV-2 and human tissue with a possible link to an increase in autoimmune diseases.** They talk about other instances where vaccines have cause autoimmune disease manifestations. They express concerns that without adequate long-term research on the new COVID-19 vaccine and its propensity to trigger autoimmune disease that we could cause a “monumental cost on humanity in the form of another epidemic, this time a rising tide of increased autoimmune diseases and the years of suffering that come with them.”

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7246018/>

From the study:

“At the moment, scientists are frantically trying to develop either a definitive cure, neutralizing antibodies, or a vaccine to protect us from contracting the disease in the first place, and they want it right now. **We must**

consider that finding a vaccine for a disease may normally take years. There are reasons for all the precautions involved in developing a vaccine, not the least of which are unwanted side-effects. **In light of the information discussed above about the cross-reactivity of the SARS-CoV-2 proteins with human tissues and the possibility of either inducing autoimmunity, exacerbating already unhealthy conditions, or otherwise resulting in unforeseen consequences, it would only be prudent to do more extensive research regarding the autoimmune-inducing capacity of the SARS-CoV-2 antigens. The promotion and implementation of such an aggressive “immune passport” program worldwide in the absence of thorough and meticulous safety studies may exact a monumental cost on humanity in the form of another epidemic, this time a rising tide of increased autoimmune diseases and the years of suffering that come with them.”**

Many prestigious scientists and doctors call for a halt to the approval due to serious safety concerns around immune enhancement, infertility and brain injury

On December 1, 2020, the ex-Pfizer head of respiratory research Dr. Michael Yeadon and the lung specialist and former head of the public health department Dr. Wolfgang Wodarg [filed an application with the EMA](#), the European Medicine Agency responsible for EU-wide drug approval, for the immediate suspension of all SARS CoV 2 vaccine studies, in particular the BioNtech/Pfizer study on BNT162b (EudraCT number 2020-002641-42). Dr. Wodarg and Dr. Yeadon demand that the studies – for the protection of the life and health of the volunteers – should not be continued until a study design is available that is suitable to address the significant safety concerns expressed by an increasing number of renowned scientists against the vaccine and the study design.

On the one hand, the petitioners demand that, due to the known lack of accuracy of the PCR test in a serious study, a so-called Sanger sequencing must be used. This is the only way to make reliable statements on the effectiveness of a vaccine against Covid-19. On the basis of the many different PCR tests of highly varying quality, neither the risk of disease nor a possible vaccine benefit can be determined with the necessary certainty, which is why testing the vaccine on humans is unethical per se.

Furthermore, they demand that it must be excluded, e.g. by means of animal experiments, that risks already known from previous studies, which partly originate from the nature of the corona viruses, can be realized.

The concerns are directed in particular to the following points:

- The formation of so-called “non-neutralizing antibodies” can lead to an exaggerated immune reaction, especially when the test person is confronted with the real, “wild” virus after vaccination. This so-called **antibody-dependent enhancement ADE** (AKA *Adverse Immune Enhancement or Pathogenic Priming*), has long been known from experiments with corona vaccines in cats, for example. In the course of these studies all cats **that initially tolerated the vaccination well died after catching the wild virus.**
- The vaccinations are expected to produce antibodies against spike proteins of SARS-CoV-2. However, **spike proteins also contain syncytin-homologous proteins**, which are essential for the formation of the placenta in mammals such as humans. **It must be absolutely ruled out that a vaccine against SARS-CoV-2 could trigger an immune reaction against syncytin-1, as otherwise infertility of indefinite duration could result in vaccinated women.**

- The mRNA vaccines from BioNTech/Pfizer contain polyethylene glycol (PEG). **70% of people develop antibodies against this substance – this means that many people can develop allergic, potentially fatal reactions to the vaccination.**
- The much too **short duration of the study** does not allow a realistic estimation of the late effects. As in the narcolepsy cases after the swine flu vaccination, **millions of healthy people would be exposed to an unacceptable risk** if an emergency approval were to be granted and the possibility of observing the late effects of the vaccination were to follow. Nevertheless, BioNTech/Pfizer apparently submitted an application for emergency approval on December 1, 2020.

<https://2020news.de/en/dr-wodarg-and-dr-yeardon-request-a-stop-of-all-corona-vaccination-studies-and-call-for-co-signing-the-petition/>

Vaccines in pregnancy

In addition to the fertility concerns discussed above, there are legitimate concerns regarding vaccinating pregnant women. The vaccines frequently cause immune activation and inflammation as they are designed to stimulate (aggravate) the immune system. The common symptoms of redness, swelling, pain, headache and fever after vaccination are a result of immune activation and inflammation. To intentionally induce this puts the fetus at risk. The following article is the latest of dozens of articles published over the last few years that expose this risk. You can view many more on this topic in my eBook found at <https://1200studies.com> .

This recent article published December 23rd, 2020 titled, **Maternal immune activation induces sustained changes in fetal microglia motility**, describes the mechanism of how maternal (mother's) strong immune activation and inflammation increase the risk of developmental and social disorders and schizophrenia. This occurs by increasing inflammation in the cells of the fetal brain's immune system called microglia. This can lead to long lasting alterations in behavior and development, especially in genetically susceptible individuals.

From the study

The above findings showed that maternal inflammation affects the fetal microglia during the embryonic stage, resulting in alterations in microglial process motility that begin at the embryonic stage and remain in the developmental stage, or even the adolescent stage. Moreover, these research results demonstrate the possibility of a connection between changes in microglial process motility and deficits in social behavior that are characteristic of developmental disorders and schizophrenia.

<https://medicalxpress.com/news/2020-12-maternal-immune-sustained-fetal-microglia.html>

Potential for causing neurodegenerative diseases

A January 2021 research article published in *Microbiology and Infectious Diseases* titled, **COVID-19 RNA Based Vaccines and the Risk of Prion Disease**, serious concerns about the mRNA vaccines causing reactions that can lead to the development of ALS (Lou Gehrig's Disease), Alzheimer's and other neurological degenerative diseases. If true, with hundreds of millions of people being vaccinated with these vaccines this could lead to a catastrophic increase in these diseases over the next decade or two.

From the article:

Development of new vaccine technology has been plagued with problems in the past. The current RNA based SARS-CoV-2 vaccines were approved in the US using an emergency order without extensive long term safety testing. In this paper the Pfizer COVID-19 vaccine was evaluated for the potential to induce prion-based disease in vaccine recipients. The RNA sequence of the vaccine as well as the spike protein target interaction were analyzed for the potential to convert intracellular RNA binding proteins TAR DNA binding protein (TDP-43) and Fused in Sarcoma (FUS) into their pathologic prion conformations.

In the current paper the concern is raised that the RNA based COVID vaccines have the potential to cause more disease than the epidemic of COVID-19. This paper focuses on a novel potential adverse event mechanism causing prion disease which could be even more common and debilitating than the viral infection the vaccine is designed to prevent. While this paper focuses on one potential adverse event there are multiple other potential fatal adverse events as discussed below.

The results indicate that the vaccine RNA has specific sequences that may induce TDP-43 and FUS to fold into their pathologic prion confirmations. In the current analysis a total of sixteen UG tandem repeats ($\Psi G \Psi G$) were identified and additional UG (ΨG) rich sequences were identified. Two GG Ψ A sequences were found.

Furthermore, the spike protein, created by the translation of the vaccine RNA, binds angiotensin converting enzyme 2 (ACE2), a zinc containing enzyme. This interaction has the potential to increase intracellular zinc. Zinc ions have been shown to cause the transformation of TDP-43 to its pathologic prion configuration. The folding of TDP-43 and FUS into their pathologic prion confirmations is known to cause ALS, front temporal lobar degeneration, Alzheimer's disease and other neurological degenerative diseases. The enclosed finding as well as additional potential risks leads the author to believe that regulatory approval of the RNA based vaccines for SARS-CoV-2 was premature and that the vaccine may cause much more harm than benefit.

<https://scivisionpub.com/pdfs/covid19-rna-based-vaccines-and-the-risk-of-prion-disease-1503.pdf>

It appears that the spike protein formed from the vaccine can cross into the brain

Much concern regarding these vaccines is how our body's immune system may react to the spike protein from the "vaccine" after being manufactured (copied) by our own cells. An article in the prestigious journal *Nature Neuroscience* December 16th, 2020 titled, **The S1 protein of SARS-CoV-2 crosses the blood-brain barrier in mice** raises some very serious and concerning questions.

First my commentary:

This is the mRNA "vaccine" design.... Once the spike protein from the "vaccine" is taken up by our cells and then duplicated or manufactured inside our cells by our cell machinery, it is expressed to the surface of the cell and starts a chain reaction within our immune system. The main goal is to force our immune system to make antibodies to the spike protein. But it also causes our immune system to mount an attack on that cell thinking it is infected with the virus itself. When Killer T-cells and other immune cells destroy the spike protein making factory (our cell), a large amount of spike proteins and protein fragments are released. This is where things can really go wrong as supported by this study. As it shows (although it is a mouse model), these spike proteins and even fragments of the spike protein can cross into the brain where the brain's immune system called microglia would have to mount an attack against these foreign proteins. When that happens,

inflammation inside the brain increases as does oxidative stress. This can lead to adverse effects on the health and well-being of the brain and potentially contribute to neurodegenerative diseases of the brain.

From the study:

“The results from this study show that I-S1 (*injected S1 segment of the spike protein*) from two different commercial sources readily crosses the mouse BBB (*Blood Brain Barrier*), at least when injected intravenously. I-S1 was taken up by all 11 brain regions examined. Such widespread entry into brain of I-S1 could explain the diverse effects of S1 and/or SARS-CoV-2 such as encephalitis, respiratory difficulties and anosmia (*loss of smell*). S1 is the SARS-CoV-2 protein that initially binds to cell-surface receptors, setting the stage for viral internalization”.

“For transport across the BBB, viral binding proteins often behave similarly to the virus itself. For example, interactions (including binding and transport) between the HIV-1 glycoprotein gp120 and the BBB are similar to those for the complete virus. Additionally, many if not most viral proteins themselves can be biologically highly active; for example, gp120 is highly toxic. Coronavirus spike proteins are often cleaved from the virus by host cell proteases. Once cleaved, coronavirus spike S1 and S2 subunits are not held covalently by disulfide bonds and so S1 could be shed from virions. It is possible that during infection by SARS-CoV-2, shed S1 is available to cross the BBB, triggering responses in the brain itself, without necessarily involving crossing of intact virus particles. Thus, determining whether S1 crosses the BBB is important for understanding whether SARS-CoV-2 and S1 itself could induce responses in the brain”.

<https://www.nature.com/articles/s41593-020-00771-8>

Spike protein introduced into and replicated by our cells from the mRNA vaccines are released into circulation when those cells are later destroyed by our immune system may cause widespread damage

Dr. J. Patrick Whelan M.D., PhD, with degrees in medicine, biochemistry and rheumatology warned the FDA in December that mRNA vaccines could cause microvascular injury to the brain, heart, liver and kidneys in ways not assessed in safety trials. That warning was ignored by the FDA.

This is from an article by Lyn Redwood of Children’s Health Defense in a February 10th, 2021 article that she wrote titled, **Could Spike Protein in Moderna, Pfizer Vaccines Cause Blood Clots, Brain Inflammation and Heart Attacks?**

From the article:

“The most likely culprit that has been identified is the COVID-19 spike protein released from the outer shell of the virus into circulation. Research cited below has documented that the viral spike protein is able to initiate a cascade of events that triggers damage to distant organs in COVID-19 patients.”

“Worryingly, several studies have found that the spike proteins alone have the capacity to cause widespread injury throughout the body, without any evidence of virus.”

“What makes this finding so disturbing is that the COVID-19 mRNA vaccines manufactured by Moderna and Pfizer and currently being administered throughout the U.S. program our cells to manufacture this same coronavirus spike protein as a way to trigger our bodies to produce antibodies to the virus. According to Whelan’s letter to the FDA, the “Pfizer/BioNTech vaccine is composed of an mRNA that produces a membrane-anchored full-length spike protein.””

To read the full article with links to references go here:

<https://childrenshealthdefense.org/defender/moderna-pfizer-vaccines-blood-clots-brain-inflammation-heart-attacks/>

Erasing the placebo group

One of the tactics vaccine manufacturers use in their clinical trials is to vaccinate all the subjects in the control or placebo arm as soon as their short 30-day or 60-day follow-up period is complete. And this is one that they are planning on using with the COVID-19 vaccine candidates. That may not be so unscrupulous if the safety studies lasted for 5 years or more like required by the FDA for most drugs. But what about when the subjects are only followed for 4- and 5-days post injection as with the two Hepatitis B vaccines Recombivax HB and Energerix B? What about when the subjects are only followed 60 days like with Varivax chicken pox vaccine? They’ve done the same thing with the HPV vaccine Gardasil and many others. And now, they are going to do it with the COVID-19 vaccines.

Now why in the world would they do that? They say it would be “unethical” not to vaccinate the control group. Is that the real reason, or is it the fact that nobody will ever be able to look at the health problems they develop 5, 10 or 20 years down the road and compare them to the vaccinated subjects? How many of each group developed cancer, autoimmune disorders, infertility, neurological disorders, allergies, mental and emotional conditions, etc.? If it would have been significantly less in the placebo group, no one will ever know. They conveniently eliminate or erase the control group for any future comparison or scrutiny.

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>

There are four potential COVID-19 vaccines that are currently in Phase III clinical trials in the United States. The clinical trials for three of these experimental vaccines – the ones to be sold by AstraZeneca, Moderna, and Johnson & Johnson – are being overseen by a DSMB created by Dr. Fauci’s National Institute of Allergy and Infectious Diseases (the **NIAID DSMB**). The clinical trial for Pfizer’s experimental vaccine is being overseen by a different DSMB (the **Pfizer DSMB**).

The members of these DSMBs were selected in secret. They meet in secret. Their identities are supposed to remain a secret. This veil of secrecy has held with the exception of two members. The identity of the

chairperson of the NIAID DSMB, Dr. Richard Whitley, was [mistakenly revealed](#) by his university in an announcement that has been scrubbed from its website. As for the Pfizer DSMB, made up of five individuals, one of its members, Dr. Kathryn Edwards, was apparently [mistakenly revealed](#) in a CBS article.

Selecting these individuals could only occur by turning a blind eye to their extremely troubling and blatant conflicts with pharmaceutical companies. For example, ICAN's investigation has revealed that one or both of these two doctors have been, among other things, consultants for Gilead Science, AstraZeneca, GlaxoSmithKline, Merck, Sanofi, Sequirus, La Roche, Allergan, Moderna, and Novartis; advisors to Merck, Bionet, GSK, and Pfizer; paid speakers for Connaught, Lederle-Praxis, Wyeth Lederle, Glaxo, and Novartis; paid millions of dollars from these companies; and, on the tab of these companies, wined-and-dined to hundreds of meals and taken dozens of trips to exotic destinations. Meaning, they have had duties to these companies as consultants and advisors, have been personally financially supported by them, and have been their mouthpieces to the public.

Only those wearing blinders could give Dr. Whitley and Dr. Edwards the label "independent." To head the "independent" DSMB, Dr. Fauci could have selected from a sea of potential scientists, many of whom have never consulted for a pharmaceutical company, were never on a pharmaceutical company speakers' bureau, and have not had hundreds of meals and dozens of exotic trips paid for by pharmaceutical companies. Instead he chose Dr. Whitley as its head. Dr. Fauci makes a mockery of the term "independent" and calls into serious question his judgment and objectivity.

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. This letter lays out in detail: the conflicts of interest that Dr. Whitley and Dr. Edwards have with pharmaceutical companies; the litany of lies told by Dr. Fauci and other public health officials regarding the supposed independence of the DSMBs; and demands that they **"remove any member of the NIAID DSMB, including Dr. Whitley, who has ever been a consultant, has been on a speakers' bureau, or has had meals or travel paid for by any pharmaceutical company."**

You can read the full demand letter [here](#).

In a response from the **FDA**, the **Informed Consent Action Network (ICAN)** says that they have declined to make any changes to the people overseeing the process, despite their conflicts of interest.

From an **ICAN Legal Update** dated November 30th, 2020...

The Director of the FDA's Center for Biologics Evaluation and Research, Dr. Peter Marks, has now responded in a letter that fails to address any of these conflicts, conceding the existence of these conflicts. It also fails to provide any vow that the FDA will replace these individuals with those that are actually independent of pharmaceutical companies. This response should send shivers down the spine of anyone considering the process by which the safety and efficacy of any COVID-19 vaccine will be evaluated.

People with religious convictions need to know that certain COVID-19 vaccines may be contaminated with DNA from aborted fetuses

Here is some background on the ethical questions surrounding the use of vaccines that contain DNA from aborted babies.

As of June 2020, thirty-three of the FDA approved vaccines on the market contain DNA fragments from various cell lines originating from aborted fetuses, where the virus is grown in the cell cultures derived from the tissues of those fetuses. Several of the COVID-19 vaccines in production also contain fetal cell lines. To see a list of all the vaccines that contain DNA from aborted fetuses and ethical alternatives, see this PDF:

<https://cogforlife.org/wp-content/uploads/vaccineListOrigFormat.pdf>

And we are not talking about insignificant numbers of this human DNA in vaccines. In vaccines, 100,000,000 (yes one hundred million) bits and strands of human DNA are allowed per dose.

As a person with very strong Christian faith and conviction, I feel that the human DNA from aborted fetal cell lines used in the MMR and many of the other vaccines, violate the sanctity of human life. I believe that human life begins at conception and the science is incontrovertible on that. Abortion is clearly the termination of a human life. As such, I am strongly opposed to abortion and the sale of aborted babies or their body parts. This would most certainly be an abomination in God's eyes. And horrifically, in many cases these babies were intentionally delivered alive before being killed for their tissues. And for each baby used, there were dozens of ones that were not used as they did not make a good match for what the "scientists" were looking for.

In addition to all of that, I believe that my body is the Temple of the Holy Spirit. Vaccines contain many other ingredients in addition to the residual human DNA from the aborted babies that are in direct conflict with the way I have chosen to honor my body as Scripture makes clear we should.

In addition to the obvious reason for a person of faith to decline having that DNA injected into their body, there is also concern among many scientists that these DNA fragments can combine with the recipient's DNA in a process called homologous recombination and that the resultant inflammatory reaction may lead to autoimmune responses and other downstream effects of the alteration of the recipient's DNA including triggering inflammation in the brain leading to regressive autism in genetically susceptible children. There is such evidence showing that when human DNA was incorporated into vaccines, there was a significant uptick in the rate of autism. This sharp increase became referred to as a "hockey stick" appearance.

A 2014 article published in the **Journal of Public Health and Epidemiology** titled, **Impact of environmental factors on the prevalence of autistic disorder after 1979**, produces convincing evidence of the effects of human fetal cell lines on the "change point" where the incidence of autism rose sharply in the late 1980s.

<https://academicjournals.org/journal/JPHE/article-full-text-pdf/C98151247042>

One explanation as to why boys are affected with autism implicates human DNA found in vaccines comes from an article from the **Journal Immunotoxicology** published in 2011 and titled, **Theoretical Aspects of Autism**. The article clearly shows that it's not just the mercury that puts children at risk from vaccines. There is human DNA and retroviruses found in childhood vaccines. This article discusses many plausible explanations for the rise in autism as a result of various vaccine related factors, including this quote: "The human DNA from the vaccine can be randomly inserted into the recipient's genes by homologous recombination, a process that occurs spontaneously only within a species. Hot spots for DNA insertion are found on the X chromosome in

eight autism-associated genes involved in nerve cell synapse formation, central nervous system development, and mitochondrial function (Deisher, 2010). This could provide some explanation of why autism is predominantly a disease of boys. Taken together, these data support the hypothesis that residual human DNA in some vaccines might cause autism.” <http://www.tandfonline.com/doi/full/10.3109/1547691X.2010.545086>

Dr. Theresa Deisher has been a very vocal critic of the use of fetal cell lines that contaminate vaccines with human DNA. Dr. Deisher is highly qualified to make speak to this issue. She obtained her PhD in Molecular and Cellular Physiology from Stanford University and has spent over 20 years in commercial biotechnology and an inventor on 23 issued US patents in the biotechnology field. <https://www.soundchoice.org/>

It is crucial that we fight for the right to oppose vaccines based on religious exemptions. This is under attack all around the country. It is a right based on medical freedom that we can't allow to be taken away from us.

For more extensive information on these cell lines, the vaccines containing them and contaminated with fetal DNA, and the potential health risks associated with them download my eBook **1200 Studies- Truth Will Prevail** at <https://1200studies.com>

The leading vaccines that have been verified to involve the use of aborted fetal tissue are the following:

- Moderna/NIAID
- Johnson & Johnson
- AstraZeneca/Oxford
- Pfizer/BionTech (used HEK-293 cells in testing, but not in the product)

See details on these and all other COVID-19 vaccines here: <https://cogforlife.org/wp-content/uploads/CovidCompareMorallmmoral.pdf>

You can find more information about the bioethics of aborted fetal tissue and medical products at ***Children of God for Life (COG)***- <https://cogforlife.org/>

Their web site describes them as ***“The Pro-Life World Leader in the Campaign for Ethical Vaccines, Medicines and Consumer Products”***.

Victims of vaccine injury will not be compensated as makers will be free of liability in most if not all countries including the U.S. You're on your own.

This is just like childhood vaccine manufacturers are exempt from product liability and injuries they cause. This is thanks to the 1986 ***National Childhood Vaccine Injury Act (NCVIA)***. This has been a disaster, because it has prevented families from being justly compensated for egregious vaccine reaction injuries, including permanent disability and death. They put in place the ***National Vaccine Injury Compensation Program (NVICP)***, but the difficulty the process presents and the extreme limitations it puts on awards, makes it unfair and unjust. Not only that, but vaccine manufacturers have become emboldened since 1986 to cut corners in their safety studies and bring vaccines to market without adequate testing. The fact that not a single vaccine on the CDC Childhood immunization schedule has ever been tested against a saline (inert) placebo in the control group tells you all you need to know. You can look at any vaccine package insert and verify that this is true.

The COVID-19 vaccines will provide a liability free environment for vaccine manufacturers as well. The liability free environment in the U.S. will be provided by the 2005 **P.R.E.P Act**.

This description off of the **U.S. Department of Health and Human Services** web site says it all.

*“The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the Secretary of the Department of Health and Human Services (Secretary) to issue a declaration (PREP Act declaration) **that provides immunity from liability (except for willful misconduct) for claims of loss caused, arising out of, relating to, or resulting from administration or use of countermeasures to diseases, threats and conditions determined by the Secretary to constitute a present, or credible risk of a future public health emergency to entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of such countermeasures. A PREP Act declaration is specifically for the purpose of providing immunity from liability, and is different from, and not dependent on, other emergency declarations.**”*

<https://www.phe.gov/Preparedness/legal/prepact/Pages/default.aspx>

In other countries, drug makers are creating similar protection agreements as they move toward a rollout of their vaccines.

Who really “needs” the vaccine? As of the time of this writing, the vaccine manufacturers are losing market share FAST and this is why.

What would that mean to the “success” of the investment made by our government in the development of COVID-19 vaccines and Operation Warp Speed? Will it be pushed on the American public because it has become too big to fail? How will that impact our individual rights and sovereignty of our own bodies? These are all questions that we the people need to ponder BEFORE they lose these freedoms that we all hold dear to us. As we are told that everyone” needs the new vaccines, what is the TRUTH?

The first truth is, that as of mid-February, there have been over 28 million confirmed cases. Based on the CDC’s formula for estimating the total number of people that have had the infection of 8 times confirmed cases (includes asymptomatic and mild cases never tested), that number is around approximately 224 million Americans. That is about 67% of the population!

That 8X ratio is according to an article posted online November 27th titled “The CDC researchers estimated that about 52.9 million Americans had been infected in the US by the end of September”. The number of confirmed COVID-19 cases was only 6.9 million up to that time. That is about an 8 to 1 ratio of those that have it and either don’t know it or have very mild symptoms and never get a test to those that do test positive. (PCR testing inaccuracy as we have seen is a whole other issue!)

<https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1780/6000389>

And at the fever pitch rate that new cases are being reported (pun intended), some estimates are that we will reach herd immunity even without the vaccines in the next few weeks. Every day that goes by more lost market share for the vaccines and their shareholders.

And here is why. Even if you have had COVID-19, the official narrative is that you should still get your vaccine shots. After all, our government and pharma have collaborated on producing billions of doses of these vaccines. And again, I am not telling you not to. BUT the science shows that immunity develops after infection and the immune response is lasting. While some studies are showing that antibody levels drop a certain percentage in the weeks and months after infection, THIS IS NORMAL! And everyone that has studied

immunology knows this. Once the threat is gone, the immune system doesn't maintain a level of "red alert". Antibody levels drop, but memory cells remain inactive. Then once the virus shows up again, they jump into action and crank out antibodies against the virus. And, because of the "maturing" of those cells the response is more robust than even during the first infection. In addition to the antibody response, the T-Cell response also has been shown to last for many years from previous coronavirus infections including SARS-CoV-1. There is no reason to believe that the same won't be true with SARS-CoV-2. And lastly, because natural immunity is always more lasting and effective against the wild virus because it covers the whole virus not just a small section like the spike protein, it will always be superior. If the mutations we are seeing in various corners of the world and those to come affect the spike protein, the vaccines will be even less effective than natural immunity.

The second truth is that young people can develop better immunity from contracting the virus and producing their own natural antibodies and t-cell immunity from the wild virus. The younger the individual, the more robust their Innate Immune response, which acts as the first line of defense against viral pathogens and consists of Cytotoxic T-Cells, Natural Killer Cells, lymphocytes, neutrophils, macrophages and other key players. That is a huge part of the reason most young people are barely affected by the virus.

Young people age 0-19 have a 99.997% survival rate. People 20-49 have a 99.98% survival rate. And even people age 50-69 have a 99.5% survival rate.

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

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>

Co-morbidities are a major consideration in addition to age

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

This is undoubtedly one of the key reasons why COVID-19 has hit countries like the U.S., that have high rates of chronic disease harder. The average person that has died from COVID-19 has 2.6 comorbidities per CDC.

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:

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>

See the table next page...

Consider this table showing of how low risk this disease is for 99.99% of young people...

10/5/20 update on C19 among students on campus since August, from 50 U.S. universities: Despite ~70,000 "+ C19 tests" near absence of reported C19 hospitalizations, & zero reported deaths*

University	Reported C19+, "Cases" (N)*	Reported Hospitalizations (N)**	Reported C19 Deaths (N)***
(1) U of Alabama sys	2861	0	0
(2) U of Georgia	3363	0	0
(3) U of Kentucky	2005	0	0
(4) Ohio State U	2987	0	0
(5) U of Dayton	1284	0	0
(6) Miami U of OH	1614	0	0
(7) Illinois State U	1358	0	0
(8) U of Iowa	2005	0	0
(9) Missouri State U	1017	0	0
(10) U of Kansas	1000	0	0
(11) Kansas State U	811	0	0
(12) Penn State U	2426	0	0
(13) U of Wisconsin	2967	1	0
(14) U of Miami	474	0	0
(15) U of S Carolina	2367	0	0
(16) U of Arizona	2338	0	0
(17) Notre Dame U	752	0	0
(18) Temple University	488	0	0
(19) James Madison U	1522	0	0
(20) Texas Tech U	1544	0	0
(21) U of Texas	1015	0	0
(22) Texas Christian U	1161	0	0
(23) Texas A & M U (incl staff)	1613	0	0
(24) U of Illinois	2566	1	0
(25) Iowa State U	1078	0	0
(26) East Carolina U	1240	0	0
(27) U of N Carolina	1146	0	0
(28) N Carolina State U	1089	0	0
(29) Auburn U	1938	0	0
(30) Arizona State U	1852	0	0
(31) San Diego State U	1106	1	0
(32) Ball State U	1015	0	0
(33) U of N. Dakota	771	0	0
(34) U of Cent Florida	1074	0	0
(35) U of Florida	853	0	0
(36) Oklahoma State U	1158	0	0
(37) SUNY-Oneonta	703	0	0
(38) U of Missouri	1630	0	0
(39) SUNY-Buffalo	444	0	0
(40) U of Michigan	573	0	0
(41) Michigan St (incl staff)	1395	0	0
(42) U of Nebraska (incl staff)	826	0	0
(43) U of Tenn sys	779	0	0
(44) Florida St U	1448	0	0
(45) Indiana U (incl staff)	1719	0	0
(46) U of Arkansas (incl staff)	1611	0	0
(47) Louisiana St U	947	0	0
(48) U of Louisville	543	0	0
(49) Arkansas St U (incl staff)	540	0	0
(50) Liberty U	428	0	0
Totals (N)	69,444	3**	0

Out of 69,444 cases of college students and staff, there were only 3 hospitalizations and ZERO deaths! Instead many schools freak when a few cases are reported, threatening shutdowns, quarantines and remote learning. This is completely insane! This is a great example of why we should not be myopic on "cases". Rather, we need to focus on hospitalizations, ICU bed availability and deaths.

And these were college age students and staff of various ages. As mentioned above, the group younger than these people are at even lower risk from COVID-19. Even so, I'm sure the pressure will be on to vaccinate all of these extremely low-risk age groups based on the "do it for the greater good" flawed premise.

The third truth is, that several studies have shown that 30-40% of the population have T-Cell immunity from previous coronavirus infections. There are 4 human coronaviruses that make up about 15-20% of the “common colds” people get. Since they are a very similar cousin to SARS-CoV-2, people that have developed T-cell and Memory B-Cell immunity to those, exhibit a cross-reactivity to the SARS-CoV-2 virus. Cytotoxic T-cells and the Innate Arm of the immune system are almost never discussed yet play a powerful role in immune protection. There are several articles that could be cited, but here is a good one that also shows that the immunity should be long-term:

<https://www.sciencemag.org/news/2020/05/t-cells-found-covid-19-patients-bode-well-long-term-immunity?#>

Even more lost market share! The bottom line is, from a logical and scientific perspective only a small certain percentage of people if any should be recommended these experimental vaccines, as more questions are being raised daily about their safety and efficacy. But do you think pharma or their agents will limit their “marketing” to the groups that are the exceptions to those I’ve listed above? I don’t know about you, but at this point I haven’t heard any mention about any Americans that they don’t feel require the vaccine. Just the full-court-press. Not surprising. One thing for certain, the only way they had a shot at selling these vaccines was a “warp speed” approach and masking, social distancing and lockdowns to try to slow the spread through the healthy population. Brilliant strategy if you think about it.

Elderly people are at risk

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>

Each person should have the right to decide if they want to assume the risk of the illness or the risks of the vaccine. But certainly, healthy people without health co-morbidities from all those age groups are low risk from COVID-19. How many will choose the vaccines? Once again, more lost market share.

Conflicts of interest and personal financial gain drive decision making for vaccine development

The Informed Consent Action Network can now officially confirm that officials within the **National Institute of Health (NIH)** who are working to develop a vaccine for novel coronavirus (COVID-19), stand to personally earn millions of dollars from sales of this vaccine. The following is from one of their recent Legal Updates.

When government officials will profit from the sale of a product, there is cause for concern regarding their licensure and promotion of that product.

The first vaccine for COVID-19 to begin trials in the United States is [mRNA-1273](#). This experimental vaccine was developed by Dr. Anthony Fauci's **National Institute of Allergy and Infectious Disease (NIAID)**, which is part of the **NIH**, along with a biotech company, Moderna Inc., the company that will sell this product to the public.

To receive a share of the profit from the sale of mRNA-1273, the inventors of this product within NIAID would submit an [Employee Invention Report](#) to the NIH Office of Technology Transfer. Each inventor stands to receive a personal payment of up to [\\$150k annually](#) from the sales of mRNA-1273. NIAID also stands to earn [millions of dollars](#) in revenue from the sale of mRNA-1273 in addition to what its inventors within NIAID earn personally.

Moderna will pay a license fee to NIAID (or its parent agency) to use its patents related to mRNA-1273 and a portion of those fees are then paid directly to the [inventors](#) within NIAID who developed those patents. There are [two patents](#) for which the following six individuals in NIAID appear to be listed as inventors which relate to development of mRNA-1273:

- Barney Graham, Deputy Director, NIAID Vaccine Research Center
- Kizzmekia Shanta Corbett, Scientific Lead, NIAID's Coronavirus Vaccine Program
- Michael Gordon Joyce, NIAID
- Hadi Yassine, NIAID
- Masaru Kanekiyo, NIAID
- Olubukola Abiona, NIAID

To confirm these findings, ICAN had its legal team, headed by Aaron Siri, obtain directly from NIH copies of the Employee Invention Reports submitted by NIAID officials with regard to the COVID-19 vaccine. NIH has now produced those [reports](#) which confirm that the above individuals are indeed listed as inventors. Hence, these individuals within Dr. Fauci's NIAID, and their [heirs](#), will each potentially earn millions of dollars personally from sales of mRNA-1273 over the next twenty years. NIAID also stands to earn millions annually from the sale of this vaccine.

Given the potentially significant personal financial interests of individuals within NIAID, it may not be surprising that NIAID used taxpayer dollars to sponsor, assume responsibility for, and perform the first [clinical trial](#) of this vaccine. There is a clear conflict in having NIAID, whose employees stand to potentially earn millions of dollars from this vaccine, overseeing and conducting the clinical trial for mRNA-1273. This clinical trial information is what NIAID's sister agency, the FDA, will then rely upon to license the mRNA-1732 for public use.

NIAID's parent department, HHS, has also awarded [\\$483 million](#) to accelerate development of mRNA-1273, including to "fund the development of mRNA-1273 to FDA licensure and manufacturing process scale-up to enable large-scale production in 2020 [before licensure is granted]." The U.S. Government has also already reached a [\\$1.5 billion](#) deal to purchase 100 million doses of mRNA-1273. HHS has even granted those developing and selling this product, including NIAID and Moderna, [broad immunity](#) from liability for injuries caused by this product.

Dr. Fauci has been tirelessly promoting the mRNA-1273 vaccine that will potentially make individuals in his agency millionaires and will drive millions more dollars into his agency. It should not be permissible that the

federal department responsible for testing and licensing a product would include individuals who stand to earn millions of dollars from selling that product. It creates conflicts of interest that can cloud the vision of the most clear-eyed individuals.

Now that the vaccines have been rolled out to elderly and long-term care facilities, unusually high rates of deaths are being reported in elderly nursing home residents after they receive the shots

As of mid-February, reports from all over the globe have been coming in that are raising serious cause for concern over the elderly and frail getting the COVID-19 vaccines.

A CNA whistleblower from a nursing facility posted a video of himself expressing concerns over what he was seeing. The video went viral in a short amount of time before being censored and taken down. It is still being shared on various alternative platforms and by individuals. The story on this particular site is titled, **CNA Nursing Home Whistleblower: Seniors Are DYING LIKE FLIES After COVID Injections! SPEAK OUT!!!**

From the article:

James (he gives his last name in the video) is a CNA (Certified Nursing Assistant), and he recorded this video as a whistleblower because he could not keep silent any longer.

James reports that in 2020 **very few residents in the nursing home where he works got sick with COVID, and none of them died during the entire year of 2020.**

However, shortly after administering the Pfizer experimental mRNA injections, 14 died within two weeks, and he reports that many others are near death.

The video is long (47 minutes), and it is clear that James is suffering from emotional stress, and he admits that he has nothing to gain from going public, and that he will probably lose his job for doing so. But he makes it very clear that these were patients he knew and cared for (he is also a “lay pastor”), and that after being injected with the mRNA shot, residents who used to walk on their own can no longer walk. Residents who used to carry on an intelligent conversation with him could no longer talk. And now they are dying. “They’re dropping like flies.”

His superiors are explaining the deaths as being caused by a COVID19 “super-spreader.” However, the residents who refused to take the injections, are not sick, according to James.

James makes it very clear that as a Christian, he cannot live with his conscience anymore, and that he can no longer remain silent. He is not anti-vaccine, but just sharing what he knows is true, regarding the people he has cared for in his profession for over 10 years now.

<https://medicalkidnap.com/2021/01/26/cna-nursing-home-whistleblower-seniors-are-dying-like-flies-after-covid-injections-speak-out/>

Once you read the article and watch the video if you choose, scroll down on that same web page and view many other stories coming in from different countries.

Norway halts vaccine rollout in the elderly due to deaths after vaccines

A January 16th article on Bloomberg.com titled [Norway Raises Concern Over Vaccine Jabs for the Elderly](https://www.bloomberg.com/news/articles/2021-01-16/norway-vaccine-fatalities-among-people-75-and-older-rise-to-29), reports on the increased deaths in the elderly and frail after the Pfizer shots.

From the article:

Until Friday, the vaccine produced by Pfizer and BioNTech SE was the only one available in Norway, and “all deaths are thus linked to this vaccine,” the Norwegian Medicines Agency said in a written response to Bloomberg on Saturday.

“There are 13 deaths that have been assessed, and we are aware of another 16 deaths that are currently being assessed,” the agency said. All the reported deaths related to “elderly people with serious basic disorders,” it said. “Most people have experienced the expected side effects of the vaccine, such as nausea and vomiting, fever, local reactions at the injection site, and worsening of their underlying condition.”

The findings have prompted Norway to suggest that Covid-19 vaccines may be too risky for the very old and terminally ill, the most cautious statement yet from a European health authority.

The Norwegian Institute of Public Health judges that “for those with the most severe frailty, even relatively mild vaccine side effects can have serious consequences. For those who have a very short remaining life span anyway, the benefit of the vaccine may be marginal or irrelevant.”

<https://www.bloomberg.com/news/articles/2021-01-16/norway-vaccine-fatalities-among-people-75-and-older-rise-to-29>

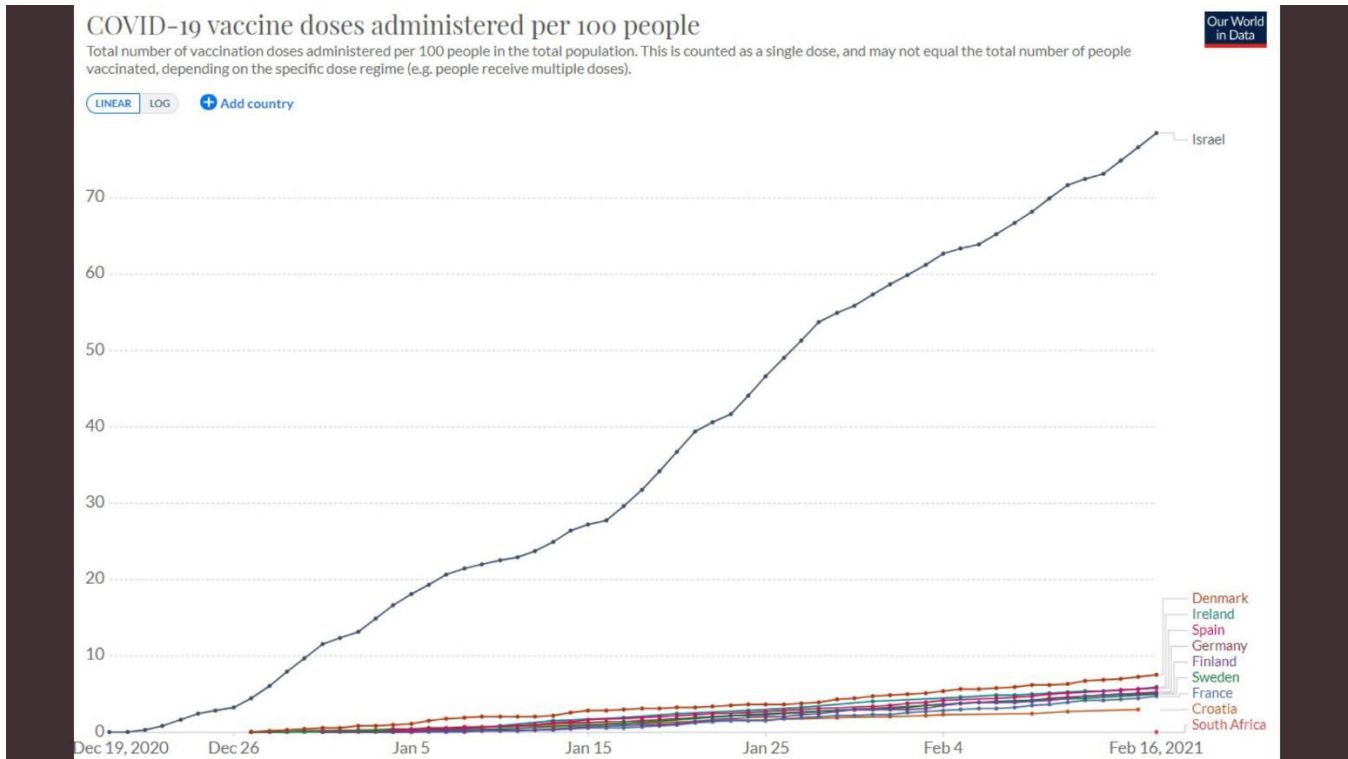
Spain halts vaccine in nursing home after 46 residents die shortly after the first Pfizer shot

Considering that the total population of the nursing home was only 145, this is an extremely high number. The residents were vaccinated in early January. In mid-February it was reported that another 28 residents and 12 staff members have tested positive for COVID-19.

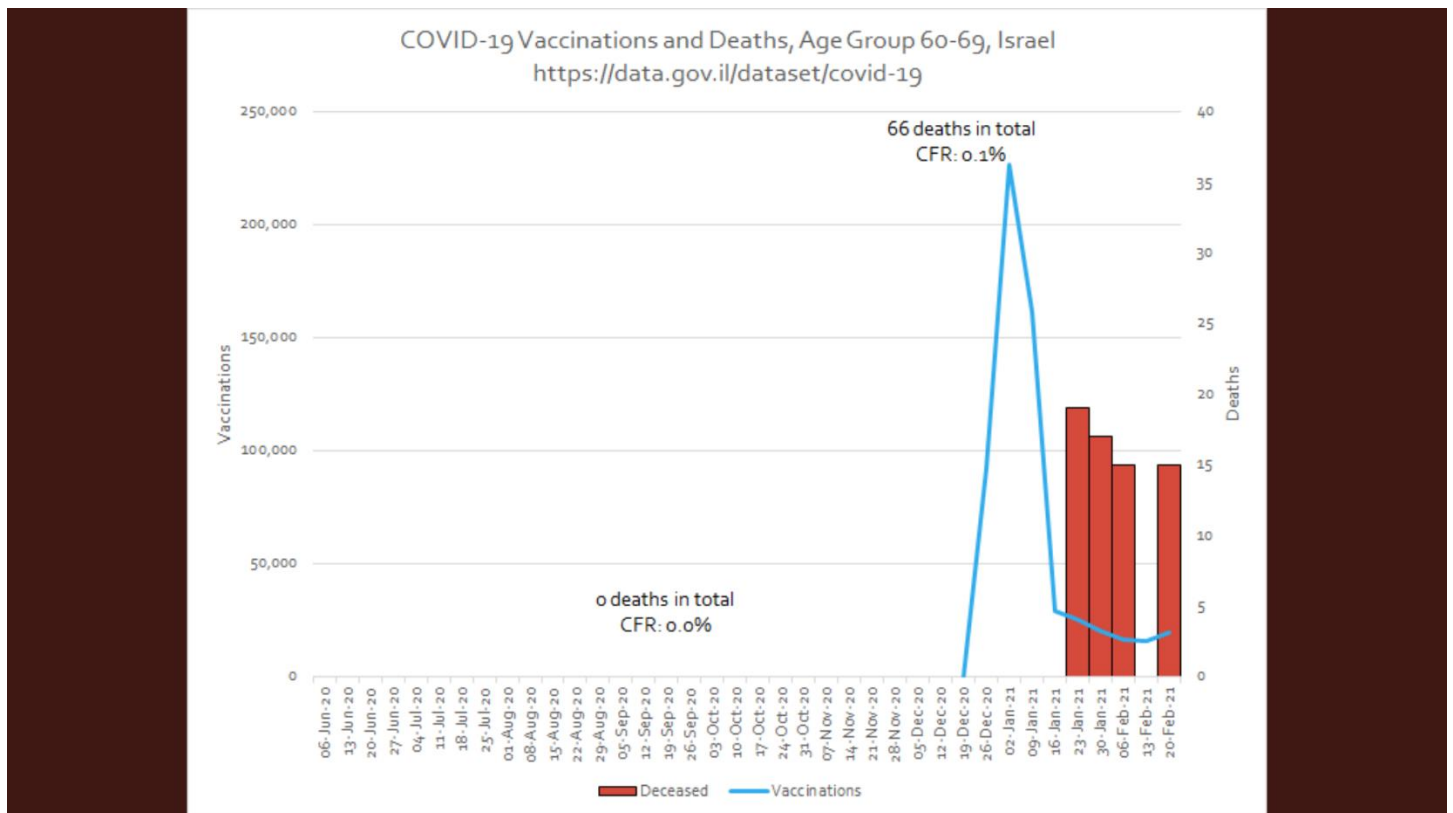
<https://europe.renaissance.com/2021/02/19/spain-second-pfizer-shots-halted-after-46-nursing-home-residents-die-after-the-first-shot/>

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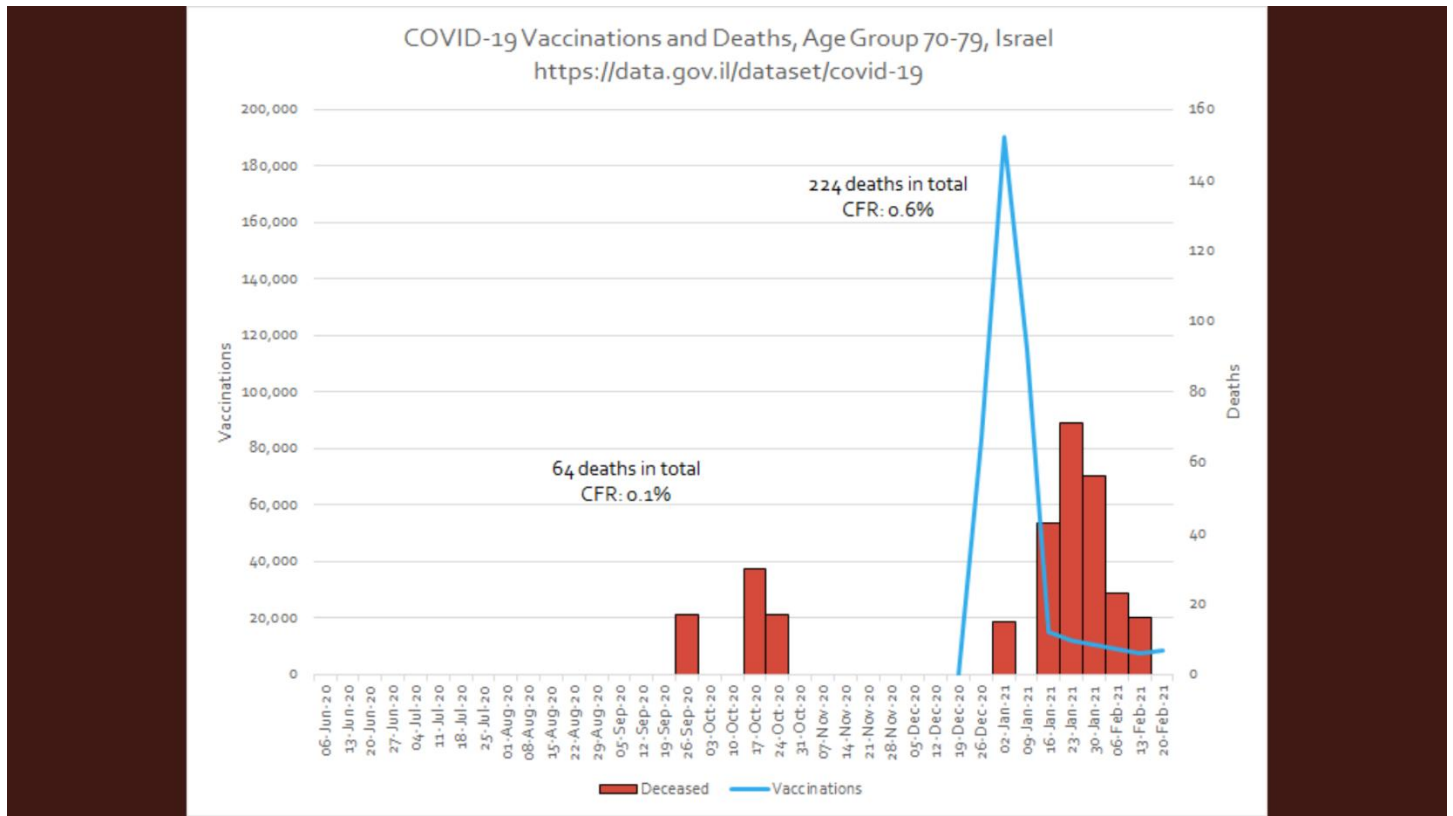
Israel has the highest rate of COVID-19 vaccine distribution in the world, but it seems to correlate with a large increase in deaths in their elderly



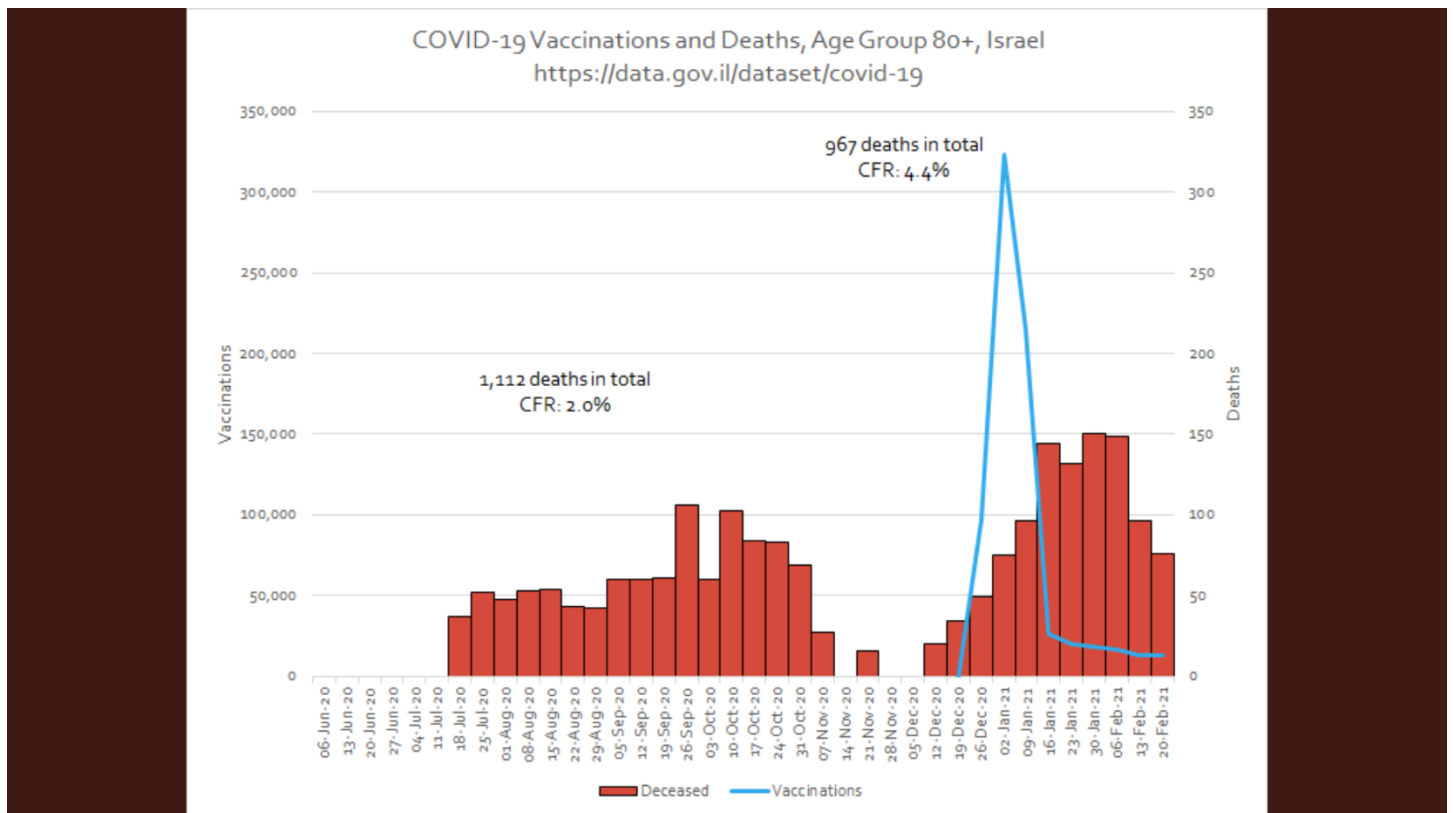
Deaths in the 60 to 69 year-old age group- Vaccination campaign is the blue line



Deaths in the 70 to 79 year-old age group- Vaccination campaign is the blue line



Deaths in the 80+ year-old age group- Vaccination campaign is the blue line



The big question is, does the large increase in deaths relate to various side effects from the vaccines that aren't tolerated by the frail and elderly, or is it the Antibody Dependent Enhancement (AKA Pathogenic Priming) scenario that so many of the world's health experts were warning about as described earlier in this paper. Either way, if you extrapolate these findings on a much larger scale in a country like the United States who are lagging far behind Israel in vaccination coverage, it should sent up major red flags that would call for further investigation before we see potentially catastrophic results here with our elderly population.

Status of Vaccine Adverse Event Reporting System (VAERS) reported injuries and deaths from COVID-19 vaccines

As of February 12th, 2021, there have been 15,923 reports of injuries and 929 deaths reported to the **Vaccine Adverse Event Reporting System (VAERS)**. <https://www.openvaers.com/covid-data>

VAERS is a PASSIVE reporting system, meaning that vaccine reactions are not required to be reported. It is completely voluntary and the person that has received the vaccine would have to know that it even exists and if they do how to report. This presents a problem of extreme under-reporting as verified by a U.S. government funded **Harvard Pilgrim Health** study that determined that less than 1% of all adverse vaccine reactions are reported to VAERS. <https://www.ncbi.nlm.nih.gov/pubmed/?term=26060294>. As of today, I have not seen a single Public Service Announcement (PSA) telling people about VAERS and that they should report any side effects from the shots. That sounds like common sense, but of course would raise concerns in the minds of the public about the possibility of adverse reactions and conflict with the public narrative. After all, they have been told ad nauseum that they are safe.

The technology for tracking vaccine recipients and monitoring their biological processes is ready for implementation

In a revealing article on Mercola.com, Whitney Webb an investigative journalist discusses the Sci-Fi reality that the biotech industries and globalists have for the human population. I'm going to devote a bit of content space to this article because it is very alarming. The rest of the article can be found here.

<https://articles.mercola.com/sites/articles/archive/2020/11/01/operation-warp-speed.aspx>

From the article:

In this interview, investigative journalist **Whitney Webb**, who does both independent work and collaborations with **The Last American Vagabond**, discusses the little-known details of **Operation Warp Speed**, a joint operation between **U.S. Health and Human Services (HHS)** and the **Department of Defense** to produce a fast-tracked COVID-19 vaccine and other therapeutics.

As you may have noticed by now, **Google, YouTube, Facebook, Twitter** and a host of other platforms are censoring information relating to COVID-19 in general and vaccine information in particular. Many commentators who touch on these issues have been deplatformed altogether, so information on these crucial topics are getting harder to come by.

“We're at a point where the line between Silicon Valley and the national security state has become so blurred, you really can't distinguish where one begins and where the other ends,” Webb says. This in large part helps explain how and why big tech is getting away with such blatant censorship as deplatforming of individuals who discuss issues the mainstream media refuse to touch.

“You can definitely make the argument that it's state censorship to a degree,” she says. “I think it's quite telling that a lot of these companies, from the very beginning of their existence, had some sort of funding from U.S. intelligence.”

Operation Warp Speed

As noted by Webb, you'd expect Operation Warp Speed, being a government program, to be governed by some federal regulatory agency like the Food and Drug Administration or the Centers for Disease Control and Prevention, or even the HHS, but no. It's almost entirely funded and operated by the CIA and the U.S. military. Webb explains:

“When Operation Warp Speed was announced ... it was essentially sold to the public as a joint operation between HHS and the Department of Defense. So, the military was involved from the beginning. But oddly enough, last month, a lot of information about Warp Speed started to come to light.

A company called Palantir was given the contract to come up with the vaccine allocation strategy and determine the critical populations each vaccine should be distributed to. Palantir, founded by Peter Thiel, was initially funded by QTL, the CIA's venture capital arm.

The CIA was its only client for the first three years of its existence. At present, Palantir is a contractor to 17 U.S. intelligence agencies and also the U.S. military. The company is also in charge of COVID-19 data under the auspices of the HHS. Hospitals must now report their COVID-19 data to Palantir or lose their Medicaid and Medicare funding. Palantir is also involved in things like predictive policing.

“There are a lot of things in Warp Speed that are concerning. One of the things I read about recently is that Google and Oracle, two large tech companies that have longstanding ties to the CIA, are going to be involved in what they describe as a pharmacovigilance surveillance system, or what was more recently referred to by the head of Warp Speed as an incredibly precise tracking system, whereby everyone who receives one of these vaccines will be tracked and surveilled, not just to make sure that they get a second dose ...

... but also to see what happens to people's physiology, because they admit that every single one of these vaccine candidates ... has never been brought to market or licensed by the government before,” Webb says.

Pharmacovigilance Surveillance

According to Webb, the plan is to monitor vaccine recipients for 24 months after the first dose. The question is, how do you monitor such a large population? One way would be to employ biosensors that collect and send biological metrics automatically.

Monsef Salafi, a long-time head of GlaxoSmithKline's vaccine division, who is now part of Warp Speed, is a leading proponent of bioelectronic medicine, the use of injectable or implantable technology for the purpose of treating nerve conditions. The MIT Technology review has referred to it as hacking the nervous system. But it also allows you to monitor the physiology of the human body from the inside.

The vaccine coordinator for Operation Warp Speed is Matt Hepburn, a former program manager for DARPA, where he oversaw the development of ProfusA,¹ an implantable biosensor that allows a person's physiology to be examined at a distance via smartphone connectivity. ProfusA is also backed by Google, the largest data mining company in the world. Salafi is also invested in a company called Galvani Bioelectronics, which was cofounded by a Google subsidiary.

"So, you have Google being contracted to monitor this pharmacovigilance surveillance system that aims to monitor the physiology and the human body for two years," Webb says.

"And then you have the ties to the ProfusA project, which oddly enough is supposed to work inside the human body for 24 months — the exact window they've said will be used to monitor people after the first [vaccine] dose."

Guinea Pigs 'R Us

In short, rather than doing long-term safety studies on both animals and humans beforehand, what's being put into place is a "safety study" after the fact, where vaccine recipients are monitored for side effects. Unfortunately, Warp Speed, being shrouded in secrecy, has not released details about what biological parameters would actually be monitored and surveilled.

As noted by Webb: *"It really doesn't make sense, if you think about it, for something that ... is funded by American taxpayers to produce a medical countermeasure or a vaccine [during] peace time, is being run by the military under extreme secrecy with a lot of involvement of intelligence contractors, or intelligence agencies themselves.*

A lot of the same initiatives proposed under that original program after 9/11 have essentially been resurrected, with updated technology, under the guise of combating COVID-19."

Later in the article Webb discusses ways that HHS is partnering with technology companies to create predictive models that will supposedly predict outbreaks before they occur in certain geographic regions. This will allow the government to shut down cities and communities even before any signs of outbreak. This is potentially ripe for abuse and very difficult for independent sources to verify and could lead to population control under the guise of "health measures".

Then there's the permanent body I.D. systems and tracking that Gate's wants to mandate along with vaccines

An article in *Scientific American* titled, **Invisible Ink Could Reveal whether Kids Have Been Vaccinated**, reveals that the M.I.T. researcher's project was funded by the Bill and Melinda Gates Foundation (surprise, surprise). And, "came about because of a direct request from Microsoft founder and philanthropist Bill Gates himself..."
<https://www.scientificamerican.com/article/invisible-ink-could-reveal-whether-kids-have-been-vaccinated/>

From the article:

"The research, conducted by M.I.T. bioengineers Robert Langer and Ana Jaklenec and their colleagues, uses a patch of tiny needles called microneedles to provide an effective vaccination without a teeth-clenching jab. Microneedles are embedded in a Band-Aid-like device that is placed on the skin; a skilled nurse or technician is

not required. Vaccines delivered with microneedles also may not need to be refrigerated, reducing both the cost and difficulty of delivery, Langer and Jaklenec say.”

“Along with the vaccine, a child would be injected with a bit of dye that is invisible to the naked eye but easily seen with a special cell-phone filter, combined with an app that shines near-infrared light onto the skin. The dye would be expected to last up to five years, according to tests on pig and rat skin and human skin in a dish.”

“Delivering the dye required the researchers to find something that was safe and would last long enough to be useful. “That’s really the biggest challenge that we overcame in the project,” Jaklenec says, adding that the team tested a number of off-the-shelf dyes that could be used in the body but could not find any that endured when exposed to sunlight. The team ended up using a technology called quantum dots, tiny semiconducting crystals that reflect light and were originally developed to label cells during research.”

In a related 2019 article titled, **Bill Gates, MIT Develop New ‘Tattoo ID’ to Check For Vaccinations**, other nefarious plans for biometric I.D.s as a means of population management is discussed.

<https://21stcenturywire.com/2019/12/23/bill-gates-develops-new-id-tattoo-to-check-for-vaccinations/>

From the article:

“Could this technology be utilized by governments as an exclusionary tool, or as a mechanism for social engineering? Certainly the potential is there to streamline these two methods of ‘people management.’ Currently the US government is quietly implementing the [REAL ID Act](#) which now requires Americans to hold a biometric ID in order to travel on airplanes. US lawmakers have been pushing for this from the 1980s, when former Attorney General William French Smith [had proposed](#) to implement a ‘perfectly harmless national ID system’ for which another cabinet minister at the time also proposed to ‘tattoo a number on each American’s forearm.’ To some, this may seem like the stuff of science fiction, and yet it’s been openly discussed by government for decades.”

And that leads us to the Bill Gates’ Microchip patent

Another kind of biometric monitoring advanced by Bill Gates and Microsoft- As this technology evolves, will vaccines be the delivery system?

I covered the microchip technology invented and patented by Bill Gates and Microsoft in my June **1200 Studies Update Newsletter**, where I’ve been covering the many behind the scenes stories related to COVID-19 that you will never hear from the mainstream media. Gates is the driving force behind world vaccination projects and with the United States having pulled out of the World Health Organization, Gates is now is the top funder of the W.H.O. along with China. And with provocative comments like, **“Normalcy only returns when we’ve largely vaccinated the entire global population.”** And what better opportunity will the people working to find a system to harvest raw biometric data from everyone than this Orwellian new order we find ourselves in.

An article titled, **Bill Gates, Vaccinations, Microchips, And Patent 060606**, published on **Orientalreview.org** April 29, 2020 reveals what the future of microchipping humans to track their location, retrieve biometric data and exchange cryptocurrency. <https://orientalreview.org/2020/04/29/bill-gates-vaccinations-microchips-and-patent-060606/>

From the article:

The case described below relates to an officially documented fact, although there is something rather biblical about it. **Patent WO/2020/060606** was registered on 26 March 2020. The patent application was filed by Microsoft Technology Licensing, LLC, headed by Bill Gates, back on 20 June 2019, and, on 22 April 2020, the [patent was granted international status](#). The title of the patent is “Cryptocurrency system using body activity data”.

So, what is this invention that the people at Microsoft decided to patent? The abstract of the patent application [online states](#): “Human body activity associated with a task provided to a user may be used in a mining process of a cryptocurrency system. A server may provide a task to a device of a user which is communicatively coupled to the server. A sensor communicatively coupled to or comprised in the device of the user may sense body activity of the user. Body activity data may be generated based on the sensed body activity of the user. The cryptocurrency system communicatively coupled to the device of the user may verify if the body activity data satisfies one or more conditions set by the cryptocurrency system, and award cryptocurrency to the user whose body activity data is verified.”

In other words, a chip will be inserted into the body that monitors a person’s daily physical activity in return for cryptocurrency. If conditions are met, then the person receives certain bonuses that can be spent on something.

A detailed [description](#) of the “invention” **provides 28 concepts for how the device could be used**.

“Microsoft’s involvement is interesting. And why has the patent been given the code number 060606? Is it a coincidence or the deliberate choice of what is referred to in the *Book of Revelation* as the number of the “mark of the beast”?

Alternatives to a vaccine- Prophylaxis and early effective treatment options

In these last sections, I will present some options for prophylaxis and early treatment with two medications and some natural alternatives like Vitamin D. Have you ever heard a public service announcement, or our health officials promote Vitamin D? I do believe Dr. Fauci did mention he takes Vitamin D one time, but that was it. But when you see the evidence on having optimal Vitamin D levels in a link to an article on my web site, you may be outraged as I am that it isn’t front page news.

Once again, I want to reiterate, that I am not saying you should not take the vaccine. Listen to and study what the people promoting them are saying. Then look at other sources of information like I have provided you. Then based on a risk vs. reward analysis, decide what is in your best interest and the best interest of your family members.

Ultimately if you decide to not take the vaccine, I have a strategy to recommend that will help you optimize your immune system’s function and bolster your defenses.

Repurposed inexpensive drugs as a first line of defense

***Disclaimer:** As a chiropractic physician, I do not prescribe medications and I do not tell people not to take their medications. I am simply acting as a journalist and reporting what is being reported and what the peer reviewed studies have shown. Each person must decide for themselves, with consultation from the medical provider what would be in their best interest. Even though these medications have been proven very safe over*

decades of use, like with any drug it may not be recommended for a very small subset of people with certain risk factors.

There are two drugs that have been getting a lot of attention as a first line medication against COVID-19. Those are:

- **Hydroxychloroquine (HCQ) WITH ZINC**- HCQ acts as a Zinc ionophore helping Zinc to get into the cells where it can interfere with replication of the SARS-CoV-2 virus. It costs about \$30 for a course of treatment. It is sometimes prescribed with Azithromycin as a prevention against secondary bacterial infection.
- **Ivermectin**- Costs about \$80 for a course of treatment. Ivermectin acts both as an anti-viral and an anti-inflammatory drug. This makes it effective early in care and later as well. The anti-inflammatory aspect may lend itself well to patients after the viral replication phase in helping to control an over-reactive immune response.

Both of these medications are very inexpensive and have been used world-wide for decades, mostly for malaria and parasites with very good safety profiles. And both have very powerful antiviral effects. HCQ is also used by millions of people in the U.S. for autoimmune disease. HCQ has been on the W.H.O.'s list of essential medications for many years.

Both of these drugs are best used early in the illness as they interfere with viral replication and can impact the exponential growth of the virus, giving the immune system a better chance of getting the upper hand. Ivermectin has also shown promise with intermediate and even some later stage illness partly because of its anti-inflammatory properties, which mitigates the hyper-immune response sometimes called a cytokine storm that occurs in some patients.

Unfortunately however, these drugs that could be a game changer according to thousands of physicians and clinics all over the world have been undermined in countries where pharma has powerful influence, including the U.S. Some recent studies looking at HCQ have been designed to fail, either omitting Zinc which is the key ingredient for success, using near lethal doses on patients that are 4-6 times what clinics are using, or using it in patients with severe advanced COVID-19 disease which is not the target population it works for. Many of the studies and reports in medical journals have been authored by people with ties to companies making competing drugs like Gilead Sciences, the makers of Remdesivir (which costs about \$3,000 for a course of treatment). This is blatant bias and conflicts of interest. Medical journals allowing these "hit pieces" should be ashamed of themselves and they should be retracted.

Doctors using HCQ with amazing success, report that it is more effective in keeping people out of the hospital by helping them get better quickly early on. It is obvious that these drugs are being sabotaged by people and groups with deep ties to pharma. Some state pharmacy boards have even restricted dispensing of HCQ prescribed by physicians for COVID-19. And why would they do that? Many speculate that it is to promote the expensive antiviral treatments (i.e., Remdesivir), those drugs in development and of course, the vaccines. All you usually have to do when asking the why question in circumstances like this, is follow the money trail. It is awful to think that these actions would be intentional, as restricting their use and availability may have contributed to the deaths of hundreds of thousands of people world-wide, while we have waited for the vaccines which is where the big money lies. Fortunately for people in countries that aren't so dominated by pharma, they are using these drugs with incredible success.

More on Hydroxychloroquine (and don't forget the Zinc)

Here is the website for **America's Frontline Doctors**. They are the group that held a press conference several weeks ago on the steps of the **Supreme Court of the United States**. The video reached about 18 million views in 6 hours before being taken down by YouTube, the arbiter of the "truth" as they or their handlers see it. It is a great resource on HCQ. <https://www.americasfrontlinedoctors.com/>

This is an AMAZING resource! It features 206 studies, 140 of which are peer-reviewed on HCQ <https://c19study.com/> They estimate that over 813,000 lives have been lost (at the time of writing this article) by not using HCQ in early treatment.

Here is a site that shows many studies and the efficacy of HCQ.

<https://www.sciencedirect.com/journal/international-journal-of-antimicrobial-agents/special-issue/10V3JMBH9GZ>

More on Ivermectin

Here is a recently released report from a consortium of doctors that have been successfully using and studying **Ivermectin**. The group is called the **FRONT LINE COVID-19 CRITICAL CARE ALLIANCE** and is made up of critical care physicians <https://covid19criticalcare.com/wp-content/uploads/2020/11/FLCCC-Ivermectin-in-the-prophylaxis-and-treatment-of-COVID-19.pdf>

Watch Dr. Pierre Kory's passionate testimony about the effectiveness of Ivermectin on December 8, 2020, at the U.S. Senate Committee on Homeland Security and Governmental Affairs.

https://www.youtube.com/watch?v=YgOAaLmoa68&feature=emb_logo

Another great source is Dr. Paul Marik's Math + Protocol

Dr. Paul Marik is board certified in Internal Medicine, Critical Care Medicine, Neurocritical Care and Nutrition Science. Dr Marik is currently Professor of Medicine and Chief of Pulmonary and Critical Care Medicine, Eastern Virginia Medical School in Norfolk, Virginia. Dr Marik has written over 400 peer reviewed journal articles, 50 book chapters and authored four critical care books.

His website and protocol can be accessed here: <https://covid19criticalcare.com/math-hospital-treatment/pdf-translations/>

Natural Alternative Options

Maintaining optimal levels of Vitamin D is one of the most important things anyone can do to prevent getting COVID-19 (the disease) and if you do get it to reduce the chances of a severe outcome. Numerous studies verify the benefits against viral respiratory infections, including many recent studies on the benefits with COVID-19. You can read all about that and see dozens of references in my article on my website at <https://www.wellnessdoc.com/vitamin-d-status-as-it-relates-to-covid-19-complications-and-death/>

There are many other nutritional compounds that also support healthy immune function and protect against viral illness. Check out my Viral Prevention and Treatment strategies page at

<https://www.wellnessdoc.com/nutritional-viral-prevention-and-treatment-products/>

and also general tips here <https://www.wellnessdoc.com/10-effective-ways-to-prevent-and-treat-viral-infections/>

Download a compilation of my *Nutrient of the Month* segments covering nutritional compounds that have shown protective anti-viral properties

HERE

For prevention (prophylaxis) of viral illness, you may want to try 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 of my monthly newsletter over the past few months.

I like to use 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 like HCQ) 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, Lymphocytes 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](#).

Agree to the consent disclaimer and then follow the links to **Nutridyn's** web site through my portal. There you would sign up as a new customer (upper right of the page). After that, you can peruse the product categories and excellent products they carry.

IMPORTANT: If you contract COVID-19 and are in the high-risk categories and/or if the illness is progressing beyond mild to moderate symptoms including low oxygen levels (which you can monitor with a home pulse oximeter), **seek medical attention**, as there are medical options that can help to prevent the illness from progressing to a severe level.

Update April 11th, 2021

Associate Editor Peter Doshi of the British Medical Journal questions the “effectiveness” claims of the Pfizer and Moderna vaccines

Dr. Peter Doshi, Associate Editor of the *BMJ* released this opinion letter highly critical of the “effectiveness” claims the public have been hearing ad nauseum. The letter was published on January 4th, 2021. The letter titled **Peter Doshi: Pfizer and Moderna’s “95% effective” vaccines—we need more details and the raw data**, reported that because of exclusionary data the actual effectiveness (and remember that only means reduction of COVID-19 symptoms), should have been reported as between 19% and 29%! In other words, the numbers had to be manipulated to get to the approximately 95% effectiveness that was reported. Remember Peter Doshi is the *Associate Editor of the British Medical Journal (BMJ)* and is a highly credible scientifically qualified source to analyze the data and comment on it.

From his letter:

“Suspected covid-19”

All attention has focused on the dramatic efficacy results: Pfizer reported 170 PCR confirmed covid-19 cases, split 8 to 162 between vaccine and placebo groups. But these numbers were dwarfed by a category of disease called “suspected covid-19”—those with symptomatic covid-19 that were not PCR confirmed. According to [FDA’s report on Pfizer’s vaccine](#), there were “3410 total cases of suspected, but unconfirmed covid-19 in the overall study population, 1594 occurred in the vaccine group vs. 1816 in the placebo group.”

With 20 times more suspected than confirmed cases, this category of disease cannot be ignored simply because there was no positive PCR test result. Indeed this makes it all the more urgent to understand. A rough estimate of vaccine efficacy against developing covid-19 symptoms, with or without a positive PCR test result, would be a relative risk reduction of 19% (see footnote)—far below the 50% effectiveness threshold for authorization set [by](#) regulators. Even after removing cases occurring within 7 days of vaccination (409 on Pfizer’s vaccine vs. 287 on placebo), which should include the majority of symptoms due to short-term vaccine reactogenicity, vaccine efficacy remains low: 29% (see footnote).

However, if confirmed covid-19 is on average more severe than suspected covid-19, we must still keep in mind that at the end of the day, it is not average clinical severity that matters, it’s the incidence of severe disease that affects hospital admissions. With 20 times more suspected covid-19 than confirmed covid-19, and trials [not designed to assess](#) whether the vaccines can interrupt viral transmission, an analysis of severe disease irrespective of etiologic agent—namely, rates of hospitalizations, ICU cases, and deaths amongst trial

participants—seems warranted, and is the only way to assess the vaccines’ real ability to take the edge off the pandemic.

There is a clear need for data to answer these questions, but Pfizer’s 92-page report didn’t mention the 3410 “suspected covid-19” cases. Nor did its [publication](#) in the *New England Journal of Medicine*. Nor did any of the reports on Moderna’s vaccine. The only source that appears to have reported it is FDA’s review of Pfizer’s vaccine.

The 371 individuals excluded from Pfizer vaccine efficacy analysis

Another reason we need more data is to analyse an unexplained detail found in a table of [FDA’s review](#) of Pfizer’s vaccine: 371 individuals excluded from the efficacy analysis for “important protocol deviations on or prior to 7 days after Dose 2.” What is concerning is the imbalance between randomized groups in the number of these excluded individuals: 311 from the vaccine group vs 60 on placebo. (In contrast, in Moderna’s trial, there were just 36 participants excluded from the efficacy analysis for “major protocol deviation” —12 vaccine group vs 24 placebo group.)

What were these protocol deviations in Pfizer’s study, and why were there five times more participants excluded in the vaccine group? The [FDA report](#) doesn’t say, and these exclusions are difficult to even spot in Pfizer’s report and journal publication.

We need the raw data

Addressing the many open questions about these trials [requires access to the raw trial data](#). But no company seems to have shared data with any third party at this point.

Pfizer says it is making data available “upon request, and subject to review.” This stops far short of making data publicly available, but at least leaves the door open. How open is unclear, since the [study protocol](#) says Pfizer will only start making data available **24 months after study completion. (My emphasis and comment: and the study isn’t scheduled to be completed until January 29th, 2023. That makes the release of the raw data January 29th, 2025! This is absurd with an experimental rushed to market product).**

Moderna’s data sharing statement states data “may be available upon request once the trial is complete.” This translates to sometime in mid-to-late 2022, as follow-up is planned for 2 years.

Things may be no different for the [Oxford/AstraZeneca vaccine which has pledged patient-level data](#) “when the trial is complete.” And the [ClinicalTrials.gov entry](#) for the Russian Sputnik V vaccine says there are no plans to share individual participant data.

Footnote

Calculations in this article are as follows: $19\% = 1 - (8+1594)/(162+1816)$; $29\% = 1 - (8 + 1594 - 409)/(162 + 1816 - 287)$. I ignored denominators as they are similar between groups.

End of excerpts: Follow the link below to read the full letter

<https://blogs.bmj.com/bmj/2021/01/04/peter-doshi-pfizer-and-modernas-95-effective-vaccines-we-need-more-details-and-the-raw-data/>

On 5 February 2021 he published a clarification to this piece. [It is available here.](#) It basically addressed some criticisms of his calculations which he defended aptly.

For those that want to see more evidence of the “fuzzy math” used to determine the “effectiveness” and the risks of the mRNA vaccines you can read this excellent article...

<https://everlyreport.com/what-you-need-to-know-about-the-covid-vaccine/>

Dr. Doshi had previously questioned the “end points” of the trials as not addressing the most important aspects for a successful vaccine, including protecting the elderly

Dr. Peter Doshi, Associate Editor for the BMJ released a letter on October 22nd article titled, **Coronavirus Vaccine Trials Underway May Not Tell if the Shots Save Lives of COVID-19 Patients: British Medical Journal Expert**. In that letter, he questioned the end points of the Moderna and Pfizer vaccine trials stating "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 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.

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. **My comment:** And this is something that as you will see in the next section, is playing out in a terrible way.

End of excerpts:

You can read the full letter here:

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

Now that the vaccines have been rolled out to elderly and long-term care facilities, unusually high rates of deaths are being reported in elderly nursing home residents after they receive the shots

As of mid-February, reports from all over the globe have been coming in that are raising serious cause for concern over the elderly and frail getting the COVID-19 vaccines.

A CNA whistleblower from a nursing facility posted a video of himself expressing concerns over what he was seeing. The video went viral in a short amount of time before being censored and taken down. It is still being shared on various alternative platforms and by individuals. The story on this particular site is titled, **CNA Nursing Home Whistleblower: Seniors Are DYING LIKE FLIES After COVID Injections! SPEAK OUT!!!**

From the article:

James (he gives his last name in the video) is a CNA (Certified Nursing Assistant), and he recorded this video as a whistleblower because he could not keep silent any longer.

James reports that in 2020 **very few residents in the nursing home where he works got sick with COVID, and none of them died during the entire year of 2020.**

However, shortly after administering the Pfizer experimental mRNA injections, 14 died within two weeks, and he reports that many others are near death.

The video is long (47 minutes), and it is clear that James is suffering from emotional stress, and he admits that he has nothing to gain from going public, and that he will probably lose his job for doing so. But he makes it very clear that these were patients he knew and cared for (he is also a “lay pastor”), and that after being injected with the mRNA shot, residents who used to walk on their own can no longer walk. Residents who used to carry on an intelligent conversation with him could no longer talk. And now they are dying. “They’re dropping like flies.”

His superiors are explaining the deaths as being caused by a COVID19 “super-spreader.” However, the residents who refused to take the injections, are not sick, according to James.

James makes it very clear that as a Christian, he cannot live with his conscience anymore, and that he can no longer remain silent. He is not anti-vaccine, but just sharing what he knows is true, regarding the people he has cared for in his profession for over 10 years now.

<https://medicalkidnap.com/2021/01/26/cna-nursing-home-whistleblower-seniors-are-dying-like-flies-after-covid-injections-speak-out/>

Once you read the article and watch the video if you choose, scroll down on that same web page and view the other stories coming in from different countries.

Norway halts vaccine rollout in the elderly due to deaths after vaccines

A January 16th article on Bloomberg.com titled **Norway Raises Concern Over Vaccine Jabs for the Elderly**, reports on the increased deaths in the elderly and frail after the Pfizer shots.

From the article:

Until Friday, the vaccine produced by Pfizer and BioNTech SE was the only one available in Norway, and “all deaths are thus linked to this vaccine,” the Norwegian Medicines Agency said in a written response to Bloomberg on Saturday.

“There are 13 deaths that have been assessed, and we are aware of another 16 deaths that are currently being assessed,” the agency said. All the reported deaths related to “elderly people with serious basic disorders,” it said. “Most people have experienced the expected side effects of the vaccine, such as nausea and vomiting, fever, local reactions at the injection site, and worsening of their underlying condition.”

The findings have prompted Norway to suggest that Covid-19 vaccines may be too risky for the very old and terminally ill, the most cautious statement yet from a European health authority.

The Norwegian Institute of Public Health judges that “for those with the most severe frailty, even relatively mild vaccine side effects can have serious consequences. For those who have a very short remaining life span anyway, the benefit of the vaccine may be marginal or irrelevant.”

<https://www.bloomberg.com/news/articles/2021-01-16/norway-vaccine-fatalities-among-people-75-and-older-rise-to-29>

Spain halts vaccine in nursing home after 46 residents die shortly after the first Pfizer shot

Considering that the total population of the nursing home was only 145, this is an extremely high number. The residents were vaccinated in early January. In mid-February it was reported that another 28 residents and 12 staff members have tested positive for COVID-19.

<https://europe.renaissance.com/2021/02/19/spain-second-pfizer-shots-halted-after-46-nursing-home-residents-die-after-the-first-shot/>

Concerns over the Johnson & Johnson's vaccine

This vaccine is similar to the AstraZeneca/Oxford vaccine. They are referred by some scientists as a “Frankenstein” vaccine. The reason is that it uses another virus, a chimpanzee adenovirus as the carrier for the section of the SARS-CoV-2 virus spike protein DNA, which is “spliced” into the adenovirus. It is a hybrid of sorts, part this and part that (hence the Frankenstein label). J & J's and AstraZeneca are both called recombinant Adenovirus vector vaccines. Adenoviruses are viruses that are part of the common cold spectrum of viruses, just like coronaviruses are. Like the Pfizer and Moderna mRNA vaccines, these vaccines are a departure from the traditional vaccine platform.

Johnson & Johnson's vaccine consists of a **replication-incompetent (genetically modified) recombinant adenovirus type 26 virus**, with the section of the SARS-CoV-2 spike protein spliced in. It also contains the following ingredients: citric acid monohydrate, trisodium citrate dihydrate, ethanol, 2-hydroxypropyl- β -cyclodextrin (HBCD), **polysorbate 80**, sodium chloride, sodium hydroxide, and hydrochloric acid. The adenovirus is also grown in the **PER.C6[®] aborted fetal cell line**.

The reason I have highlighted those 3 ingredients, is because they have proven to be problematic in other vaccines.

1. **A replication-incompetent (genetically modified) recombinant adenovirus type 26 virus** is concerning because it uses the prior mentioned technology where a virus is made incapable of replicating (Adenovirus) and the gene sequences from another virus (in this case the SARS-CoV-2 spike protein are inserted into the modified Adenovirus. There is historical context to make this a major concern. In 2015 a vaccine against Dengue Fever was developed by Sanofi Pasteur and rolled out on children in the Philippines. In that case it was a Yellow Fever Virus that had gene sequences of the Dengue Virus spliced into it. This experiment on children in the Philippines went horribly wrong resulting in criminal charges brought against researchers, health officials and Sanofi Pasteur.

The following excerpt is from an April 24th, 2019 article published in *ScienceMag* titled **Dengue vaccine fiasco leads to criminal charges for researcher in the Philippines.**

<https://www.sciencemag.org/news/2019/04/dengue-vaccine-fiasco-leads-criminal-charges-researcher-philippines>

Dengvaxia consists of an attenuated yellow fever virus that expresses genes of each of the four types of dengue virus. The Philippine FDA greenlighted the vaccine in December 2015, based on research funded by Sanofi Pasteur in which Capeding played an important role. For example, she was the first author on a 2014 paper in *The Lancet* detailing a study among more than 10,000 children in five Asian countries that showed Dengvaxia worked and had a good safety profile. In April 2016, the Philippine government launched a \$67 million public school–based immunization program for Dengvaxia.

That alarmed some scientists, because the dengue virus is peculiar: A first infection is rarely fatal, but a second one with a different virus type can lead to much more serious disease, because of what is called antibody-dependent enhancement (ADE), in which the immune response to the first virus amplifies the effect of the second type. Scott Halstead, a retired dengue expert formerly at the Uniformed Services University of the Health Sciences in Bethesda, Maryland, argued that dengue vaccines could have the same effect, and warned that Dengvaxia should not be given to children never infected with dengue. But a vaccine panel at the World Health Organization (WHO) concluded in 2016 that Dengvaxia was safe for children aged 9 and older.

Halstead's concerns proved valid. In November 2017, Sanofi Pasteur announced that the vaccine could indeed exacerbate cases of dengue in children never previously infected, and the Philippines halted the campaign immediately. (WHO now recommends the vaccine be used only after a test to be sure children have had at least one brush with dengue.)

End of excerpts

Many in the science world are concerned that the ADE or sometimes called Pathogenic Priming may not have been solely a result of the vaccine being given to children that had not had a prior infection, but that the vaccine platform (ie. The genetically modified organism created by recombinant virus splicing) may be what triggers this reaction in certain susceptible individuals. Couple that with the history of the failed prior attempts to create a coronavirus vaccine leading to termination of the trials after animal studies as a result of the numbers of animals that developed ADE and became severely ill and many dying.

2. **The PER.C6 cell line** is derived from human embryonic retinal cells, originally from the retinal tissue of an 18-week-old fetus aborted in 1985. Notoriously, DNA from the aborted fetus is present in vaccines and biologics where the viruses were grown on these cells. The FDA allows for 100,000,000 bits and strands of human DNA per dose. That is problematic, because as Dr. Theresa Deisher has warned can cause insertion into the recipient's DNA of this other human DNA (called homologous recombination) and lead to development of autoimmunity and other chronic health issues. Not to mention that it is abhorrent for many persons of faith to have human DNA from a fetus that was aborted for this purpose to be injected into their own body and potentially become part of their own DNA.

You can read about more about aborted fetal cell lines, Dr. Deisher's work in this area as well as the many problems with Polysorbate 80 in my eBook available at <https://1200studies.com>.

3. **Polysorbate 80** has been shown to cause allergic and even anaphylactic reactions in some people. It also has been shown to disrupt the blood-brain-barrier and aid in transport of drugs, chemicals and nanoparticles, even mercury and aluminum into the brain.

As a footnote, in October 2020 Johnson & Johnson paused its trial due to an undisclosed “unexplained illness” in one of its participants. This illness has not been disclosed publicly.

The AstraZeneca/Oxford vaccine has the same genetically modified virus technology

The AstraZeneca Vaccine has the same recombinant technology as the Johnson & Johnson Vaccine described below. Recombinant in this case means that DNA is combined in a lab from two different viruses into a hybrid organism (genetically modified organism- GMO), that would not normally be found in nature. Read on about the Johnson & Johnson Vaccine to see why that is such a concern by many scientists.

Johnson & Johnson’s Vaccine hits a snag as multiple people suffer adverse effects at various vaccine sites

North Carolina paused two vaccine sites April 8th, as 18 people suffered reactions and four were hospitalized. In Colorado Wednesday, eleven people had adverse reactions and two were hospitalized. , Iowa and Georgia also reported adverse reactions.

In an article written by Megan Redshaw and released on *Children’s Health Defense* website April 9th, the following was reported....In response to the recent reports of site closings, the vaccine maker said in a statement, “there is no greater priority than the safety and well-being of the people we serve. When we receive reports of adverse events in individuals receiving our medicines and vaccines, we collect necessary information and carefully assess the events.”

As *The Defender, Children’s Health Defense* publication reported in March, J&J has a criminal track record involving safety concerns with numerous products. The company has paid billions of dollars in fines and punitive damages related to fraud and other dubious practices for its role in the opioid crisis, for failure to warn that Risperdal — an antipsychotic drug produced by the company — could lead to breast growth in boys and for its asbestos-tainted baby powder associated with cancer, which the company knew about for almost 50 years and failed to disclose.

On Wednesday, EU regulators confirmed a “possible link” between AstraZeneca and blood clots resulting in suspension of AstraZeneca’s vaccine in younger populations in many European countries, and guidance in the UK that the vaccine not be used in people under 30.

The European Medicines Agency said Wednesday during a press conference it is also looking carefully at the J&J vaccine, as three cases of blood clots associated with low platelets, similar to the cases reported after AstraZeneca vaccines, have been reported, as well as one instance of thrombosis in a clinical trial.

End of excerpts

New concerns over the Moderna and Pfizer mRNA vaccines

Spike protein introduced into and replicated by our cells from the mRNA vaccines are released into circulation when those cells are later destroyed by our immune system may cause widespread damage

Dr. J. Patrick Whelan M.D., PhD, with degrees in medicine, biochemistry and rheumatology warned the FDA in December that mRNA vaccines could cause microvascular injury to the brain, heart, liver and kidneys in ways not assessed in safety trials. That warning was ignored by the FDA.

This is from an article by Lyn Redwood of Children's Health Defense in a February 10th, 2021 article that she wrote titled, **Could Spike Protein in Moderna, Pfizer Vaccines Cause Blood Clots, Brain Inflammation and Heart Attacks?**

From the article:

"The most likely culprit that has been identified is the COVID-19 spike protein released from the outer shell of the virus into circulation. Research cited below has documented that the viral spike protein is able to initiate a cascade of events that triggers damage to distant organs in COVID-19 patients."

"Worryingly, several studies have found that the spike proteins alone have the capacity to cause widespread injury throughout the body, without any evidence of virus."

"What makes this finding so disturbing is that the COVID-19 mRNA vaccines manufactured by Moderna and Pfizer and currently being administered throughout the U.S. program our cells to manufacture this same coronavirus spike protein as a way to trigger our bodies to produce antibodies to the virus.

According to Whelan's letter to the FDA, the "Pfizer/BioNTech vaccine is composed of an mRNA that produces a membrane-anchored full-length spike protein."

To read the full article with links to references go here:

<https://childrenshealthdefense.org/defender/moderna-pfizer-vaccines-blood-clots-brain-inflammation-heart-attacks/>

Polyethylene Glycol (PEG) is suspected in severe anaphylactic reactions and deaths from the COVID-19 vaccines

The mRNA vaccines from Pfizer/BioNTech and Moderna contain polyethylene glycol (PEG). The mRNA is packaged into lipid and Polyethylene Glycol (PEG) nanoparticles. **70% of people develop antibodies against this substance – this means that many people can develop allergic, potentially fatal reactions to the vaccination.**

There have been many reports of severe reactions thought to be attributed to the PEG in the vaccines. Another concern revolves around the easy uptake by the brain of this lipophilic (easily absorbed by fatty tissue) molecule, potentially causing brain inflammation due to activation of the brain's microglia (immune cells). The brain is composed of around 60% fat, making a lipid nanoparticle easily absorbed.

There are 3 articles of interest I came across in the last month...

1. **Polyethylene glycol as a cause of anaphylaxis** from the Journal *Allergy, Asthma & Clinical Immunology*. <https://pubmed.ncbi.nlm.nih.gov/27999603/>

Conclusion: Potential life-threatening hypersensitivity reactions to hidden molecules like macrogol may be underdiagnosed. Cases of immediate-type PEG hypersensitivity were reported with increasing frequency. The awareness regarding the allergenic potential of PEG should be raised and a proper product labelling is crucial to prevent PEG mediated hypersensitivity.

2. **Analysis of Pre-existing IgG and IgM Antibodies against Polyethylene Glycol (PEG) in the General Population** from the journal *Analytical Chemistry*. <https://pubmed.ncbi.nlm.nih.gov/27804292/>

From the study: The widespread prevalence of pre-existing anti- PEG Ab, coupled with high Ab levels in a subset of the population, underscores the potential importance of screening patients for anti-PEG Ab levels prior to administration of therapeutics containing PEG.

Now we all know that isn't happening before the administration of the vaccines!

3. **Physician Awareness of Immune Responses to Polyethylene Glycol-Drug Conjugates** from *Clinical and Translational Science*. <https://pubmed.ncbi.nlm.nih.gov/29383836/>

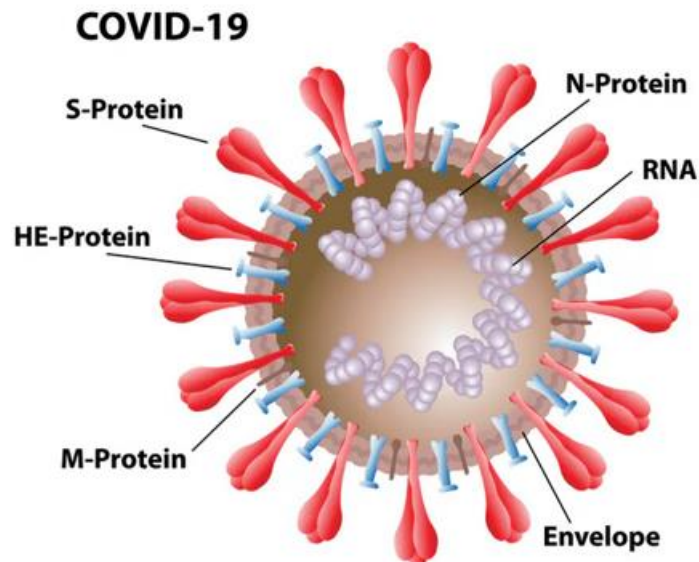
This article reinforces that doctors have a poor level of awareness of the scope of the risk of allergic reactions to PEG. This is especially concerning since we are seeing a large uptick in allergic reactions from the COVID-19 vaccines, some fatal. Doctors need to know that this risk exists, how to recognize it and report them to the VAERS system when they occur.

4. **COVID-19 vaccine-associated anaphylaxis: A statement of the World Allergy Organization Anaphylaxis Committee** from the *World Allergy Organization Journal* <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7857113/pdf/main.pdf>

This article is very interesting in that it covers various aspects of allergy and anaphylaxis, suggesting that these reactions may be due to more than the PEG in the Messenger RNA vaccines. It covers the role that PEG plays in anaphylaxis, but it also suggests a possible reaction to the mRNA itself or other components. It also gives a table of indicators that would suggest caution or avoidance of vaccination in certain individuals. Because of the credibility and reputation of this organization, these recommendations may be used to help protect and then individuals right to avoid the potential for serious adverse reactions.

Another reason why natural immunity and acquired immunity from getting COVID-19 is better than the vaccine

The graphic below is from an article in *Discover Magazine* titled, **COVID Vaccines Focus on the Spike Protein – But Here’s Another Target**. One detail I would like to point out is that the virus is not called COVID-19. COVID-19 is the illness caused by the virus which is called SARS-CoV-2.



As you can see, there are 5 proteins that form the overall structure of the virus.

1. The Spike protein (S)
2. The Nucleocapsid protein (N)
3. The Envelope protein (E)
4. The Membrane protein (M)
5. The Hemagglutinin protein (HE)

<https://www.discovermagazine.com/health/covid-vaccines-focus-on-the-spike-protein-but-heres-another-target>

The COVID-19 vaccine model of “immunity”

All the vaccine candidates that have been developed and now introduced into the market concentrate on introducing the Spike protein to our immune system. This is the portion of the virus that “docks” with the ACE-2 receptors on our cell membrane. This then starts the process of entry for the virus into our cells where it can use our cell as a host to replicate. This fragment of the spike protein that is introduced into our body by the vaccines causes our immune system to recognize that particular DNA or RNA specific to the Spike protein and produces antibodies that recognize the spike protein when a person is later exposed to the wild virus. This then tells other parts of the immune system to respond to the threat.

The body's model of immunity

Unlike the limited recognition by our immune system of only one of the five SARS-CoV-2 proteins, an infection with the wild virus triggers immune recognition of all 5 of the viral proteins, essentially the total virus. Why is this important? It is because as the virus mutates as they always do (and we certainly have been hearing a lot about that lately), some of those mutations may happen with the Spike protein. This results in the antibodies that are trained to recognize the original Spike protein DNA sequences from the vaccine not recognizing the mutated form that is now in circulation. And therefore, an immune response would not be triggered. Of course, as pharma would like you to believe, you could always get the next version of the vaccine where they have "fine-tuned" it. And on and on and on just like the flu shot. But maybe that was the plan all along. The people working in vaccine development are certainly smart enough (one would think anyway) to know this would happen. Once again, natural immunity trumps vaccinology every time.

Shockingly, Anthony Fauci knows that injected vaccines do not interrupt infection or transmission. This is a striking admission!

In an article authored by Dr. Fauci published January 19th, 2021 titled **SARS-CoV-2 Vaccines: Much Accomplished, Much to Learn**, a startling revelation came to light. This is a screen capture of the journal page with our "illustrious" Dr. Fauci listed as an author.

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Special Article | 19 January 2021

SARS-CoV-2 Vaccines: Much Accomplished, Much to Learn FREE

Mark Connors, MD  , Barney S. Graham, MD , H. Clifford Lane, MD , Anthony S. Fauci, MD

[Author, Article and Disclosure Information](#)

<https://doi.org/10.7326/M21-0111>

The following is a quote from the article...

Given that recent polling suggests that only 40% to 60% of people in the United States are currently planning to get vaccinated, it is conceivable that without some impact on transmission, the virus will continue to circulate, infect, and cause serious disease in certain segments of the unvaccinated population. Administration of parenterally administered vaccines alone typically does not result in potent mucosal immunity that might interrupt infection or transmission (9). <https://pubmed.ncbi.nlm.nih.gov/33460347/>

That reference (#9) is to an article published in *Frontiers in Immunology*, November 2020 and titled **Mucosal Immunity in COVID-19: A Neglected but Critical Aspect of SARS-CoV-2 Infection.**

In that article it states the following, essentially saying that the injectable vaccines are not going to be effective and suggesting nasal spray vaccines and other delivery methods. Get ready for the next wave of vaccine delivery systems:

“Almost all efforts at vaccine development against COVID-19 focus on systemic injection, which predominantly induces circulatory IgG antibodies and, potentially, cytotoxic T cells (18). **These routes are poorly effective at generating mucosal immune responses, which can only be induced by mucosal routes of immunization, including through the NALT in the URT** (*NALT is Nasopharynx-Associated Lymphoid Tissue and URT is Upper Respiratory Tract*). Mucosal immune responses are partly compartmentalized, as the distribution of the responses depends on the actual route of induction (7, 19). For example, the enteric route predominantly generates responses in the gastro-intestinal tract, whereas the nasal route predominantly generates responses in the respiratory tract and salivary glands (7)”.

“Finally we expect that efforts in vaccine development aimed at inducing mucosal immune responses and memory cells, especially in the URT, would yield benefits not seen with conventional parenteral (*injectable*) routes of vaccine administration. Intranasal vaccines are already available against influenza and others are under development (30, 38). The advantages, in addition to needle-free administration, include the generation of both mucosal (SIgA) and circulating (IgG and IgA) antibodies, as well as T-cell responses. As discussed above, such responses might achieve desirable results not obtained with systemic immunization routes.”

<https://www.frontiersin.org/articles/10.3389/fimmu.2020.611337/full>

Ironically, the ACE-2 receptors of mucosal cells are the way SARS-CoV-2 infects humans. Therefore, mucosal immunity is a critical aspect to defending against the virus. So, essentially what this paper authored by Fauci is saying, is that injected vaccines are not going to trigger mucosal immunity effectively. Why isn't this being communicated to the public?

I have one simple question. Why is Anthony Fauci and the government agencies he is involved with pushing experimental vaccines that he knows are most likely not going to be effective and preventing infection or transmission and marketing it with language (i.e. 95% “effective”), which leaves people with the impression that it will help us to end the pandemic, knowing full well that is not true?

Now people of the world are Guinea Pigs for the world's largest ever human experiment and a very dangerous one at that, because of the novel technology never before used in humans in a rushed-to-market vaccine that was developed in 10% of the time normally required to safety test a new vaccine. Am I the only one this infuriates?

What are the latest Infection Fatality Rates for different age groups in the U.S.?

Updated on CDC site 03-19-21

Table 1. Parameter Values that vary among the five COVID-19 Pandemic Planning Scenarios. The scenarios are intended to advance public health preparedness and planning. They are **not** predictions or estimates of the expected impact of COVID-19.

Parameter	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5: Current Best Estimate
R_0^*	2.0		4.0		2.5
Infection fatality ratio (Estimated number of deaths per 1,000,000 infections) [†]	0–17 years old: 6 18–49 years old: 150 50–64 years old: 1,800 65+ years old: 26,000		0–17 years old: 80 18–49 years old: 1,700 50–64 years old: 20,000 65+ years old: 270,000		0–17 years old: 20 18–49 years old: 500 50–64 years old: 6,000 65+ years old: 90,000
Percent of infections that are asymptomatic [§]	15%	70%	15%	70%	30%
Infectiousness of asymptomatic individuals relative to symptomatic [¶]	25%	100%	25%	100%	75%
Percentage of transmission occurring prior to symptom onset ^{**}	30%	70%	30%	70%	50%

Later in this newsletter we will compare these death rates from COVID-19 to the reported and also the more likely death rates from the vaccines...Stay tuned!

World renowned vaccine scientist warns of a global catastrophe from the vaccine program

First, I would like to present this scientist/researcher's credentials

Geert Vanden Bossche, PhD, DVM

GSK biologicals:

- Senior Project Leader of Adolescent Vaccine Projects
- New Biotech Vaccine Development and QC-QA Manager
- Head of Adjuvant Technologies and Alternative Deliveries, R&D

Novartis vaccines and diagnostics:

- Director, Research Program Leader and Head of Adjuvants

Solvay Biologicals:

- Global Project Director Influenza Vaccines

Bill and Melinda Gates Foundation:

- Senior Program Officer, Global Health, Vaccine Discovery

Global Alliance for Vaccines and Immunization (GAVI)

- Program Manager

Univac

- Chief Innovation and Scientific Officer

German Center for Infection Research (DZIF)

- Head of the Vaccine Development Office

VARECO

- Managing Director

<https://www.bitchute.com/video/BGtSE3OfO2wv/> Starts at 56:30

Here are the opening sections of his letter:

Geert Vanden Bossche, DMV, PhD, independent virologist and vaccine expert, formerly employed at GAVI and The Bill & Melinda Gates Foundation.

To all authorities, scientists and experts around the world, to whom this concerns: the entire world population.

I am all but an antivaxxer. As a scientist I do not usually appeal to any platform of this kind to make a stand on vaccine-related topics. As a dedicated virologist and vaccine expert I only make an exception when health authorities allow vaccines to be administered in ways that threaten public health, most certainly when scientific evidence is being ignored. The present extremely critical situation forces me to

spread this emergency call. As the unprecedented extent of human intervention in the Covid-19-pandemic is now at risk of resulting in a global catastrophe without equal, this call cannot sound loudly and strongly enough.

As stated, I am not against vaccination. On the contrary, I can assure you that each of the current vaccines have been designed, developed and manufactured by brilliant and competent scientists. However, this type of prophylactic vaccines are completely inappropriate, and even highly dangerous, when used in mass vaccination campaigns during a viral pandemic. Vaccinologists, scientists and clinicians are blinded by the positive short-term effects in individual patients, but don't seem to bother about the disastrous consequences for global health. Unless I am scientifically proven wrong, it is difficult to understand how current human interventions will prevent circulating variants from turning into a wild monster.

Racing against the clock, I am completing my scientific manuscript, the publication of which is, unfortunately, likely to come too late given the ever increasing threat from rapidly spreading, highly infectious variants. This is why I decided to already post a summary of my findings as well as my keynote speech at the recent *Vaccine Summit* in Ohio on LinkedIn. Last Monday, I provided international health organizations, including the WHO, with my analysis of the current pandemic as based on scientifically informed insights in the immune biology of Covid-19. Given the level of emergency, I urged them to consider my concerns and to initiate a debate on the detrimental consequences of further 'viral immune escape'. For those who are no experts in this field, I am attaching below a more accessible and comprehensible version of the science behind this insidious phenomenon.

You can read the entire letter here:

https://mcusercontent.com/92561d6dedb66a43fe9a6548f/files/beam7203-0798-4ac8-abe2-076208015556/Public_health_emergency_of_international_concert_Geert_Vanden_Bossche.01.pdf

Typically, as viruses mutate, they may become more contagious, but less virulent (deadly). That may still hold true with SARS-CoV-2, at least to the non-vaccinated. But what about the vaccinated? Whether Dr. Vanden Bossche's predictions come true or not remain to be seen, but they do highlight one of the very possible risks that have been seen with other vaccination programs (measles and pertussis to name a couple) and one that is not beyond the realm of possibility with the rush vaccination efforts during this pandemic.

A brilliant evolutionary biologist and scientist lays out the most likely scenario for the COVID-19 vaccines to result in an epidemic of future illness in vaccinees and risk of autoimmune disease

James Lyons-Weiler PhD, CEO and Director of *IPAK, the Institute for Pure and Applied Knowledge* is a brilliant critical thinker. And his background makes him a perfect voice of reason that the scientific community had better listen to.

In an opinion piece March 17, 2021, he lays out the mechanisms for a likely autoimmune epidemic in COVID-19 vaccine recipients in the coming months and years. He also makes a case for natural immunity being superior to partial (vaccine derived) immunity. It can be a little technical, but for you science nerds like me (and you know who you are), you're going to love and appreciate it!

Here goes:

I've been doing a deep dive into the immunology of COVID19 scientific literature for weeks now, and it seems someone somewhere has proposed nearly every possible ill effect of the virus on the immune system. Few have bothered to transfer that concern over fully to vaccine effects.

We've all suspected **antigenic shift** and **antigenic drift** from all of the pediatric vaccines for quite some time.

Original antigenic sin has been known to be a problem with fixed vaccines - specifically w/influenza - since the 1950s. Andy (Wakefield) published a beautiful write-up on MMR vaccine failure; we know the mumps portion is failing because the vaccine lineage is older than anyone born after 1961.

The deal w/SARS-CoV-2, is that everything is happening on a massive scale at an accelerated pace: new variants are emerging due to RNA virus evolution - but they are increasing in frequency (proliferating) on an adaptive landscape specifically because of flattening, not truncating, the curve (in descending order of importance, i.e., size of selection coefficient, my guesstimate):

- (1) **viremia** being allowed to increase in infected people (denial of early treatment) because new mutations occur in people
- (2) **test escape** (increased survival and transmission of viruses due to non-isolation of people infected w/variants that escape the test)
- (3) **immunological escape** (survival and transmission of viruses that can escape our immune responses)
- (4) **migration** (heterogeneity in public health response (maintenance of all variants at different frequencies somewhere in the globe))
- (5) **genetic drift**

All of the above interact and are not competing.

In the meantime, allopathy has written itself another permission slip to skip Antibody Dependent Enhancement (ADE) in COVID19 - with highly questionable reliance on "authority" that absolutely misrepresents ADE (it's illness of infected immune cells, but allopathy does not want to make that part well known because the answer is antivirals, which compete w/vaccines.

https://www.medpagetoday.com/special-reports/exclusives/91648?xid=nl_mpt_DHE_2021-03-17

This completely ignores the pathogenic priming of people toward autoimmunity.

Definition of epitope: a molecular region on the surface of an antigen capable of eliciting an immune response and of combining with the specific antibody produced by such a response.

As an evolutionary biologist, my focus is on **pathoimmunogenic EPITOPES**, not vaccine, not virus. **EPITOPES**.

The pathoimmunogenic epitopes cause disease when introduced to the human body **via infection or vaccine**.

Real-world contemporary example

Let's call the spike protein in the current vaccines **spike2019**.

Due to original antigenic sin, a partial immune response to viral epitopes in the spike protein only will cause people to mount an ineffective immune response to the virus when it evolves new spike protein epitope variants. These people will not have long-term adaptive immunity to the other pathoimmunogenic epitopes from the virus, and thus they will experience a new immune response - **as if they have not been vaccinated**.

So, we will see full-blown COVID-19 in some vaccinees regardless of their immunity to spike2019 epitopes (antigenic shifting).

Some of these people will have the same baseline rate of morbidity and mortality as anyone else... but will fail to seek care because they are vaccinated - they will not receive early treatment and thus morbidity and mortality will be higher.

Some **non-immune vaccinees** (who will not mount an adequate immune response to spike2020+ epitopes) will also have had occult infection (subclinical COVID19) before, during or after their vaccination.

Some of these non-immune vaccinees people are at full risk of ADE and autoimmunity from infection following secondary infection.

Why? Because we're keeping the virus around so long, because public health failed to truncate the curve. Failed early testing.

So, at this point, pathogenic priming is all-important (validated by Harvard scientists, very much recognized in the scientific literature) because autoimmunity from exposure to viral immunopathogenic epitopes is important and non-immune vaccinees are sitting ducks for it.

Natural immunity brings about a wide repertoire of responses to all of the immunogenic epitopes (diverse IgG, diverse memory B-cells, diverse T-cells).

People who have broad, lasting immunity can feel safer in a world w/COVID-19.

We need studies of the antibody responses to non-spike immunogenic epitopes... titres against spike2019 won't prove immunity for anyone for the reasons outlined above.

What about "Recurrent Infection"?

Some articles that show Spike proteins DID contribute to ADE and that "recurrent infection" can occur (likely due to new variants). I would not call it "recurrent infection"; I would call it "new infection by a non-vaccine-targeted lineage of SARS-CoV-2."

Also, here is some info on **immune escape**.

Their fabled, magical belief in "protection" from vaccines is going to be shattered by COVID-19, and it's going to be a wake-up call to those who wanted the vaccine so badly. They won't be able to keep up via updates to

the vaccine, it's just not possible. Recall what's going on w/HPV vaccination - type replacement - it's the same thing.

<https://www.sciencedirect.com/science/article/pii/S0163445321000438>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7749790/>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3187504/>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7115648/>

<https://www.sciencedirect.com/science/article/pii/S0163445321000104>

<https://www.sciencedirect.com/science/article/pii/S0163445321000438>

They can try to deny ADE, but once chronic illness due to vaccination (as outlined below) is in full swing, there will be no denying it. THUS, they will require 100% vaccination to disallow any control group.

Risks vs “benefits” of the COVID-19 vaccines- JLW

(1) The vaccines can only be expected to provide protection against severe COVID19 and death for viruses that have the same spike protein epitopes against which people have been vaccinated. It's wishful thinking to expect cross-protection.

(2) The vaccines do not confer immunity from antibodies from any of the other viral epitopes; thus, when evolutionary pressure (antigenic shifting) makes the SARS-CoV-2 vaccines obsolete, those who believe they immune will be fully vulnerable to infection from SARS-CoV-20, 21, 22 etc. Only those who had prior COVID-19 INFECTION will be immune; the vaccine does not deserve ANY credit for immunity due to SARS-CoV-2 infection. To attribute immunity to SVCV2 vaccines is a form of "stolen valor". Objectivity dictates that we assay vaccinees and non-vaccinees for non-spike protein antibody immunity so proper scientific understanding of human immunity against SARS-CoV-2 can be procured.

(3) The total "benefit" of the SVCV2 vaccination program MUST include the full assessment, over one human lifetime, to the contribution of the vaccine-induced autoimmunity due to unsafe (immunopathological) epitopes - and a strategic misjudgment in vaccine formulation. The vaccines should have been multi-epitope with unsafe (autoimmunogenic) epitopes removed.

Given all of the above, and given that diseases of unknown origin have been on the increase since 1976 when the 1st national vaccination program against a respiratory virus was started (see <https://jameslyonsweiler.com/2018/01/31/diseases-with-unknown-etiology-trace-back-to-mass-vaccination-against-influenza-in-1976/> for the compelling finding), I cannot in good faith promote the currently available vaccines.

The actual risk to benefit equation is undefined. Thus, choice. Thus, no mandate. Thus, more science on vaccinated vs. unvaccinated.

Here, for example, is an example of a SARS-CoV-1 autoimmunity induced in vaccinated animals.

Glycan arrays lead to the discovery of autoimmunogenic activity of SARS-CoV
<https://journals.physiology.org/doi/pdf/10.1152/physiolgenomics.00102.2004>

Which patients do worse from COVID-19 and thus potentially from the vaccines? JLW

We're not questioning basic principles of immunology. We're just taking in ALL of the information - the good and bad of it. As any science should.

My concern is reliance on unwarranted over-generalizations based on immunogenicity, ignoring pathimmunogenicity.

You're all about risk of vaccination given a certain condition (residual viral material).

But check this out, for example

"Patients that tested positive for auto-antibodies had a significantly more severe prognosis than other patients did: 6 of 15 patients (40%) with auto-antibodies died due to COVID-19 complications during hospitalization, whereas only 1 of 18 patients (5.5%) who did not have auto-antibodies died (P=0.03)." <https://pubmed.ncbi.nlm.nih.gov/32989903/>

To me, this meant that those who have prior autoreactogenic immune systems do poorly.

We should focus on finding out what causes people to have Th2-skew and pro-autoreactogenic immune systems.

We see these features of poor immune health in highly vaccinated populations, esp. w/Aluminum.

Animal studies routinely use aluminum hydroxide to induce autoimmunity in animals. I've consumed all of that literature - the doses overlap per body weight up to year 2.

If so many people didn't have autoimmunity, would COVID-19 be much less of a threat?

Again, a determination of full cost/benefit of vaccine calculation requires full, unbiased accounting of the costs.

Denialism (by the public health oligarchy) in the name of "vaccine efficacy" has prevented objective analysis. Even IOM/NAS was rigged to prevent vaccine hesitancy. An utter waste of time, at great expense to our nation's health.

Here's more evidence that people w/autoreactogenic immune systems are at higher risk and are walking into a storm - unlike most people -

Latent rheumatic, thyroid and phospholipid autoimmunity in hospitalized patients with COVID-19 Juan-Manuel Anaya 1 , Diana M Monsalve 1 , Man
<https://pubmed.ncbi.nlm.nih.gov/33681751/>

Thank you Dr. Lyons-Weiler for a very insightful discussion and hopefully a wake-up call for the perpetrators of the mass vaccination program experiment before it's too late.

A new study showcases the advantage of natural infection over vaccine immunity with regard to SARS-CoV-2 variant strains

As a great follow up on the previous discussion on natural immunity, a new pre-print study titled **Memory B cell repertoire for recognition of evolving SARS-CoV-2 spike** highlights the effectiveness of long-term capabilities, diversity and flexibility of memory immune function.

From the abstract:

Memory B cell reserves can generate protective antibodies against repeated SARS-CoV-2 infections, but with an unknown reach from original infection to antigenically drifted variants.

The results furnish a global atlas of the S-specific memory B cell repertoire and illustrate properties conferring robustness against emerging SARS-CoV-2 variants.

More from the study:

(PC = Plasma Cells, GC = Lymphoid tissue Germinal Centers, ABs = Antibodies and SHM = gene Somatic Hyper-Mutation)

Both PC-derived secreted antibody and memory B cells supply immune memory to prevent repeat infection, but with non-redundant roles. Secreted antibodies can prophylactically thwart pathogen invasion with fixed recognition capability, while memory B cells harbor expanded pathogen recognition capacity and can differentiate quickly into PCs to contribute dynamically to the secreted antibody repertoire (4). Moreover, memory B cells retain plasticity to adapt to viral variants through GC re-entry and SHM-mediated evolution (5).

In a comprehensive competition analysis of 152 monoclonal antibodies (mAbs) from 19 subjects for binding with trimeric S ectodomain, we have identified 7 recurrently targeted competition groups -- three for antibodies with epitopes on the receptor-binding domain (RBD), two for epitopes on the N-terminal domain (NTD), and two for S2 epitopes. We show that these groups represent the major practical antibody footprints, with rare antibodies outside them.

Discussion:

Our results illustrate the landscape of memory B cell coverage of the SARS-CoV-2 S glycoprotein in convalescent donors. Unlike the terminally differentiated plasma cells that determine the profile of serum antibodies, memory B cells will clonally expand upon re-exposure to antigen, some differentiating into fresh antibody secreting cells and others re-entering germinal centers and undergoing further SHM-mediated diversification and affinity maturation. These outcomes offer a layer of flexibility for adaptation to drifted or related viral strains, if available secreted antibodies fail to prevent initial infection. Loss of protection against overt or severe disease is not an inevitable consequence of a waning serum antibody titer. This atlas of B cell memory therefore maps systematically a crucial component of the long-term immune response to SARS-CoV-2 infection.

Complementary recognition of non-overlapping viral targets by non-competing antibodies in the repertoire can reduce the likelihood of viral escape (41). Our data suggest an additional mechanism for preventing viral escape: competing antibodies may help retain recognition of a rapidly evolving antigen by their differential sensitivity to specific mutations. The potential dynamic reach of otherwise redundant mAb recognition, illustrated by selective retention of affinity for the UK variant by some antibodies within a cluster but not by

others, may give selective advantage to immune mechanisms that yield multiple competing antibodies to critical epitopes, as those that retain adequate affinity can then re-activate, expand, and potentially undergo further affinity maturation. The emergence of strains that may have gained selective advantage by escape from neutralization emphasizes the importance of determining whether the level of retained affinity for the S protein by some antibodies in the immunodominant clusters influences protection from clinical disease.

<https://europepmc.org/article/MED/33758863>

Urgent letter from doctors and scientists to the European Medicines Agency over COVID-19 Vaccine concerns

An article titled, **Urgent Open Letter from Doctors and Scientists to the European Medicines Agency regarding COVID-19 Vaccine Safety Concerns**, was published on the *Doctors for Covid Ethics* site.

The letter in its entirety:

Emer Cooke, Executive Director, European Medicines Agency, Amsterdam, The Netherlands

28 February 2021

Dear Sirs/Mesdames,

FOR THE URGENT PERSONAL ATTENTION OF: EMER COOKE, EXECUTIVE DIRECTOR OF THE EUROPEAN MEDICINES AGENCY

As physicians and scientists, we are supportive in principle of the use of new medical interventions which are appropriately developed and deployed, having obtained informed consent from the patient. This stance encompasses vaccines in the same way as therapeutics.

We note that a wide range of side effects is being reported following vaccination of previously healthy younger individuals with the gene-based COVID-19 vaccines. Moreover, there have been numerous media reports from around the world of care homes being struck by COVID-19 within days of vaccination of residents. While we recognise that these occurrences might, every one of them, have been unfortunate coincidences, we are concerned that there has been and there continues to be inadequate scrutiny of the possible causes of illness or death under these circumstances, and especially so in the absence of post-mortem examinations.

In particular, we question whether cardinal issues regarding the safety of the vaccines were adequately addressed prior to their approval by the European Medicines Agency (EMA).

As a matter of great urgency, we herewith request that the EMA provide us with responses to the following issues:

1. Following intramuscular injection, it must be expected that the gene-based vaccines will reach the bloodstream and disseminate throughout the body [1]. We request evidence that this possibility was excluded in pre-clinical animal models with all three vaccines prior to their approval for use in humans by the EMA.

2. If such evidence is not available, it must be expected that the vaccines will remain entrapped in the circulation and be taken up by endothelial cells. There is reason to assume that this will happen particularly at sites of slow blood flow, i.e. in small vessels and capillaries [2]. We request evidence that this probability was excluded in pre-clinical animal models with all three vaccines prior to their approval for use in humans by the EMA.

3. If such evidence is not available, it must be expected that during expression of the vaccines' nucleic acids, peptides derived from the spike protein will be presented via the MHC I — pathway at the luminal surface of the cells. Many healthy individuals have CD8-lymphocytes that recognize such peptides, which may be due to prior COVID infection, but also to cross-reactions with other types of Coronavirus [3; 4] [5]. We must assume that these lymphocytes will mount an attack on the respective cells. We request evidence that this probability was excluded in pre-clinical animal models with all three vaccines prior to their approval for use in humans by the EMA.

4. If such evidence is not available, it must be expected that endothelial damage with subsequent triggering of blood coagulation via platelet activation will ensue at countless sites throughout the body. We request evidence that this probability was excluded in pre-clinical animal models with all three vaccines prior to their approval for use in humans by the EMA.

5. If such evidence is not available, it must be expected that this will lead to a drop in platelet counts, appearance of D-dimers in the blood, and to myriad ischaemic lesions throughout the body including in the brain, spinal cord and heart. Bleeding disorders might occur in the wake of this novel type of DIC-syndrome including, amongst other possibilities, profuse bleedings and haemorrhagic stroke. We request evidence that all these possibilities were excluded in pre-clinical animal models with all three vaccines prior to their approval for use in humans by the EMA.

6. The SARS-CoV-2 spike protein binds to the ACE2 receptor on platelets, which results in their activation [6]. Thrombocytopenia has been reported in severe cases of SARS-CoV-2 infection [7]. Thrombocytopenia has also been reported in vaccinated individuals [8]. We request evidence that the potential danger of platelet activation that would also lead to disseminated intravascular coagulation (DIC) was excluded with all three vaccines prior to their approval for use in humans by the EMA.

7. The sweeping across the globe of SARS-CoV-2 created a pandemic of illness associated with many deaths. However, by the time of consideration for approval of the vaccines, the health systems of most countries were no longer under imminent threat of being overwhelmed because a growing proportion of the world had already been infected and the worst of the pandemic had already abated. Consequently, we demand conclusive evidence that an actual emergency existed at the time of the EMA granting Conditional Marketing Authorisation to the manufacturers of all three vaccines, to justify their approval for use in humans by the EMA, purportedly because of such an emergency.

Should all such evidence not be available, we demand that approval for use of the gene-based vaccines be withdrawn until all the above issues have been properly addressed by the exercise of due diligence by the EMA.

There are serious concerns, including but not confined to those outlined above, that the approval of the COVID-19 vaccines by the EMA was premature and reckless, and that the administration of the vaccines constituted and still does constitute "human experimentation", which was and still is in violation of the Nuremberg Code.

In view of the urgency of the situation, we request that you reply to this email within seven days and address all our concerns substantively. Should you choose not to comply with this reasonable request, we will make this letter public.

<https://doctors4covidethics.medium.com/urgent-open-letter-from-doctors-and-scientists-to-the-european-medicines-agency-regarding-covid-19-f6e17c311595>

The letter also provides a list of references to studies supporting their concerns and a list of the doctors and scientists that have generated the letter.

New research points to link between AstraZeneca Vaccine and blood clots

Researchers in Norway and Germany say they've identified antibodies that provoke immune reactions leading to the type of cerebral blood clots experienced by some people who received AstraZeneca's COVID vaccine.

A March 22nd article posted on ***Children's Health Defense*** by Megan Redshaw reveals the mechanisms of the suspected connection between the rash of fatalities and strokes and the AstraZeneca Vaccine.

Researchers at the Greifswald teaching hospital in northern Germany said Friday they've discovered how the AstraZeneca COVID vaccine could cause blood clots that could lead to rare thrombosis in the brain, public broadcaster Norddeutscher Rundfunk reported.

The researchers found that AstraZeneca's vaccine activates blood platelets, or thrombocytes, which typically only happens in the body when a wound is healing — when the blood coagulates as the wound closes. In some patients, the vaccination activated a mechanism that caused blood clots to form in the brain.

The German research team did not release detailed data but planned to submit their findings to The Lancet.

While researchers were studying cases in Germany, a team led by Pål Andre Holme, chief physician at Oslo University Hospital, was investigating three cases of post-vaccination blood clots in Norway that occurred in healthcare workers under the age of 50.

Holme told the Norwegian newspaper VG he's confident they've identified antibodies triggered by the vaccine that caused an overreaction of the immune system leading to blood clots.

"Our theory is that this is a strong immune response that most likely comes after the vaccine," Holme said. "There is no other thing than the vaccine that can explain this immune response," Holme said.

The European Medicines Agency (EMA) investigated the reports of blood clot-related injuries and deaths and concluded that AstraZeneca's vaccine was not associated with an overall risk of blood clots in those vaccinated.

My comment: Of course they didn't!

See the rest of the article with all the links here:

https://childrenshealthdefense.org/defender/link-astrazeneca-vaccine-blood-clots/?itm_term=home

***Late March 30th update: Germany halts distribution of AstraZeneca vaccine in people under 60 years of age due to blood clots in the brain known as sinus vein thrombosis. At least thirty-one people have now suffered these effects in Germany.**

A data breach reveals confidential emails showing that the spike protein RNA in the mRNA vaccines may not be as advertised

In an investigation published in the *BMJ* on March 10th, 2021 titled **The EMA covid-19 data leak, and what it tells us about mRNA instability**, reveals that between 55-78% of the mRNA in the Pfizer vaccine is not the DNA/protein sequences they are intended to be. This could have vast implications as it relates to the possibility of causing autoimmune disease in the people receiving the vaccine. If the degraded protein sequences are similar to proteins in the host tissues of the people receiving the vaccine, the person's immune system may mount a persistent attack against those tissues.

From the article:

As it conducted its analysis of the Pfizer-BioNTech covid-19 vaccine in December, the European Medicines Agency (EMA) was the victim of a cyberattack.¹ More than 40 megabytes of classified information from the agency's review were published on the dark web, and several journalists—including from *The BMJ*—and academics worldwide were sent copies of the leaks. They came from anonymous email accounts and most efforts to interact with the senders were unsuccessful. None of the senders revealed their identity, and the EMA says it is pursuing a criminal investigation.

The BMJ has reviewed the documents, which show that regulators had major concerns over unexpectedly low quantities of intact mRNA in batches of the vaccine developed for commercial production.

EMA scientists tasked with ensuring manufacturing quality—the chemistry, manufacturing, and control aspects of Pfizer's submission to the EMA—worried about “truncated and modified mRNA species present in the finished product.” Among the many files leaked to *The BMJ*, an email dated 23 November by a high ranking EMA official outlined a raft of issues. In short, commercial manufacturing was not producing vaccines to the specifications expected, and regulators were unsure of the implications. EMA responded by filing two “major objections” with Pfizer, along with a host of other questions it wanted addressed.

The email identified “a significant difference in % RNA integrity/truncated species” between the clinical batches and proposed commercial batches—from around 78% to 55%. The root cause was unknown and the impact of this loss of RNA integrity on safety and efficacy of the vaccine was “yet to be defined,” the email said. suffers from contain “a significant difference in % RNA integrity/truncated species”.

RNA instability is one of the biggest hurdles for researchers developing nucleic acid based vaccines. It is the primary reason for the technology's stringent cold chain requirements and has been addressed by encapsulating the mRNA in lipid nanoparticles (box).

“The complete, intact mRNA molecule is essential to its potency as a vaccine,” professor of biopharmaceutics Daan J.A. Crommelin and colleagues wrote in a review article in *The Journal of Pharmaceutical Sciences* late last year. “Even a minor degradation reaction, anywhere along a mRNA strand, can severely slow or stop proper translation performance of that strand and thus result in the incomplete expression of the target antigen.”⁶

AN IMPORTANT SECTION AT THE END OF THE ARTICLE:

Lipid nanoparticles—where do they go and what do they do?

Conceived three decades ago, RNA based therapeutics¹¹ have long inspired imaginations for their theoretical potential to transform cells of the body into “an on-demand drug factory.”¹² But despite heavy investment by the biotech industry, bench-to-bedside translation was constantly hindered by the fragility of mRNA.

Over the years, researchers attempted to resolve intrinsic instability by encapsulating mRNA in nanocarriers made of polymers, lipids, or inorganic materials. Lipid nanoparticles (LNPs) were chosen by Moderna, Pfizer-BioNTech, CureVac, and Imperial College London for their covid-19 vaccines. This has attracted the attention of specialists in the field of pharmaceutical biotechnology, some of whom have raised concerns about further unknowns.

In a rapid response posted on bmj.com, JW Ulm, a gene therapy specialist who has published on tissue targeting of therapeutic vectors,¹³ raised concerns about the biodistribution of LNPs: “At present, relatively little has been reported on the tissue localisation of the LNPs used to encase the SARS-CoV-2 spike protein-encoding messenger RNA, and it is vital to have more specific information on precisely where the liposomal nanoparticles are going after injection.”¹⁴ It is an unknown that Ulm worries could have implications for vaccine safety.

End of excerpts

A concern about this revelation from a scientist that specializes in immunoreactivity.

“On a good day at the vaccine plant, as much as 30% of the mRNA in the vaccine can be “truncated and modified” due to instability. 45% on a bad day. That means instead of producing the target spike protein, this mRNA will direct the cell to produce RANDOMLY modified proteins with RANDOMLY modified peptides that can have high homology to ANY protein/peptide. These randomly modified proteins can have peptides that have high homology to self-proteins, food proteins, aeroallergen proteins, etc. The result is the immune system could be trained to attack self-proteins (autoimmunity), food proteins (food allergy), aeroallergen (asthma) etc.” Quote from Vinu Arumugham

Final thoughts

Not only does this article expose defects in the final product that raise concerns over host autoimmune reactions, but what how does that huge deficiency affect the efficacy of the vaccine, when the person’s cells make the wrong proteins to be displayed to the immune system? The only possible answer is that the effectiveness can’t be nearly as expected. And lastly, the unknowns over the Lipid Nanoparticles (LNPs). Is it prudent to test these “unknowns” on much of the world’s population? What could possibly go wrong!!!?

Pfizer revises ultra-cold storage guidance for Covid-19 jab to refrigerator temperatures- This raises suspicions

Considering the previous report, isn’t it ironic that Pfizer has now announced that its vaccine does not need to be stored at the ultra-cold temperatures previously recommended. The article is titled, **Pfizer revises ultra-**

[cold storage guidance for Covid-19 jab, says vaccine is stable at refrigerator temperatures](#), and was published on RT.com.

Given the original rationale for the ultra-cold storage as the fact that the mRNA is unstable at “warmer” temperatures. Based on the previous report, the mRNA appears to be very unstable even in the manufacturing process. So, if the final product is left with an unacceptably high level of degraded and incomplete mRNA already, does it make any sense that they are now promoting a storage temperature that they were convinced from the outset was necessary to maintain stability?

<https://www.rt.com/news/516069-pfizer-covid19-vaccine-refrigerator-cold/>

Is the death rate from the vaccines higher than from COVID-19?

On its face, that sounds like a ludicrous and highly improbable possibility but consider this.

According to a January 2021 article published in the *Annals of Internal Medicine* titled, [Infection Fatality Ratios for COVID-19 Among Non-institutionalized Persons 12 and Older: Results of a Random-Sample Prevalence Study](#), the infection Fatality Rate (IFR) for persons under age 40 is just 0.01% or 1 in 10,000. <https://www.acpjournals.org/doi/10.7326/M20-5352>

So, how does that compare to the IFR estimates in different age demographics according to the CDC’s statistics as of March 19th 2021?

The screenshot shows the CDC website's COVID-19 section. At the top, there is a search bar with "Search COVID-19" and a navigation menu with options like "Your Health", "Vaccines", "Cases & Data", "Work & School", "Healthcare Workers", "Health Depts", and "Science". Below the navigation, the main heading is "COVID-19 Pandemic Planning Scenarios". There are icons for "WEAR A MASK", "STAY 6 FEET APART", and "AVOID CROWDS". A yellow highlight indicates the page was "Updated Mar. 19, 2021". A "Print" button is also visible. The URL in the browser's address bar is <https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html#>.

The SUMMARY of most likely scenario according to the CDC:

- In the 0-17 year-old age group, the Infection Fatality Rate is 0.002% (20 deaths per million infections, or 1 death in every 50,000 infections)
- In the 18-49 year-old age group it is 0.05% (500 deaths per million infections, or 1 death in every 2,000)

infections)

- In the 50-64 year-old age group it is 0.6% (6,000 deaths per million infections, or 1 death in every 167 infections)
- In the 65+ age group it is 9% (90,000 deaths per million infections, or 1 death in every 11 infections). The CDC previously reported in June 2020, that people 65 and over account for 80.73% of all COVID-19 deaths. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html>

Footnote: We have to keep in mind the significant over-reporting of what consists of a COVID-19 death. But let's set that aside for now and compare suspected vaccination deaths to what the CDC has been considering COVID-19 deaths.

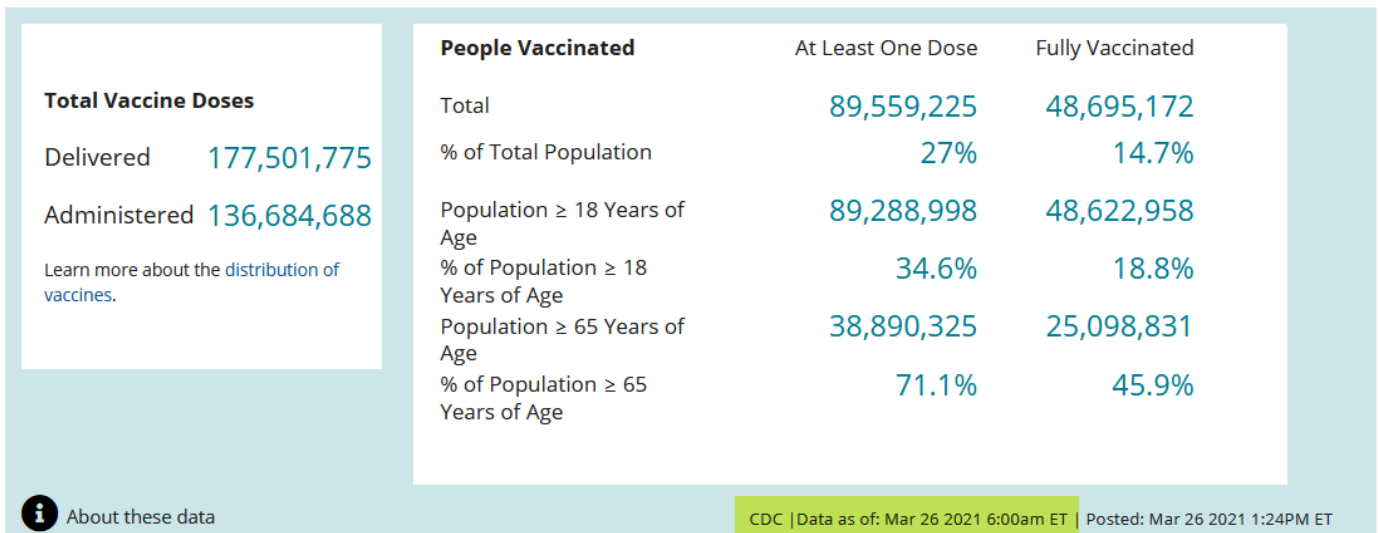
So, what is the death rate for those getting the vaccine? We have no way to now for sure, but we can play out different scenarios based on what we know so far.

As seen in the screen capture below, as of March 26th, there have been 48,695,172 people FULLY vaccinated in the U.S.

COVID-19 Vaccinations in the United States

Overall US COVID-19 Vaccine | Deliveries and Administration; Maps, charts, and data provided by CDC, updated daily by 8 pm ET[†]

Represents all vaccine partners including jurisdictional partner clinics, retail pharmacies, long-term care facilities, Federal Emergency Management Agency and Health Resources and Services Administration partner sites, and federal entity facilities.

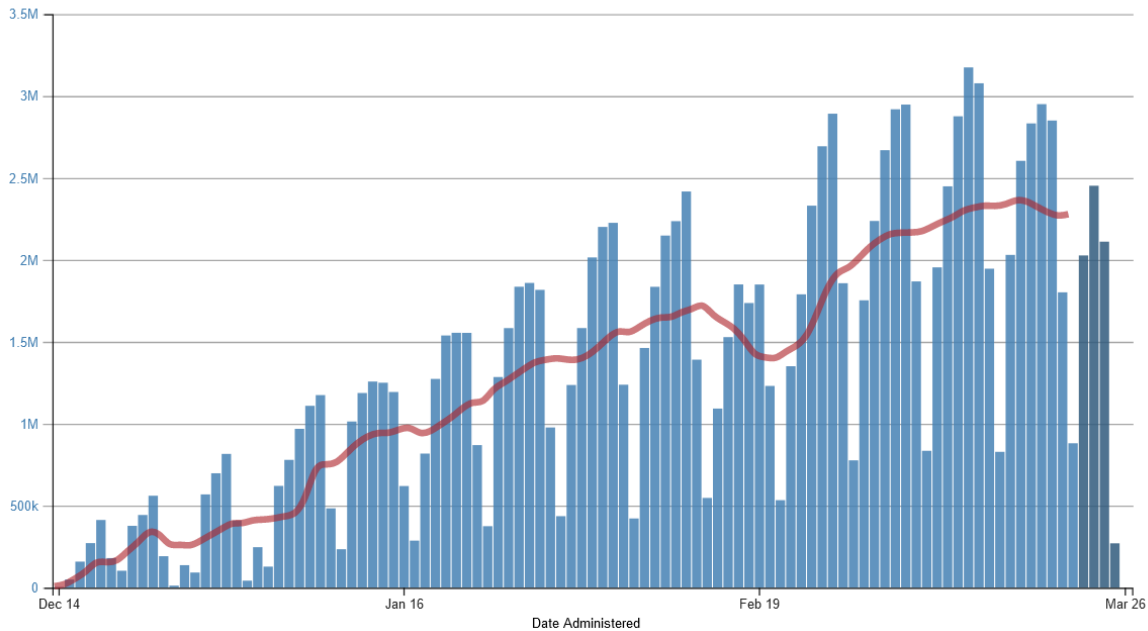


<https://covid.cdc.gov/covid-data-tracker/#vaccinations>

Since the latest reported VAERS death totals were as of March 19th, and this chart was through March 25th, I had to back out the doses given from March 19th through March 25th. This is how I did that. I used the data from the CDC's web site shown in the chart below. It is an interactive chart, so I could see how many doses were given each day. Since both the Pfizer and Moderna vaccines require 2-doses to be fully vaccinated I cut the number of doses to back out from the total in half.

<https://covid.cdc.gov/covid-data-tracker/#vaccination-trends>

Daily Count of Total Doses Administered and Reported to the CDC by Date Administered, United States



My calculation resulted in 14,123,487 doses March 19th (last VAERS death total available) through the 25th, the last full day reported for vaccines doses administered. Since I am calculating the number of people fully vaccinated and Pfizer and Moderna require 2 doses, I will divide the 14,123,487 does by 2. That equals another 7,061,744 fewer people fully vaccinated by March 19th than the reported numbers for March 26th. That means approximately 41,633,428 people were fully vaccinated by March 19th.

Deaths reported to the Vaccine Adverse Event Reporting System (VAERS)

There have been 2,050 VAERS reported deaths as of March 19th, 2021.

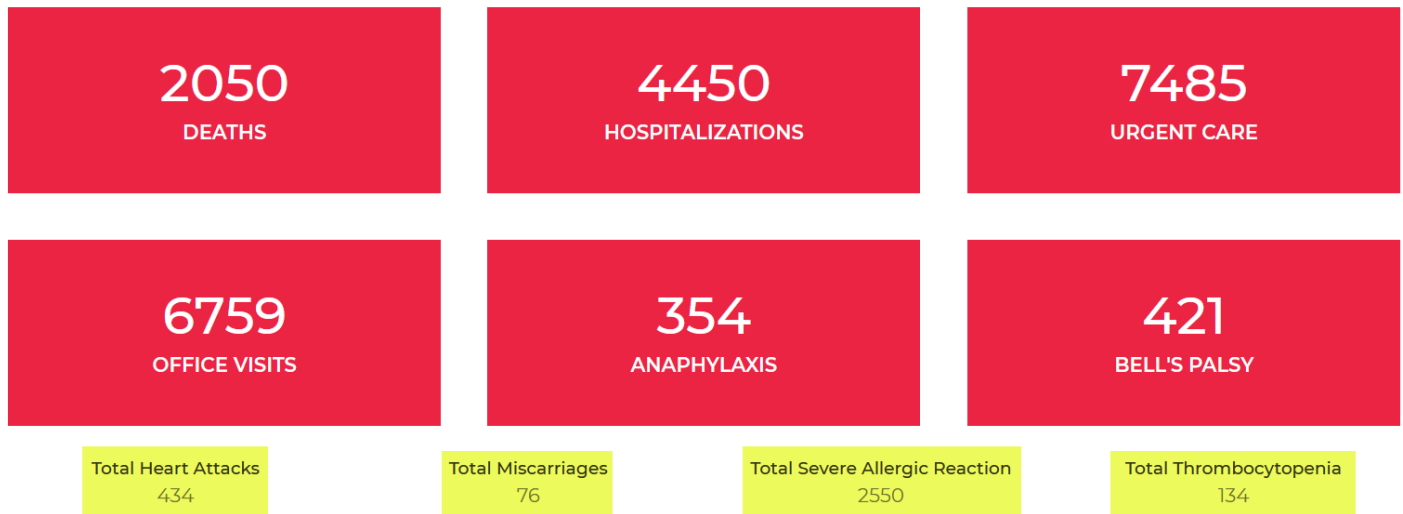
See chart next page...

Note: This is not the latest data but was the data I used to make the calculations below. Now that the reported deaths (as of April 2nd, 2021) are 2,342, it makes the death by vaccine numbers that much higher. And the concerning thing is, this number will continue to climb weekly until the vaccinations stop.

VAERS COVID REPORTS

44,606 Reports Through March 19, 2021*

[jump to browse reports](#) ▾



Now the calculations

Dividing 2,050 (deaths) by 41,633,428 (fully vaccinated individuals) equals a 0.0049% mortality (death) rate from the vaccines.

It is critical to consider that there has been every attempt possible to deny that any deaths were related to the vaccine and people are afraid to even go there, because they will be ridiculed and accused of giving the “anti-vaxxers” ammunition to push back against the vaccines. Even the many cases of deaths in reportedly healthy people have been roundly denied without any investigative efforts. With all that going on, the reported deaths may actually be less than 1% of the actual deaths.

So, taking 1% reporting as has been shown to be accurate according to the *CDC funded Harvard Pilgrim Health Study*, discussed previously in this newsletter, the actual death rate would be 100 times higher and calculates to 0.49% (take 0.0049% and move 2 decimal places to the right). That will calculate to 204,000 deaths. As strange and ironic as it sounds, that is one death in every 204 fully vaccinated people (204 X 204,000 = 41,616,000 or 41,633,428 / 204,000 = 204). Compare that number to the 50-64 year-old age group in the CDC table of 1 death in every 167 people infected with SARS-CoV-2.

It's doubtful, but let's consider that maybe as high as 10% of deaths are being reported to VAERS. That would mean that as of March 19th, there would have been 20,500 deaths from the vaccines rather than the 2,050 that have been reported. **With 41,633,428 people fully vaccinated, that would be a death rate of 0.049% or one person in 2,041 fully vaccinated people.** So the notion that death as a consequence of the vaccines is a one-in-a-million as many like to parrot is ridiculous.

So once again. **If only 10% of the deaths from the vaccines are being reported to VAERS**, compare that death rate from the vaccines spread across all age groups at 0.049% to the CDC's data for the following age groups:

- **The 0-17 year-old age group-** The risk of death from the vaccines is approximately 25 times higher than from the infection itself! (0.002% to 0.49%). Now we don't know what the death rate in those under 17 will be from the vaccines, because thank God they haven't started vaccinating them YET, but they intend to. And it is unconscionable that they are even considering risking the short-term, the long-term and the potential risk of fatality in an age group with such low mortality from the disease. But that's the upside-down world we live in right now. And all driven by pharma's insatiable profit hungry motives.
- **The 18-49 year-old age group-** The risk of death from the vaccines is approximately 10 times higher from the vaccines than from the infection! (0.49% to 0.5%)
- **The 50-64 year-old age group-** The risk of death is nearly the same from the vaccines as compared to the infection. (.49% to .6%)

And remember, according to the *Annals of Internal Medicine* article above, the Infection Fatality Rate for the under 40 age group is only 0.01%. So according to their statistics the risk of death from the vaccines are nearly 5 times higher!

And to reiterate, one thing we have to keep in mind as we speculate as to the number of deaths and other serious adverse reaction reporting is that there is intense pressure from medical providers, the media and those in government that are highly invested in seeing that the vaccination program rolls on unencumbered by pesky reports like these. After all, if any causation is attributed to the vaccine for any of these reactions and deaths, it would "fuel the fires of vaccine hesitancy." And for heaven's sake, we wouldn't want truth and informed decision-making to get in the way!

Other interesting comparisons can be made looking at the number of adverse events reported through VAERS as of March 19th, 2021. As seen above, there were 44,606 reports registered. If that represents 1% of their actual adverse reactions, the real number would be 4,460,600. With 41,633,428 people fully vaccinated, 4,460,600 AEs represents 11% of all vaccinated individuals. "One in a million" huh?

First lawsuit challenging mandatory vaccines

You could have seen the video here: <https://www.youtube.com/watch?v=t3P9CYGg9M4> , but the arbiters of truth have taken it down.



This video has been removed for violating YouTube's Community Guidelines.
[Learn more](#)

AstraZeneca Vaccine linked to blood clots leading to deaths and severe injury

A March 16th article appeared on *theBusinessInsider.com* titled, **Sweden joins Germany, France, and 15 other countries in suspending AstraZeneca's vaccine over possible side effects.**

The article reported the following:

Multiple countries have paused the use of AstraZeneca's COVID-19 vaccine as a precaution while investigators look into cases of blood clots among vaccinated people.

Austrian authorities said March 7 that a 49-year-old woman had died as a result of severe coagulation disorder after taking the shot, and that a 35-year-old had developed blood clots in the lungs, but was recovering. Both had received vaccines from the same batch, the authorities said.

Danish authorities said on March 10 that one person who had clots after receiving the vaccine had died.

The European Medicines Agency (EMA) on the same day noted one death in a person with multiple blood clots after receiving the shots, and one person who had been hospitalized from a blood clot in their lung. It didn't specifically say whether these were the same as the two incidents reported in Austria.

The EMA noted two other "thrombotic events" in people who had received the vaccines, without giving details.

And on Sunday, the Dutch said there had been six new reports of clotting and thrombocytopenia — low platelet count — in adults under 50 in Denmark and Norway over that weekend.

<https://www.businessinsider.com/astrazeneca-covid-vaccine-countries-suspend-denmark-thailand-batch-blood-clots-2021-3?op=1>

In a related April 6th story published on *Reuter's* titled **Clear link between AstraZeneca vaccine and rare blood clots in brain, EMA official tells paper**, it appears that the connection between the vaccine and these adverse events is becoming clearer.

From the story:

There is a link between AstraZeneca's COVID-19 vaccine and very rare blood clots in the brain but the possible causes are still unknown, a senior official for the European Medicines Agency (EMA) said in an interview published on Tuesday.

"In my opinion, we can now say it, it is clear that there is an association (of the brain blood clots) with the vaccine. However, we still do not know what causes this reaction," Marco Cavaleri, chair of the vaccine evaluation team at the EMA, told Italian daily *Il Messaggero*.

A high proportion among the reported cases affected young and middle-aged women but that did not lead EMA to conclude this cohort was particularly at risk from AstraZeneca's shot.

European investigators have put forward one theory that the vaccine triggers an unusual antibody in some rare cases; others are trying to understand whether the cases are linked with birth control pills.

The AstraZeneca vaccine is based on a modified chimpanzee adenovirus vector, ChAdOx1, developed at Oxford University, and is one of several adenovirus-vector COVID-19 vaccines. The current vaccine rollout represents the first use of viral vector vaccines on such a global scale.

<https://www.reuters.com/article/us-health-coronavirus-astrazeneca-vaccin-idUSKBN2BT1ER>

One more story was published in *MedScape* on April 1st, 2021 titled **AstraZeneca COVID Vaccine: Clotting Disorder Mechanism Revealed?**

From the story:

Use of the vaccine has been suspended for individuals younger than 55 or 60 years in several European countries and in Canada after reports of a prothrombotic disorder and thrombocytopenia, mainly in younger individuals.

Now, more information on the prothrombotic disorder has become available. The vaccine appears to be linked to a condition that clinically resembles heparin-induced thrombocytopenia (HIT) and that occurs mainly in younger women.

They found that serum from four patients who were tested showed platelet-activating antibodies directed against platelet factor 4 (PF4), similar to what is seen in HIT.

They are proposing naming the condition "vaccine-induced prothrombotic immune thrombocytopenia (VIPIT)" to avoid confusion with HIT.

"Vaccinated people should be aware of the remote possibility of these very rare types of blood clots occurring. If they have symptoms suggestive of clotting problems as described in the product information, they should seek immediate medical attention and inform healthcare professionals of their recent vaccination."

<https://www.medscape.com/viewarticle/948560>

Bill Gates says a third shot may now be needed

"Doctor" Gates is at it again. In a *CBS News* article, he says that the new variants may require his buddies in the vax industry to try to stay one step ahead of the virus. I guess he is setting us up for the eventual pitch that the public will "need" regular injections, maybe something similar to the low effectiveness "crap shoot" that is the annual flu shot campaign. And you can bet the shareholders for these companies are salivating at the idea.

The February 17th, 2021 article was titled, **Third shot may be needed to combat new coronavirus variants, Bill Gates says.**

And, in case you care what Gates had to say, here are some choice quotes:

"The discussion now is do we just need to get a super high coverage of the current vaccine, or do we need a third dose that's just the same, or do we need a modified vaccine?" Gates told "[CBS Evening News](#)" anchor and managing editor Norah O'Donnell.

"All five of the companies that have U.S. vaccines are looking at making that modification and adding that in so that people who've already had two shots might need to get a third shot," he said. "I think it's reasonably likely that we will have a tuned vaccine just to make absolutely sure that as these variants hit the U.S. that they're not escaping from vaccine protection."

If the coronavirus is not eradicated, he said, additional shots may be necessary in the future. "Probably not yearly, but as long as it's out there, we want as many Americans as possible not to be spreading it to each other," he said.

End of excerpts:

<https://www.cbsnews.com/news/covid-vaccine-variants-third-shot-bill-gates/>

Obviously, Bill is one of the few people that haven't heard that the vaccines have not been shown to prevent infection and transmission. His comment either shows his ignorance, or a pathological desire to deceive the public.

When will it end?

If you think the third shot is the end of the PUSH (pun intended) for ongoing vaccines, you are sadly mistaken. The real question is, are you willing to line up for you annual or semi-annual "booster" for this just like the flu vaccine? And consider, if you are pro-vaccine passports you will be regretting that decision later when they inevitably roll out all kinds of other new vaccines. And don't say I didn't tell you so.

Personal anecdotes of serious and fatal reactions:

In my close circle of friends, I have been told of three instances, one critical, one fatal reaction and one miscarriage.

1. The person that died from the vaccine was an elderly man with dementia living in a care home. He was otherwise doing well prior to the vaccine. After the shot he lapsed into confusion to the point of "being incoherent" and had extreme difficulty breathing as my friend (his daughter) related to me. Shortly thereafter he developed fluid in his lungs and had to have them drained three times. Sadly, he passed away shortly thereafter.
2. The other person was an ex-firefighter, 61 years old who was a health and fitness fanatic in great shape. He was not intending to get the vaccine, but the only reason he got the vaccine was to travel to Nepal to climb up to "Base Camp" on Everest with a group of firefighters. They were doing that trip to bring about awareness of the high rates of cancer in the firefighter community. Again, this man had been training for this expedition and was incredibly fit. After receiving his first vaccine, he suffered a reaction that has left him fighting for his life in the hospital. Both lungs have "collapsed" according to my friend who is a retired fellow fire fighter. He is waiting on a double lung transplant.

3. The third is someone that was 7 months pregnant and chose to get the vaccine. After being vaccinated she lost the baby. Prior to the vaccine she was having no complications and her pregnancy was progressing normally.

These are three events that were completely preventable. The shocking and maddening thing is that this is happening all over our country and the world, yet the media is silent. Doctors are either afraid or unwilling to report them because of being criticized for doing the right thing, or in some warped and twisted way not wanting to contribute to “vaccine hesitancy.”

On one last note: The Federal Government has just pledged to spend 3 BILLION dollars to convince people to get the vaccines. And the marketing campaigns are everywhere you look. If you’ve seen celebrities peddling them lately, guess what? Yes, YOU are paying them and the media to convince YOU to get the shots. Isn’t that a messed-up proposition to say the least? They’ve pledged billions of dollars to pharma to produce these gene therapy biologicals. Now they are paying billions to promote them and by golly, they are going to get their money’s worth!

May 1st Update

Latest VAERS COVID vaccine injury reports and the incredibly high real-world numbers

VAERS, the **Vaccine Adverse Event Reporting System** is a voluntary (passive) reporting system. There are no requirements to report, and most people have no idea it even exists. Therefore, the number of adverse events from vaccines are grossly under-reported as you will see below.

VAERS COVID REPORTS

(Vaccine Adverse Events Reporting System, USA)

157,277 Reports

Through April 30, 2021

*

[jump to browse reports](#) ▾

3837

DEATHS

10715

HOSPITALIZATIONS

21623

URGENT CARE

26046

OFFICE VISITS

834

ANAPHYLAXIS

942

BELL'S PALSY

Heart Attacks
1132

Miscarriages
213

Severe Allergic Reaction
7463

Thrombocytopenia/Low Platelet
822

The CDC funded a Harvard study that found that less than 1% of adverse reactions to vaccines are reported

More about that in a second. But imagine if this is true, you would ADD two zeros to each of the above numbers, i.e., 224,900 deaths! Some say that with serious reactions like deaths it may be higher reporting. If instead of <1%, what if only 10% were reported. You would then add one zero to the reported deaths and the actual number would be 22,490 thus far. The next logical question would have to be, “how many is too many?”

Here's the proof of the <1% reporting claim

Harvard Pilgrim Health Care performed the study between 12/01/2007 -09/30/2010. The report was titled, **Electronic Support for Public Health–Vaccine Adverse Event Reporting System (ESP: VAERS)**
<https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf>

The Purpose of the Study:

“This research project was funded to improve the quality of vaccination programs by improving the quality of physician adverse vaccine event detection and reporting to the national Vaccine Adverse Event Reporting System (VAERS)...

“The CDC’s Public Health Information Network Messaging System (PHIN-MS) software was installed within the facilities so that the approved reports could be securely transferred to VAERS as electronic messages in an interoperable health data exchange format using Health Level 7 (HL7).”

Results from the study:

“Preliminary data were collected from June 2006 through October 2009 on 715,000 patients, and 1.4 million doses (of 45 different vaccines) were given to 376,452 individuals. Of these doses, 35,570 possible reactions (2.6 percent of vaccinations) were identified. This is an average of 890 possible events, an average of 1.3 events per clinician, per month. These data were presented at the 2009 AMIA conference.”

Dividing 1.4 million doses between 376,452 people is an average of 3.72 doses per person. And, if there were 35,570 reactions in 1.4 million doses given, that is one adverse reaction for every 39.4 doses. Perhaps what is most striking here is that if each person reacting experienced on adverse reaction only, of the 376,452 individuals vaccinated, nearly 10% experienced a possible reaction!

“Adverse events from drugs and vaccines are common, but underreported. Although 25% of ambulatory patients experience an adverse drug event, less than 0.3% of all adverse drug events and 1-13% of serious events are reported to the Food and Drug Administration (FDA). Likewise, fewer than 1% of vaccine adverse events are reported. Low reporting rates preclude or slow the identification of “problem” drugs and vaccines that endanger public health.”

In addition, ESP: VAERS investigators participated on a panel to explore the perspective of clinicians, electronic health record (EHR) vendors, the pharmaceutical industry, and the FDA towards systems that use proactive, automated adverse event reporting.” (Since in the end, this improved automated reporting system was stymied and went nowhere, one has to wonder what influence the pharma reps on the panel had on that).

Here's the kicker. After spending nearly 3 years and a million dollars, the CDC went dark on the program. Was it because the surveillance system would significantly increase the reporting of vaccine adverse reactions?

The last statement from the Results section of the article says it all...

“Unfortunately, there was never an opportunity to perform system performance assessments because the necessary CDC contacts were no longer available and the CDC consultants responsible for receiving data were no longer responsive to our multiple requests to proceed with testing and evaluation.”

One has to wonder what is stopping the automation of the vaccine adverse reporting system from being implemented. This report suggested that its implementation would be easy to accomplish. That was in 2010. It is now 2018 and nothing has been done to accomplish this vital information system. And lives hang in the balance.

It is feared that the greatest number of deaths will not occur for some time to come

Many scientists and researchers warn that the potential for ***Antibody Dependent Enhancement*** AKA ***Pathogenic Priming*** as well as other autoimmune and immune dysregulation effects from the vaccines can lead to a large number of delayed deaths from the vaccines.

And here's an example of one of those raising a red flag!

The Spike Protein as the progenitor of the epidemic of thrombotic events occurring post-vaccination around the globe

In the first part of this newsletter, I am going to concentrate on the clotting issue that many top experts now believe is leading to the unprecedented number of cases of severe injury and death happening around the world post COVID-19 “vaccines”. I personally know of three people that this has happened to as relayed to me from my closest circle of friends. This is just one of the many potential mechanisms of injury, but I believe is an important one to take a deeper dive into.

I've used scare quotes around the word vaccine, because as many of you reading this know, these are not vaccines in the traditional sense. The top four products are actually gene modifying technologies that introduce the spike protein into our cells either by a lipid nanoparticle encapsulating it (Moderna and Pfizer) or a viral vector with the spike protein spliced into an adenovirus (Johnson and Johnson and AstraZeneca). These two methods are the delivery mechanism to get the spike protein inside our cells. Once inside our cells, the ribosomes within the cell then manufacture or make copies of the spike protein sequences. These then are presented on the surface of the cell as they “bud” through the exterior layers and are eventually released into our circulation. Aside from that method of release into our body, our immune system upon recognizing these budding viral proteins mount an attack on the cell, eventually essentially blowing up the cell. When that happens all of the manufactured spike proteins are released into circulation to travel throughout the body and wreak havoc.

It has often been said as these novel technologies were being produced, that they will turn our cells into vaccine making factories. This ability of the spike proteins produced by our own cells as a result of the programming or “hacking the software of life” as Tal Zacs, Moderna's Chief Scientific Officer is quoted as

saying about their mRNA vaccine technology in a **Ted Talk** is a risky proposition, especially when attempts to make vaccines in the past were never able to make it past animal trials due to the lethality of the vaccines.

https://www.ted.com/talks/tal_zaks_the_disease_eradicating_potential_of_gene_editing

As I said months ago when I first saw this video..."Hacking the software of life? What could possibly go wrong!"

As this release of spike protein happens throughout the body in the hours and days after a person receives the vaccine, some people have an exaggerated reaction to this exposure to the spike protein and develop this clotting phenomenon in the small blood vessels of organs, leading to severe complications and death. As I've studied this, I have heard experts express concern and reservation about how this is then treated in the hospital, as they say that the traditional way of treating these clotting disorders with blood thinners may actually make matters worse.

We are really in uncharted territory here. And that is why you don't shortcut long-term safety studies for vaccines, especially new and experimental technologies. This is especially true for a virus that has a world-wide infection survival rate of 99.95% for people under 70 years of age.

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

A prime example of the dangers of the spike protein

This March 8th, 2021 pre-print study titled **SARS-CoV-2 spike protein S1 induces fibrin(ogen) resistant to fibrinolysis: Implications for microclot formation in COVID-19**, is a wake-up call for the need for an intensive INDEPENDENT investigation to the injuries and deaths post COVID vaccines all around the world. This is something that I have been suspicious about and have reported on in previous newsletters.

The spike protein is thought to be the triggering mechanism for the thrombotic (clotting) disorders seen in the microvasculature of the body in some patients with COVID-19. After this section I will show one of the mechanisms for how that happens.

But first, I think it is important to read some very relevant sections of this study. I've included a good portion of the study because I believe it is a powerful wake up call for the world and the use of these experimental products.

***PPP stands for Platelet Poor Plasma.**

ABSTRACT

Severe acute respiratory syndrome coronavirus 2 (SARS-Cov-2) -induced infection, the cause of coronavirus disease 2019 (COVID-19), is characterized by unprecedented clinical pathologies. One of the most important pathologies, is hypercoagulation and microclots in the lungs of patients. Here we study the effect of isolated SARS-CoV-2 spike protein S1 subunit as potential inflammagen *sui generis*. Using scanning electron and fluorescence microscopy as well as mass spectrometry, we investigate the potential of this inflammagen to interact with platelets and fibrin(ogen) directly to cause blood hypercoagulation. Using platelet poor plasma (PPP), we show that spike protein may interfere with blood flow. Mass spectrometry also showed that when spike protein S1 is added to healthy PPP, it results in structural changes to β and γ fibrin(ogen), complement 3,

and prothrombin. These proteins were substantially resistant to trypsinization, in the presence of spike protein S1. Here we suggest that, in part, the presence of spike protein in circulation may contribute to the hypercoagulation in COVID-19 positive patients and may cause substantial impairment of fibrinolysis. Such lytic impairment may result in the persistent large microclots we have noted here and previously in plasma samples of COVID-19 patients. This observation may have important clinical relevance in the treatment of hypercoagulability in COVID-19 patients.

From the study:

Spike protein, can however be shed, and it has been detected in various organs, including the urinary tract (George et al., 2021). S1 proteins can also cross the blood-brain-barrier (Rhea et al., 2021). Free S1 particles may also play a role in the pathogenesis of the disease (Letarov et al., 2020, Buzhdygan et al., 2020). Free spike protein can potentially be released due to spontaneous “firing” of the S protein trimers on the surface of virions, and infected cells liberates free receptor binding domain-containing S1 particles (Letarov et al., 2020). Here we study the effect of isolated SARS-CoV-2 spike protein S1 subunit as potential proinflammatory inflammagen *sui generis*. We investigate the potential of this inflammagen to directly interact with platelets and fibrin(ogen) to cause fibrin(ogen) protein changes and blood hypercoagulation. We also determine if the spike protein may interfere with blood flow, by comparing naïve healthy PPP samples, with and without added spike protein, to PPP samples from COVID-19 positive patients (before treatment). We conclude that the spike protein may have pathological effects directly, without being taken up by cells.

Discussion:

In this laboratory analysis, we provide evidence that spike protein does indeed play a major role in hypercoagulability seen in COVID-19 patients. It causes anomalous clotting in both purified fluorescent fibrinogen and in PPP, where the nature of the clots were shown to be amyloid (ThT as our amyloid dye of choice). An interesting observation was that these dense deposits were noted both in smears exposed to spike protein, and when thrombin was added. The addition of thrombin causes purified (Alexa Fluor™488) fibrinogen to polymerize into fibrin networks. Typically, these networks are netlike (Figure 3A). In the presence of spike protein, the structure changed to form dense clot deposits (Figure 3B). These deposits were seen in our fluorescent fibrin(ogen) model and PPP from healthy individuals exposed to spike protein. In healthy PPP exposed to spike protein, followed by incubation with ThT, there was a significant increase in anomalous clots with an amyloid nature, (Figure 4D), when compared to the health PPP. Spike protein also caused major ultrastructural changes in WB (as viewed with the SEM), where platelet hyperactivation were noted (Figure 6C and D). Increased in spontaneously formed fibrin network, as well as anomalous clot formation were also observed in SEM micrographs (Figure 6E - H). Interestingly, extensive spontaneous fibrin network formation was noted, without the addition of thrombin. This is in line with results that were recently published, where we showed similar ultrastructure in blood smears from COVID-19 positive patients. In these patient’s platelet hyperactivation, anomalous clotting with amyloid signal and spontaneous fibrin fibre formation were also observed (Pretorius et al., 2020, Venter et al., 2020).

Figure 4: Representative fluorescence micrographs of platelet poor plasma (PPP) from healthy individuals after addition of ThT (green fluorescent signal). **A)** PPP smear. **B)** PPP with spike protein. **C)** PPP with thrombin to create extensive fibrin clot; **D)** PPP exposed to spike protein followed by addition of thrombin. Final spike protein concentration was 1ng.mL^{-1} .

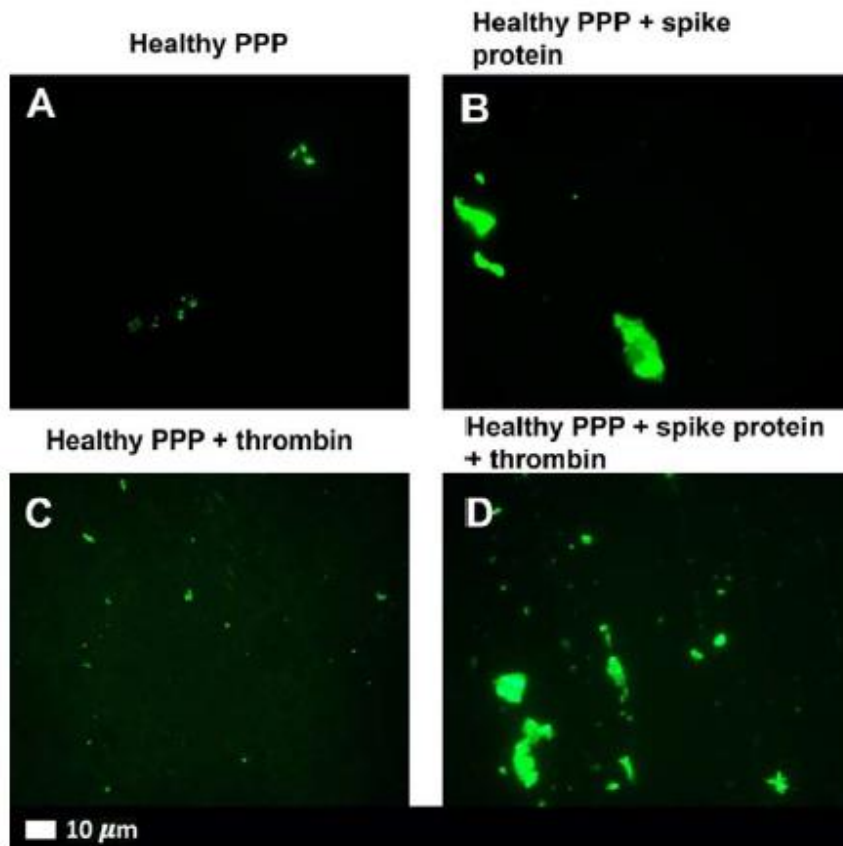


Figure 5A: Fluorescence microscopy micrographs of representative naive whole blood (WB), where platelets were incubated with fluorescent marker, CD62P-PE. **B)** WB after exposure to spike protein. The white arrows point to hyperactivated activated platelets.

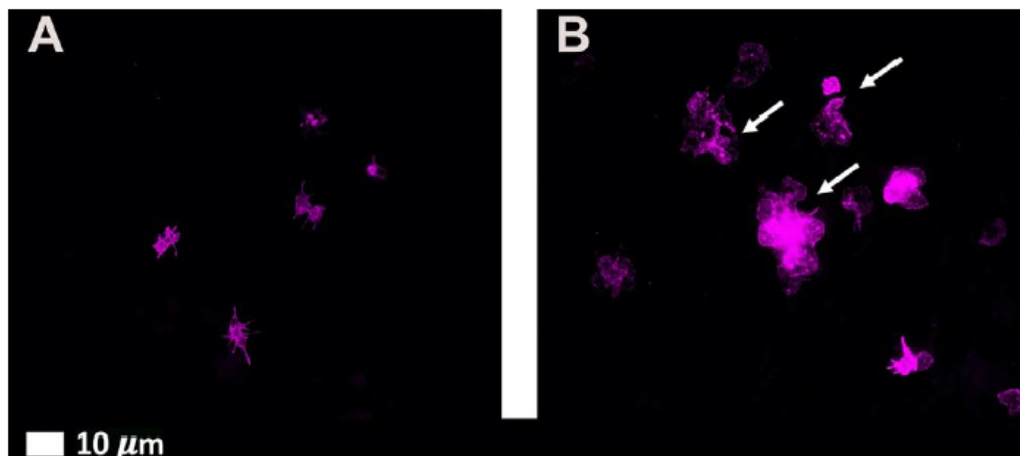


Figure 6A to H: Representative scanning electron micrographs of healthy control whole blood (WB), with and without spike protein. **A and B)** Healthy WB smears, with arrow indicating normal erythrocyte ultrastructure. **C to H)** Healthy WB exposed to spike protein (1 ng.mL^{-1} final concentration), with **C and D)** indicating the activated platelets (arrow), **E and F)** showing the spontaneously formed fibrin network and **G and H)** the anomalous deposits that is amyloid in nature (arrows) (Scale bars: E: $20\mu\text{m}$; A: $10\mu\text{m}$; F and G: $5\mu\text{m}$; H: $2\mu\text{m}$; C: $1\mu\text{m}$; B and D: 500nm).

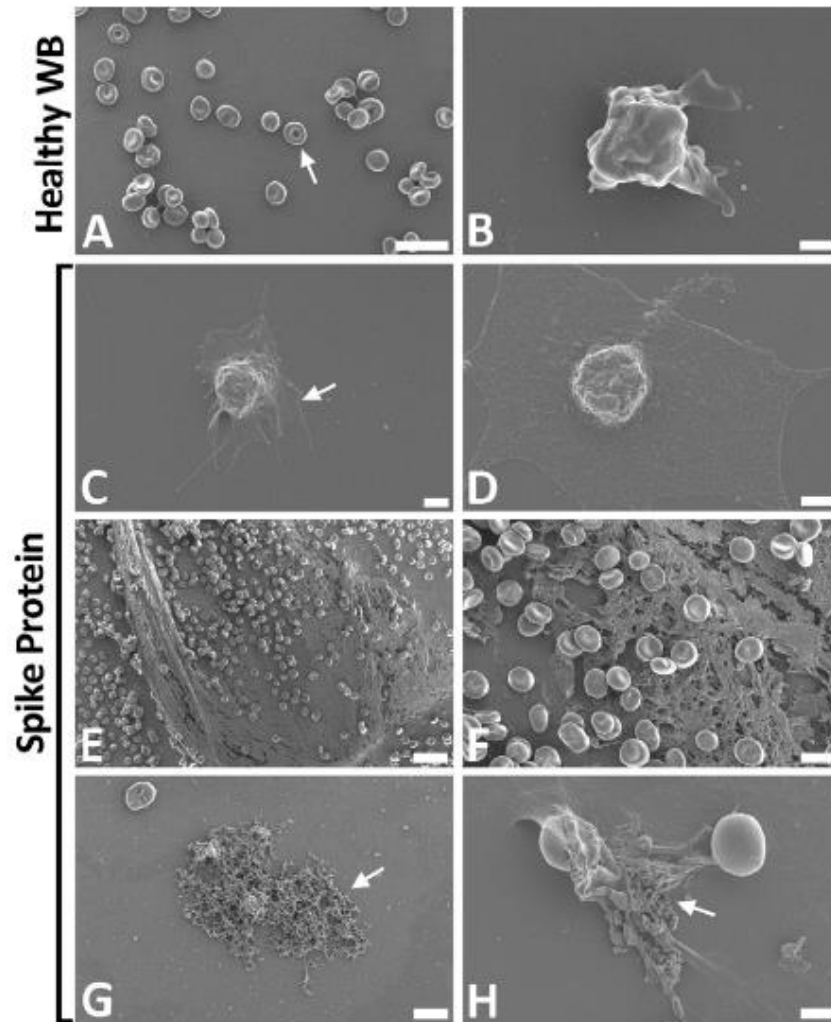
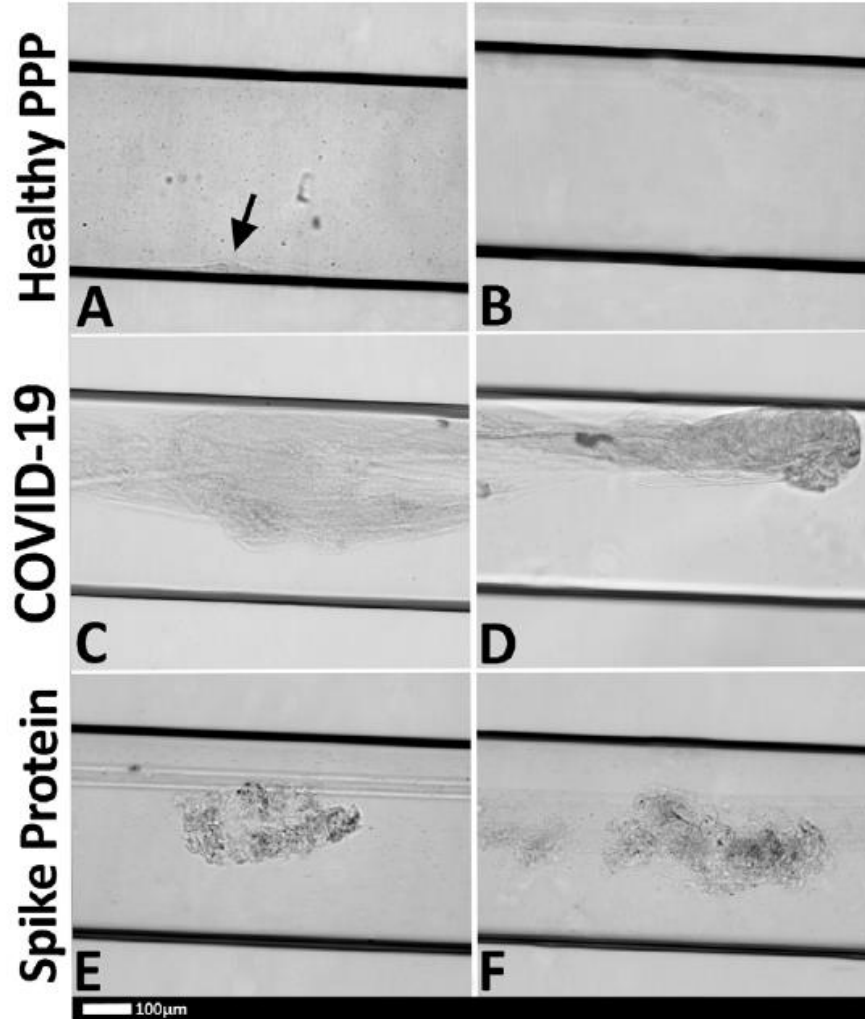


Figure 7: Representative micrographs of PPP clots in the microfluidic chambers (black horizontal lines are the outlines of the chambers) that were coated with thrombin. A) Healthy PPP clot, with small clot formation (arrow), with B) no clot formed in the healthy PPP sample; C and D) examples of clots from COVID-19 PPP samples and E and F) healthy PPP clot with spike protein.



The clots that were observed in the healthy PPP with added spike protein, were of particular interest as they demonstrated a bridge between healthy PPP clots and COVID-19 clots. As described in the results, the healthy PPP clots were relatively small and orderly, while COVID-19 PPP clots were large, disorderly masses that formed rapidly and disrupted PPP flow in the channel. The healthy PPP clots with added spike protein, were a combination of the two, demonstrating disorderly clumped clot areas, co-existing with laminar fibrous PPP clots (which were larger than the healthy PPP clots). This intermediate state may arise from a number of factors, including the interaction of other biological actors which were absent from the flow setup and the time of exposure to spike protein. Further investigations would be beneficial for understanding the clotting mechanisms that are altered in the presence of spike protein.

The Conclusion:

Scanning electron- and fluorescence microscopy revealed large dense anomalous and amyloid masses in whole blood and PPP of healthy individuals where spike protein was added to the samples. Mass spectrometry confirmed that when spike protein was added to PPP, it interacts with plasma proteins, resulting in fibrin(ogen), prothrombin and other proteins linked to coagulation, to become substantially resistant to

trypsinization, resulting in less fragments. Flow analysis confirmed that microclots may impair blood flow. Here we suggest that, in part, the presence of spike protein in circulation may contribute to the hypercoagulation in COVID-19 positive patients and may cause severe impairment of fibrinolysis. Such lytic impairment may be the direct cause of the large microclots we have noted here in SEM and fluorescence microscopy, and previously in plasma samples of COVID-19 patients (Pretorius et al., 2020, Venter et al., 2020).

End of excerpts

Have the vaccines contributed to the fall in cases?

This is the multi-billion-dollar question. The timing of the release of the vaccine was almost perfect to take advantage of the appearance that they would be effective. But there are at least three problems with I see with that assumption. Here are the key factors I see at play.

1. The timing of the release and increase of population vaccination coverage correlated closely with the normal decrease in respiratory viral patterns due to seasonality. The question is would the cases, hospitalizations and deaths have decreased at the same rate without any vaccines?
2. The CDC has predicted that 8 times more people than have tested PCR positive have had the infection. As of the writing of this newsletter, approximately 33,000,000 people have tested positive in the U.S. Eight times 33,000,000 is 264,000,000 people. Add the 33,000,000 to that number and you have 297,000,000 people that have had the SARS-CoV-2 virus to date. With a population of 335 million people in the U.S., that means that approximately 91% of the population has immunity. With predictions ranging from 70-90% to reach herd immunity, we have to be there or very close by now.

That 8X ratio is according to an article posted online November 27th titled **Estimated Incidence of Coronavirus Disease 2019 (COVID-19) Illness and Hospitalization—United States, February–September 2020**

“The CDC researchers estimated that about 52.9 million Americans had been infected in the U.S. by the end of September”. The number of confirmed COVID-19 cases was only 6.9 million up to that time. That is about an 8 to 1 ratio of those that have it and either don’t know it or have very mild symptoms and never get a test to those that do test positive. (PCR testing inaccuracy as we have seen is a whole other issue!) <https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1780/6000389>

3. The WHO, CDC and numerous credible scientific experts have admitted the fact that the “Vaccines” do NOT prevent infection and do NOT prevent transmission. Therefore, there is no way that they could be responsible for falling cases. (see my next story to find out why I’ve used the scare quotes). They MAY reduce symptoms is all that they have been able to demonstrate. But to what extent?

Dr. Peter Doshi, Associate Editor of the ***British Medical Journal (BMJ)*** released an opinion letter highly critical of the “effectiveness” claims the public have been hearing ad nauseum. The letter was published on January 4th, 2021. The letter titled **Peter Doshi: Pfizer and Moderna’s “95% effective” vaccines—we need more details and the raw data**, reported that because of exclusionary data the actual effectiveness (and remember that only means reduction of COVID-19 symptoms), should have been reported as between 19% and 29%! In other words, the numbers had to be manipulated to get to

the approximately 95% effectiveness that was reported. Peter Doshi is a highly credible scientifically qualified source to analyze the data and comment on it.

One of the issues Dr. Doshi had with Pfizer's reporting of the clinical data was the following...

“Another reason we need more data is to analyse an unexplained detail found in a table of [FDA's review](#) of Pfizer's vaccine: 371 individuals excluded from the efficacy analysis for “important protocol deviations on or prior to 7 days after Dose 2.” What is concerning is the imbalance between randomized groups in the number of these excluded individuals: 311 from the vaccine group vs 60 on placebo.” This could obviously skew the numbers in favor of the vaccinated group to make the efficacy look better than it was.

Another issue was exclusion of “suspected” COVID-19 cases.

“All attention has focused on the dramatic efficacy results: Pfizer reported 170 PCR confirmed covid-19 cases, split 8 to 162 between vaccine and placebo groups. But these numbers were dwarfed by a category of disease called “suspected covid-19”—those with symptomatic covid-19 that were not PCR confirmed. According to [FDA's report on Pfizer's vaccine](#), there were “3410 total cases of suspected, but unconfirmed covid-19 in the overall study population, 1594 occurred in the vaccine group vs. 1816 in the placebo group.”

“With 20 times more suspected than confirmed cases, this category of disease cannot be ignored simply because there was no positive PCR test result. Indeed this makes it all the more urgent to understand. A rough estimate of vaccine efficacy against developing covid-19 symptoms, with or without a positive PCR test result, would be a relative risk reduction of 19% (see footnote)—far below the 50% effectiveness threshold for authorization set [by](#) regulators. Even after removing cases occurring within 7 days of vaccination (409 on Pfizer's vaccine vs. 287 on placebo), which should include the majority of symptoms due to short-term vaccine reactogenicity, vaccine efficacy remains low: 29%.”

<https://blogs.bmj.com/bmj/2021/01/04/peter-doshi-pfizer-and-modernas-95-effective-vaccines-we-need-more-details-and-the-raw-data/>

Are they really vaccines? See what the government filed documents say

We are continually told that the COVID-19 shots are vaccines. But are they really?

It appears from the following documents that they are really “Gene Therapy”. It makes sense when you hear Dr. Fauci and others say that they may reduce symptoms of clinical disease. In essence, they are a treatment and do not prevent infection as would be the traditional role of a vaccine.

See next page....

BioNtech's SEC Filing Source:
<https://www.sec.gov/Archives/edgar/data/1776985/000119312519241112/d635330df1.htm>

The screenshot shows a mobile browser view of a SEC Form F-1 filing. The browser address bar displays 'sec.gov'. The document title is 'F-1 1 d635330df1.htm F-1'. A 'Table of Contents' link is visible. The filing date is 'September 9, 2019' and the registration number is '333-'. The document is titled 'UNITED STATES SECURITIES AND EXCHANGE COMMISSION' and 'FORM F-1 REGISTRATION STATEMENT UNDER THE SECURITIES ACT OF 1933'. The registrant is 'BioNtech SE', with the exact name as specified in its charter. The registrant's address is 'Prof. Ugur Sahin, M.D., An der Goldgrube 12, D-55131 Mainz, Germany', with a telephone number of '+49 631 9084'. The document also includes fields for 'Federal Republic of Germany' and 'ISIN'.

Shortened Link: <https://bit.ly/3cwKEOL>

BioNtech's SEC Filing Source:
<https://www.sec.gov/Archives/edgar/data/1776985/000119312519241112/d635330df1.htm>

BLA, or a new drug application, or NDAs, to the FDA, a Marketing Authorization Application, or MAA, to the EMA, and similar marketing applications to comparable global regulatory authorities, for each product candidate and, consequently, the ultimate approval and commercial marketing of any product candidates.

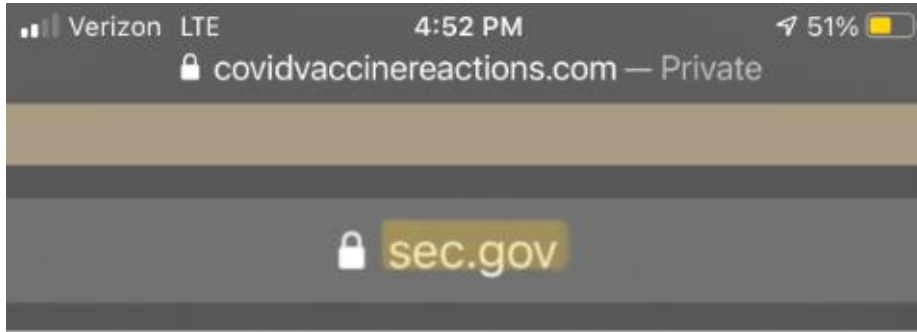
Failure to obtain marketing approval for a product candidate will prevent us from commercializing the product candidate in a given jurisdiction. We have not received approval to market any biopharmaceutical product candidates from regulatory authorities in any jurisdiction, and it is possible that none of our product candidates, or any product candidates we may seek to develop in the future, will ever obtain regulatory approval. We have limited experience in filing and supporting the applications necessary to gain marketing approvals and may need to rely on third-party contract research organizations, or CROs, regulatory consultants or collaborators to assist us in this process. To our knowledge, there is no current precedent for an mRNA-based immunotherapy such as the type we are developing being approved for sale by the FDA, European Commission or any other regulatory agency elsewhere in the world. Although we expect to submit BLAs for our mRNA-based product candidates in the United States, and in the European Union, mRNA therapies have been classified as gene therapy medicinal products, other jurisdictions may consider our mRNA-based product candidates to be new drugs, not biologics or gene therapy medicinal products, and require different marketing applications. Securing regulatory approval requires the submission of extensive preclinical and clinical data and supporting information to the various regulatory authorities for each therapeutic indication to establish the product candidate's safety and efficacy. Securing regulatory approval also requires the submission of information about the product manufacturing process to, and inspection of manufacturing facilities by, the relevant regulatory authority. Any product candidates we develop may not be effective, may be only moderately effective, or may prove to have

21

Shortened Link: <https://bit.ly/3cwKEOL>

ENLARGED

CROs, regulatory consultants or collaborators to assist us in this process. To our knowledge, there is no current precedent for an mRNA-based immunotherapy such as the type we are developing being approved for sale by the FDA, European Commission or any other regulatory agency elsewhere in the world. Although we expect to submit BLAs for our mRNA-based product candidates in the United States, and in the European Union, mRNA therapies have been classified as gene therapy medicinal products, other jurisdictions may consider our mRNA-based product candidates to be new drugs, not biologics or gene therapy medicinal products, and require different marketing applications. Securing regulatory approval requires the submission of extensive preclinical and clinical data and supporting information to the various regulatory authorities for each therapeutic indication to establish the product candidate's safety and efficacy. Securing regulatory approval also requires the submission of information about the product manufacturing process to, and inspection of manufacturing facilities by, the relevant regulatory authority. Any product candidates we develop may not be effective, may be only moderately effective, or may prove to have



**UNITED STATES
SECURITIES AND EXCHANGE COMMISSION**
Washington, DC 20549
FORM 10-Q

REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT
For the quarterly period ended **June 30, 2020**
OR
REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT
For the transition period from to
Commission File Number: [001-38753](#)

moderna

Moderna, Inc.

(Exact Name of Registrant as Specified in Its Charter)

Delaware (State or Other Jurisdiction of Incorporation or Organization)	81-3467528 (IRS Employer Identification No.)
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200 Technology Square Cambridge, Massachusetts (Address of Principal Executive Offices)	02139 (Zip Code)
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(617) [714-6500](#)

(Registrant's Telephone Number, Including Area Code)

Shortened Link: <https://bit.ly/2NitVGI>

Continued next page....

Moderna's SEC Filing Source:
<https://www.sec.gov/Archives/edgar/data/1682852/000168285220000017/mrna-20200630.htm>

medicine uneconomical or noncompetitive with other therapies;

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- failure to timely advance our programs or receive the necessary regulatory approvals or a delay in receiving such approvals, due to, among other reasons, slow or failure to complete enrollment in clinical trials, withdrawal by trial participants from trials, failure to achieve trial endpoints, additional time requirements for data analysis, data integrity issues, Biologics License Application, or BLA, or the equivalent application, discussions with the FDA or EMA, a regulatory request for additional nonclinical or clinical data, or safety formulation or manufacturing issues may lead to our inability to obtain sufficient funding; and
- the proprietary rights of others and their competing products and technologies that may prevent our mRNA medicines from being commercialized.

Currently, mRNA is considered a gene therapy product by the FDA. Unlike certain gene therapies that irreversibly alter cell DNA and could act as a source of side effects, mRNA-based medicines are designed to not irreversibly change cell DNA; however, side effects observed in gene therapy could negatively impact the perception of mRNA medicines despite the differences in mechanism. In addition, because no product in which mRNA is the primary active ingredient has been approved, the regulatory pathway for approval is uncertain. The number and design of the clinical trials and preclinical studies required for the approval of these types of medicines have not been established, may be different from those required for gene therapy products, or may require safety testing like gene therapy products. Moreover, the length of time necessary to complete clinical trials and to submit an application for marketing approval for a final decision by a regulatory authority varies significantly from one pharmaceutical product to the next, and may be difficult to predict.

Shortened Link: <https://bit.ly/2NitVG1>

ENLARGED

Currently, mRNA is considered a gene therapy product by the FDA. Unlike certain gene therapies that irreversibly alter cell DNA and could act as a source of side effects, mRNA-based medicines are designed to not irreversibly change cell DNA; however, side effects observed in gene therapy could negatively impact the perception of mRNA medicines despite the differences in mechanism. In addition, because no product in which mRNA is the primary active ingredient has been approved, the regulatory pathway for approval is uncertain. The number and design of the clinical trials and preclinical studies required for the approval of

What is Gene Therapy?



Human gene therapy seeks to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use ¹.

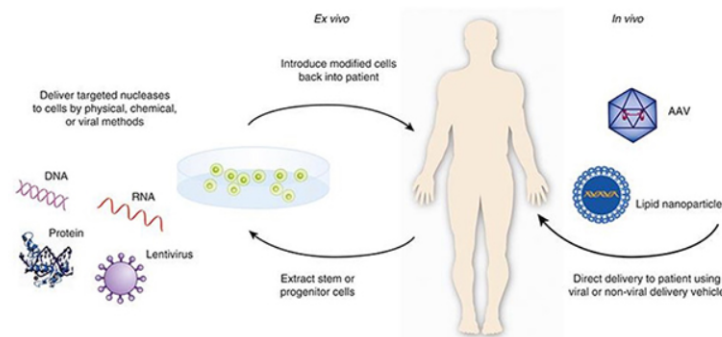
Gene therapy is a technique that modifies a person's genes to treat or cure disease. Gene therapies can work by several mechanisms:

- Replacing a disease-causing gene with a healthy copy of the gene
- Inactivating a disease-causing gene that is not functioning properly
- Introducing a new or modified gene into the body to help treat a disease

Gene therapy products are being studied to treat diseases including cancer, genetic diseases, and infectious diseases.

There are a variety of types of gene therapy products, including:

- **Plasmid DNA:** Circular DNA molecules can be genetically engineered to carry therapeutic genes into human cells.
- **Viral vectors:** Viruses have a natural ability to deliver genetic material into cells, and therefore some gene therapy products are derived from viruses. Once viruses have been modified to remove their ability to cause infectious disease, these modified viruses can be used as vectors (vehicles) to carry therapeutic genes into human cells.
- **Bacterial vectors:** Bacteria can be modified to prevent them from causing infectious disease and then used as vectors (vehicles) to carry therapeutic genes into human tissues.
- **Human gene editing technology:** The goals of gene editing are to disrupt harmful genes or to repair mutated genes.
- **Patient-derived cellular gene therapy products:** Cells are removed from the patient, genetically modified (often using a viral vector) and then returned to the patient.



Gene therapy products are biological products regulated by the FDA's Center for Biologics Evaluation and Research (CBER). Clinical studies in humans require the submission of an investigational new drug application (IND) prior to initiating clinical studies in the United States. Marketing a gene therapy product requires submission and approval of a biologics license application (BLA).

¹ Long Term Follow-Up After Administration of Human Gene Therapy Products; Guidance for Industry, January 2020

So, why not call them what they are?

Here are some obvious reasons I can think of:

1. *It is very likely that experimental gene therapy technology would not be able to be authorized for emergency use* under the **Emergency Use Authorization (EUA)** Rule? But certainly “vaccines” could. Sleight of hand?
2. Another reason could be that *the public would be much more likely to comply with a new “vaccine” than a new gene therapy technology*. Then the question becomes...Was that decision made to “save more lives” or to sell more product?
3. *By calling them vaccines rather than gene therapy, they can get the buy-in of the public on the false narrative that these “vaccines” are necessary to reach herd immunity*. The truth is, if they don't prevent infection and allow a vaccinated person that gets infected to transmit to others, they can't possibly help us get to herd immunity.

What about herd immunity? Where are we at?

The good news however is, that the U.S. is most likely at or very close to herd immunity. This is due to the number of people that have had the SARS-CoV-2 infection and not due to the vaccine. Let's assume that the 33 million PCR positive infections are really true infections and take the CDC's 8X figure of people that have had the infection and were never tested and considered in that 33 million positives number and add them to the 33 million number. It would mean that 91% of the population has had the infection. Now, I have to say that because the PCR test has a notoriously high level of false positives, there may have only been a fraction of those 33 million positive cases that truly had the infection. Let's assume that 70% of those 33 million were really infected with SARS-CoV-2, that would be 23,100,000 people infected. Eight times that number of untested infections would be another 184,800,000 infections. Added to the 23,100,000 PCR confirmed cases would total 207,900,000 total people that have been infected. Compared to 330 million people in the U.S. population, that equates to 63% of the population.

The R-naught (R_0) number discussed below is the effective **Reproduction Number** of a virus or contagion. The number is the estimated number of people on average that will be infected by a person with the infection. For example, if one person infects 10 other people, the R-naught number is 10. If they infect 4 people, the R-naught number is 4. The higher the number, the more contagious the pathogen. Measles for example has been estimated to have an R-naught number somewhere between 12 and 18. Influenza depending on the strain is thought to be between 1.0 and 2. The common cold between 2 and 3. For an outbreak to subside, the (R_0) number must drop below 1.

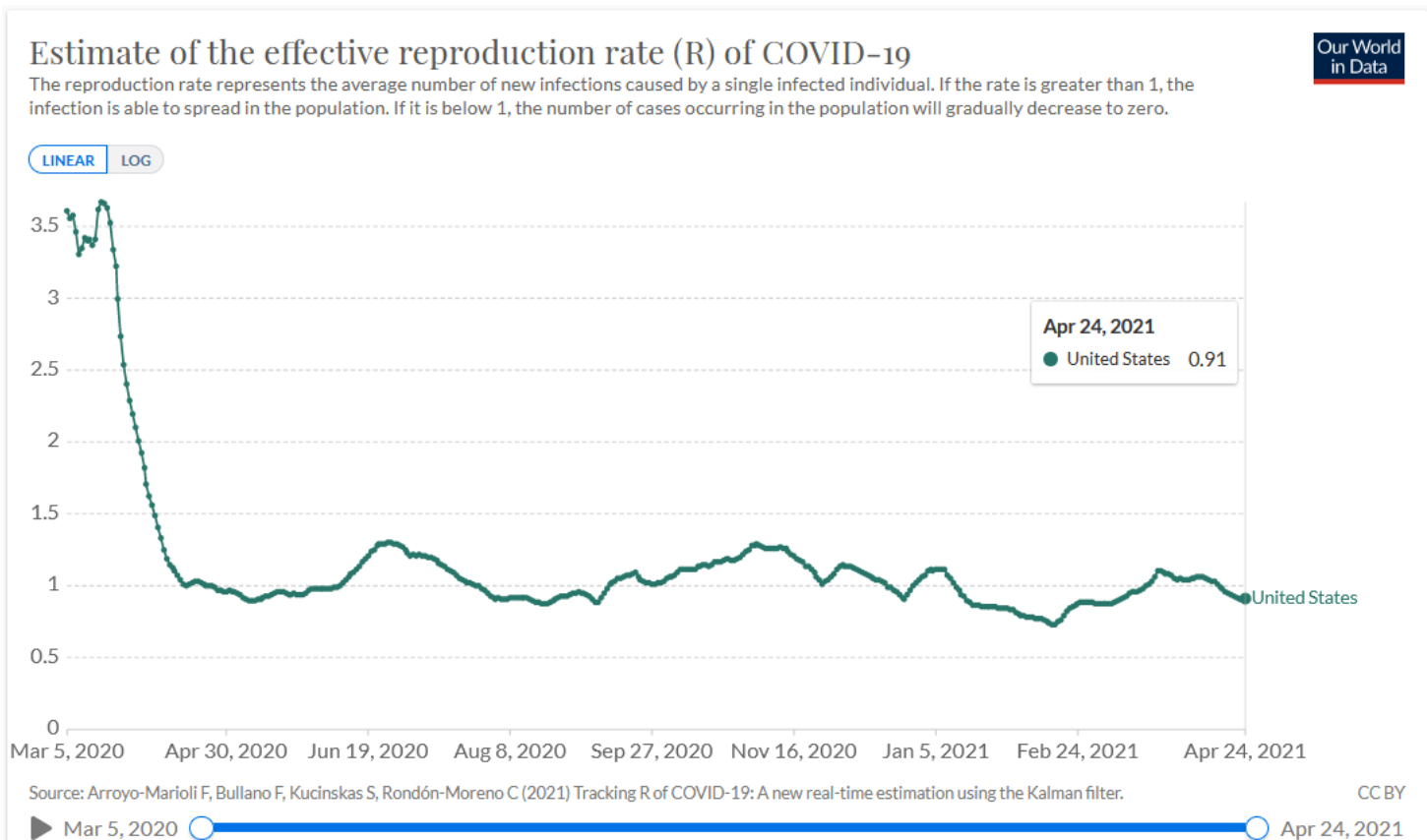
- **Herd immunity** is calculated by the following formula. 1 minus 1/the R-naught #, times 100 to get the percentage of the population that would need immunity to provide protection for the remainder of the population. The R-naught for SARS-CoV-2 has been estimated at between 2.0 and 2.5 especially earlier in the pandemic (although as the virus burns out it becomes lower and lower). For calculation, let's take the higher estimate of 2.5.....1 divided by 2.5 = 0.4. So, 1 minus 0.4 = 0.6. 0.6 times 100 = 60%. With a population of 330 million, that would mean that **198,000,000** people would need to have had the infection to protect the other 132 million people. Taking the lower hypothetical from above that **207,900,000** people have been infected,

it would mean that we are over the number required to achieve herd immunity at a 60% coverage. Now there are certain things that have to be taken into consideration for this estimate to be accurate.

- Is the CDC's estimate of 8X number of infections over PCR confirmed cases accurate? <https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1780/6000389>
- What is the real number of CASES of COVID-19? Meaning how many people have really had the DISEASE COVID-19, not just had the infection and never developed the disease? Of the 32 million "cases" meaning positive PCR, how many of those were false positives and really influenza or other seasonal respiratory viruses. As we've seen in the beginning this issue of **1200 Studies Newsletter** as well as the last few issues, the flu is virtually gone this year. But where did it go?

Regardless of those specifics, suffice to say we are moving in the right direction and must be getting very close to population (herd) immunity. And this next graph makes the prospects even better!

Based on this graph from the **Our World in Data COVID-19 Data Explorer** the R-naught number for the U.S. is lower than previously projected. That is very good news with respect to herd immunity! (<https://ourworldindata.org>),

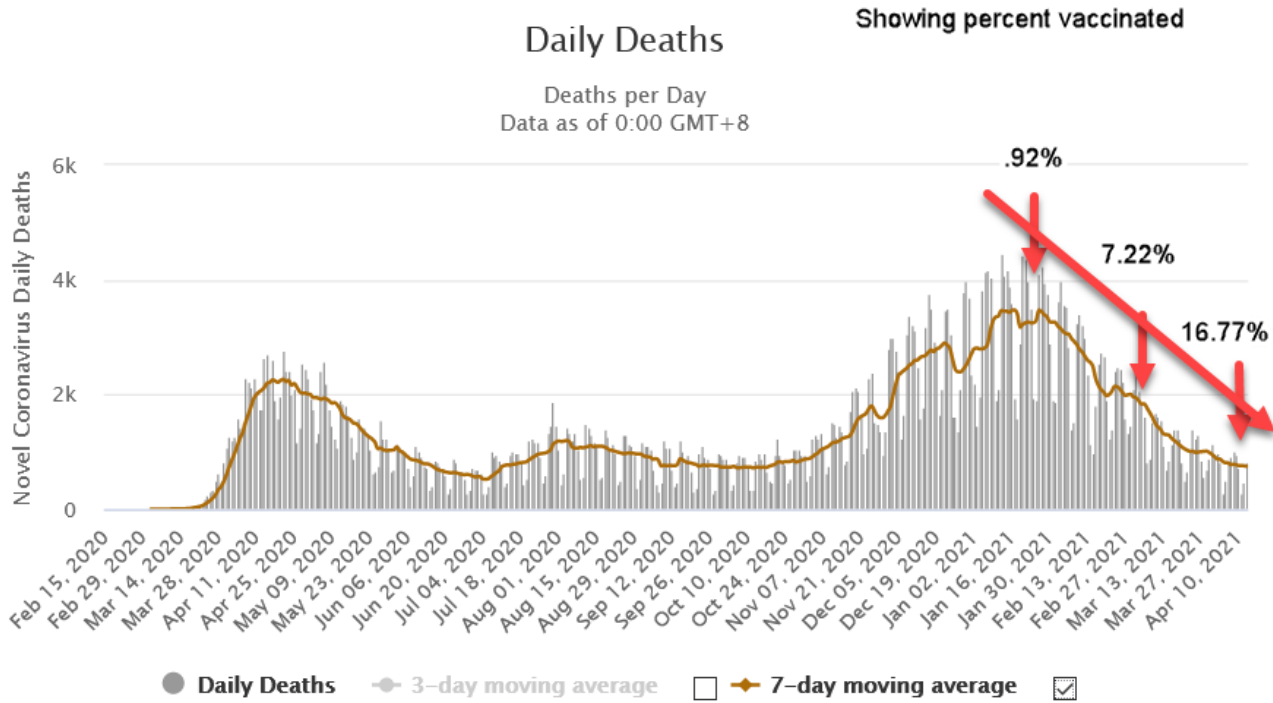


As of April 24th, the R-naught or Reproduction Rate of SARS-CoV-2 in the U.S. is under 1 at 0.91. That is a great sign and could be another indicator that we are reaching herd immunity.

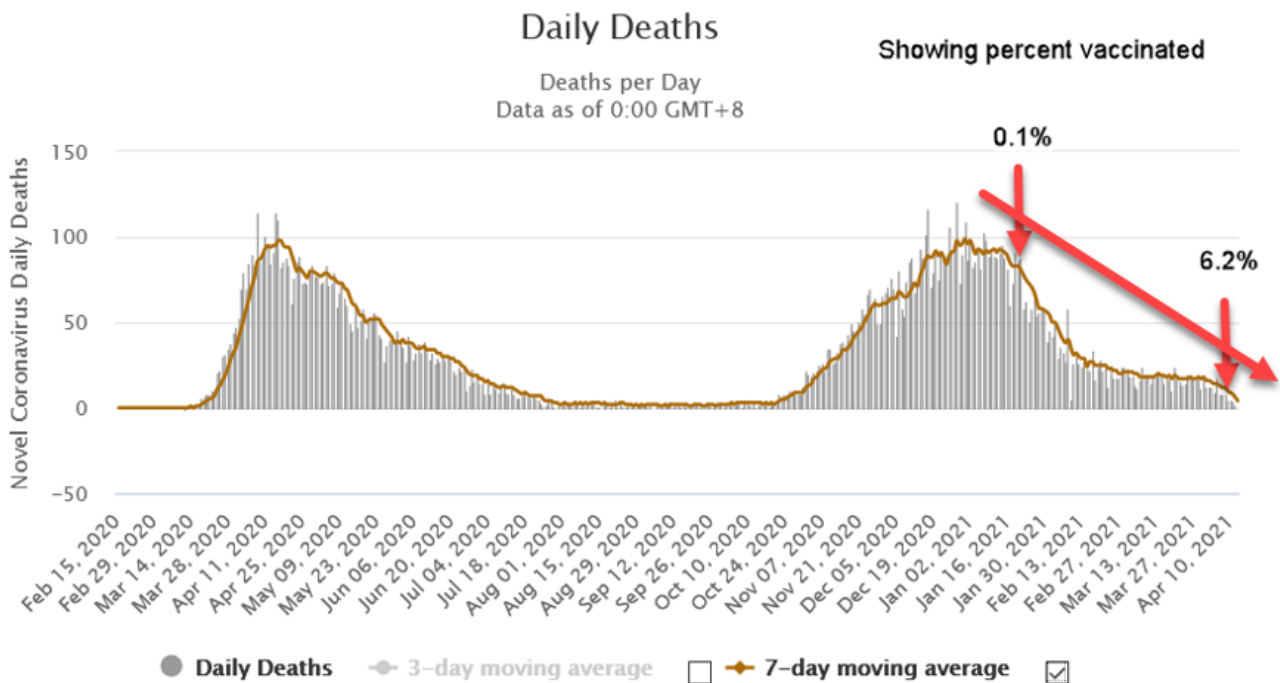
How much are the vaccines responsible for the drop in COVID-19 deaths?

As of April 8th, the U.S. has 16.77% of the population fully vaccinated. Compared to Sweden at only 6.2%.

Daily New Deaths in the United States



Daily New Deaths in Sweden



Very similar downward trajectory in the 7-day moving average of deaths, right?

Since Sweden, a country that never locked down and destroyed business and their economy, kept their kids in school and didn't inflict a huge emotional toll on their population is experiencing the same success in their death rates as the U.S. even without vaccine coverage that would explain that drop in mortality, there is no reason to believe the narrative about gene therapy treatments helping to end the pandemic.

More concerns over the blood clotting issues from the COVID-19 vaccines

An April 13th article in Natural News by Mike Adams titled **Vaccine antibodies CAUSE blood clots in the brain, lungs and heart... FDA calls halt to J&J vaccine as deaths accelerate** raises serious concerns over the large numbers of clotting issues seen not just with the Johnson and Johnson vaccine, but the other mRNA vaccines as well.

From the article:

In the wake of accelerating deaths from vaccine-induced blood clots, the FDA has now called a nationwide halt to the Johnson & Johnson covid-19 vaccine.

In truth, **all covid-19 vaccines cause deadly blood clots** for the simple reason that **spike protein structures are biologically active** and lead to blood coagulation (clotting) inside the body. These blood clots travel to the brain, heart, lungs and other organs, causing strokes, heart attacks (rapper DMX was killed this way), pulmonary embolisms (blood clots in the lungs) and other similar causes of death, none of which are officially listed as "vaccine" deaths.

The fact that mRNA vaccines hijack the body's cells to generate spike proteins which cause blood clotting is an open admission that **mRNA vaccines are death shots** — a form of vaccine euthanasia. And people who are foolish enough to take these vaccine shots are signing up for "vaccine suicide" as part of a global depopulation agenda.

Even worse, none of the vaccines actually do anything useful to reduce deaths from covid. As Dr. Richard Fleming recently told ***the War Room*** broadcast, the vaccine efficacy data from Pfizer, Moderna and Johnson & Johnson, "all show their vaccines make zero difference in stopping covid." From that article: *Fleming warned the effects could take a year and half to show in humans.*

Fleming, who in the 1990s discovered inflammation causes cardiovascular disease, said man-made spike proteins in the vaccines also cause inflammation. The Johnson & Johnson vaccine was pulled for its link to blood clots in women.

The vaccines have "no statistically significant benefit," Fleming said, but cause "inflammation and blood clotting, Lewy bodies [associated with dementia], Mad Cow disease, and nothing to benefit."

Fleming said the Biden regime should call for immediate reevaluation of "whether there's any demonstrated efficacy" of the vaccines, "because there's not."

"Secondly, what are the potential consequences of having already vaccinated a substantial number of individuals in this country?" Fleming said.

In today's *Situation Update podcast*, I cover the blood clotting problems with the vaccine, revealing why so many people are already dying from an experimental intervention the government lied about and insisted was safe:

[Brighteon.com/b3132a4a-a952-43a4-8475-7372b91a8690](https://www.brighteon.com/b3132a4a-a952-43a4-8475-7372b91a8690)

Deep vein thrombosis after Pfizer vaccine

An article published in Internal and Emergency Medicine March 9th, 2021 titled **Deep vein thrombosis (DVT) occurring shortly after the second dose of mRNA SARS-CoV-2 vaccine**, describes a case of a 66 year-old woman who developed the blood clots after her second dose of vaccine.

From the report:

Venous thromboembolic (VTE) complications have been consistently reported to be increased in SARS-CoV-2 infection, most probably as the results of a thrombophilic state secondary to inflammation and immunethrombosis.

A 66-year-old woman received the first dose of mRNA Covid-19 vaccine (BNT162b2, Comirnaty, Pfizer/BioNTech) subcutaneously on January 4th, 2021, without any reported clinical problem; she was scheduled for the second dose on January 25th. Her medical history was unremarkable except for post-trauma left leg neuropathy. She never had previous thrombotic events; she had one successful delivery. Her body mass index was 23 kg/m²; she did not smoke or had no allergic problems; she intermittently took painkillers for the neuropathy. On January 26th, 24 h after the second vaccine dose, she received acetaminophen for persistent fever with chills, fatigue, malaise, and muscle pain. On January 27th, 48 h after the second vaccine dose, persistent fever was still present, and acute right calf pain appeared in the absence of trauma. On January 28th, she was admitted for evaluation at the emergency room because of persistent pain and inability to walk. Physical examination was unremarkable except for mild edema in the right calf. Blood tests (Blood count, INR, PTT, fibrinogen, renal and hepatic function) were normal, as notably was the D-dimer measurement. A Color-Doppler ultrasound scan revealed the presence of deep vein thrombosis involving the right peroneal vein and extending up to the popliteal vein, without signs of venous insufficiency. Thrombophilia screening was otherwise negative except for the presence of heterozygous FV Leiden mutation. The patient started apixaban 10 mg bid for 1 week, followed by 5 mg bid, with rapid symptoms resolution.

End of excerpts

This report follows many such reports coming in from all over the world and was the reason two dozen European countries called a pause to the AstraZeneca vaccine.

Another report in the *British Medical Journal (BMJ)* published April 14th, 2021 titled **Thrombosis after covid-19 vaccination**

From the report:

During March, however, concerns were raised over possible thromboses after immunisation with the AstraZeneca vaccine. One of the first official reports from the European Medicines Agency, on 10 March, noted four cases of thrombosis in people immunised with a single batch of the vaccine in Austria, including at

least two severe cases and one death.³ The batch was withdrawn from use. The following day reports emerged of a death in Denmark and the country suspended use of the vaccine to allow time for investigation. Several other countries followed suit.⁴

Subsequently, the focus of attention narrowed from thrombosis in general to cerebral venous sinus thrombosis (CVST), a rare condition with a background incidence of about 15 cases per million people each year according to recent studies from Australia and the Netherlands.⁵ CVST is a rare cause of stroke that generally affects younger adults and women more than men. Important risk factors are pregnancy and hormonal contraception.⁵

Proving cause and effect is never easy, especially for rare events. Chance clusters of rare events occur quite commonly in observations or analyses of large groups.⁶ Nevertheless, the balance of evidence was clearly shifting at the beginning of April. Increased reporting of CVST in the UK as well as in Europe, along with the almost total absence of cases after immunisation with Pfizer or Moderna vaccines were strong indicators that this may be a real association. That many of those affected also had thrombocytopenia, which is not normally found in CVST, was an additional pointer that this was not a random association.

Both European and UK medicines regulators reported their conclusions on 7 April.⁷ From the EMA briefing we learnt that other blood clots associated with thrombocytopenia were also being reported following the AstraZeneca vaccine, including arterial thromboses and splanchnic vein thrombosis.⁸ The EMA compared the clinical picture to a similar heparin induced thrombocytopenia,⁹ and two recently published case series have confirmed this similarity.¹⁰¹¹ All patients in each series had high levels of antibodies against antigenic complexes of platelet factor 4 (PF4), as seen in heparin induced thrombocytopenia. None of the patients had received heparin.¹⁰¹¹ Further studies in two patients confirmed PF4 dependent platelet activation.¹⁰ The authors coined the term vaccine induced immune thrombotic thrombocytopenia for this condition. Potential treatment options include high dose immunoglobulins and certain non-heparin anticoagulants.¹⁰

The UK's Medicines and Healthcare Products Regulatory Agency had received 79 reports of thrombosis associated with low platelets by 31 March, of which 44 were CVST.¹² Of these 79 cases, 51 (13 fatal) were in women and 28 (six fatal) in men. So far all of the UK cases have occurred after the first dose. The risk was higher in the younger age groups, starting at 1.1 serious harm events for 100 000 immunised people among those aged 20-29 years and falling to 0.2/100 000 in those aged 60-69. For comparison, in women taking hormonal contraceptives the risk of thrombosis is about 60/100 000 person years and risk of fatal pulmonary embolism is about 1/100 000.¹³¹⁴ In most adult age groups, the benefits of the AstraZeneca vaccine far outweigh the risks. The exception is the 20-29 year age group, for which the risk-benefit equation is more finely balanced when community transmission is low.

<https://www.bmj.com/content/373/bmj.n958>

A response to that article is VERY revealing

In an April 14th, 2021 **BMJ Rapid Response** to the **Thrombosis after covid-19 vaccination** article, much more important information about the increasing awareness of these events by physicians is discussed.

The title of the response is:

CoViD-19 post-vaccine menorrhagia, metrorrhagia or postmenopausal bleeding and potential risk of vaccine-induced thrombocytopenia in women

Dear Editor,

Many women across the world after receiving CoViD vaccines are complaining of irregularities in their menstrual bleeding; some experiencing heavy menstrual bleeding (menorrhagia), some bleeding before their periods were due or bleeding frequently (metrorrhagia/polymenorrhea), whereas some are complaining of postmenopausal bleeding.

As of 5th April 2021, there have been ~958 cases of post-vaccination menstrual irregularities, including vaginal haemorrhages, that were recorded in MHRA's adverse event reports. There were twice more cases of menstrual irregularities with CoViD Vaccine AstraZeneca than Pfizer (643 vs 315 respectively) [1]. It is anticipated that the actual numbers of cases are much higher than the numbers recorded in the pharmacovigilance systems as many women in different cultural context may have felt uncomfortable to talk about it, may not have thought that it was vaccine-related, or may have not been encouraged by their clinicians to make an official report into the adverse events reporting system.

There have been recent reports of haemorrhage, blood clots and thrombocytopenia following administration of CoViD-19 vaccines that have raised concerns over the safety of genetic vaccines for people with pre-existing coagulation disorders or those on certain medications. Regulatory bodies have also issued warnings to the patients and healthcare professionals to be vigilant and seek prompt medical assistance if they experienced typical symptoms of cerebral venous sinus thrombosis (CVST), a potentially fatal clot in the brain [2,3]. European Medicines Agency has also revised the summary of product characteristics and listed thrombocytopenia (very low platelets) as a 'common' side effect (i.e., 1 in 100 to 1 in 10) of Vaxzevria, i.e., the CoViD vaccine AstraZeneca [4]. The pharmacovigilance data also suggests that thrombocytopenia is also a frequent observation followed by mRNA CoViD vaccines such as Pfizer or Moderna.

The 'heavy menstrual bleeding' has been previously reported in females with underlying platelets disorders [5]. It is plausible that the vaccine-induced thrombocytopenia may be an explanation for the recent incidences of heavy menstrual bleeding experienced by women in different countries after the CoViD-19 vaccination. The significant loss of blood in many women may lead to severe anaemia, further exacerbate thrombocytopenia, and therefore may significantly increase the risk of haemorrhages and clots.

Clinicians and front-line healthcare workers are advised to encourage women to report heavy menstrual bleeding or other extraordinary bleeding events post-vaccination formally into the vaccine adverse events reporting system and seek prompt medical advice. Public health agencies and regulatory authorities are also requested to investigate these incidences and issue further warnings, as this can, possibly be an early sign of potentially fatal vaccine-induced prothrombotic thrombocytopenia leading to rare CVST events in younger women. There may be some women with pre-existing conditions or those on certain medications that may be at increased risk of experiencing post-vaccination severe adverse events and early warnings will help saving lives.

<https://www.bmj.com/content/373/bmj.n958/rr-2>

References:

- [1] <https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-...>
- [2] <https://doi.org/10.1186/s40545-021-00315-w>
- [3] <https://www.ema.europa.eu/en/news/covid-19-vaccine-astrazeneca-benefits-...>
- [4] <https://www.ema.europa.eu/en/documents/product-information/vaxzevria-pre...>
- [5] <https://www.sciencedirect.com/science/article/pii/S1083318816001637>

Study shows the spike protein cause damage to the Blood-Brain-Barrier (BBB) and resultant brain inflammation

These findings have implications for the COVID-19 vaccines as they prompt our cells to make spike protein. Those manufactured spike proteins could migrate to the brain and trigger a cascade of events that may result in neurovascular injury, microthrombi (clots) and brain damage.

The study published December 2020 in the journal *Neurobiology of Disease* and titled The SARS-CoV-2 spike protein alters barrier function in 2D static and 3D microfluidic in-vitro models of the human blood-brain barrier, reveals a possible mechanism for the brain pathology caused by the SARS-CoV-2 Spike Protein.

From the Abstract:

As researchers across the globe have focused their attention on understanding SARS-CoV-2, the picture that is emerging is that of a virus that has serious effects on the vasculature in multiple organ systems including the cerebral vasculature. Observed effects on the central nervous system include neurological symptoms (headache, nausea, dizziness), fatal microclot formation and in rare cases encephalitis. However, our understanding of how the virus causes these mild to severe neurological symptoms and how the cerebral vasculature is impacted remains unclear. Thus, the results presented in this report explored whether deleterious outcomes from the SARS-CoV-2 viral spike protein on primary human brain microvascular endothelial cells (hBMVECs) could be observed. The spike protein, which plays a key role in receptor recognition, is formed by the S1 subunit containing a receptor binding domain (RBD) and the S2 subunit. First, using postmortem brain tissue, we show that the angiotensin converting enzyme 2 or ACE2 (a known binding target for the SARS-CoV-2 spike protein), is ubiquitously expressed throughout various vessel calibers in the frontal cortex. Moreover, ACE2 expression was upregulated in cases of hypertension and dementia.

Introduction of spike proteins to *invitro* models of the blood-brain barrier (BBB) showed significant changes to barrier properties. Key to our findings is the demonstration that S1 promotes loss of barrier integrity in an advanced 3D microfluidic model of the human BBB, a platform that more closely resembles the physiological conditions at this CNS interface. Evidence provided suggests that the SARS-CoV-2 spike proteins trigger a pro-inflammatory response on brain endothelial cells that may contribute to an altered state of BBB function. Together, these results are the first to show the direct impact that the SARS-CoV-2 spike protein could have on brain endothelial cells; thereby offering a plausible explanation for the neurological consequences seen in COVID-19 patients.

From the Discussion:

SARS-CoV-2 can induce microclots formation in the vasculature of periphery tissues and within the vessels of the CNS. In fact, Bryce et al.³² found that 6 out of 20 cases had microthrombi and acute infarction in the brain. Here we report the evident breakdown of the BBB by SARS-CoV-2 spike protein, thus offering a possible avenue for counteracting the consequences of acute ischemic stroke observed in COVID-19 patients younger than 50 years old. However, future studies should place focus on interrogating the connection between virus-mediated barrier disruption and coagulation to determine the unique cerebrovascular mechanisms responsible for heightening the risk of strokes in COVID-19 patients.

Taking together our data of elevated MMP3, CCL5, CXCL10 and CAMs, we can speculate that SARS-CoV-2 is a potentially neuroinvasive virus as it turns on the machinery to facilitate the migration of infected immune cells as “Trojan horses” into the brain parenchyma.

To our knowledge, this is the first reported evaluation that examined the effects of the SARS-CoV-2 spike protein on the BBB. Our findings provide insight into the continued theme that this novel coronavirus triggers responses at the endothelium. Specifically, in regard to the brain endothelium, the SARS-CoV-2 spike protein induced destabilization of the BBB, promoted a pro-inflammatory status but did not appear to alter cell viability acutely. Dysfunction of the barrier offers a plausible explanation to the observed neurological complications seen in COVID-19. Lastly, the opening of the BBB, hints at the possible means in which the SARS-CoV-2 pathogen could also neuroinvade.

End of excerpts

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7547916/>

Tiny country of Gibraltar sees unexpected increase in deaths in elderly population after vaccination with COVID-19 vaccines

In an article by Lance D. Johnson and published on Dr Eddy Bettermann MD’s website titled, **Elderly population suddenly dying off for unexplained reasons, and it’s no longer coded as covid-19**, the sudden deaths in the elderly of Gibraltar immediately after the vaccination program began is called the worst loss of life there in over 100 years.

Around the world, medical authorities are seeing a spike in elderly deaths, after covid-19 vaccination. Gibraltar, a nation located at the southern tip of Spain, is suffering from an unexplained surge in elderly deaths. In the second week of January, a subset of the elderly population suddenly started to die off. The new wave of unexplained elderly deaths is occurring at nearly three times the magnitude of covid-19 deaths that were recorded during 2020.

The new, unexplained surge in elderly deaths is occurring approximately forty times faster when compared to the overall timeline of covid-19 deaths that occurred since a pandemic was first declared. This surge in elderly deaths occurred after 5,847 doses of experimental mRNA injections were administered to the citizens of Gibraltar. In just one week, 17 percent of the country’s population had been inoculated with the first dose of Pfizer’s mRNA experiment.

Before the vaccine experiment began, the covid-19 related death toll accounted for ten people. After the vaccine rollout, the total number of deaths had skyrocketed to forty-five people. In the first eight days of the vaccination program, thirty-five seniors suddenly passed away.

After the first week of vaccination, Chief Minister Fabian Picardo said, “This is now the worst loss of life of Gibraltarians in over 100 years. Even in war, we have never lost so many in such a short time.”

Vaccine-induced deaths to be blamed on new “covid-variant”

In 2020, medical examiners would have easily labeled these sudden deaths as covid-19, but now these deaths are somehow unexplained, with no definitive cause. Before the covid-19 vaccines were unleashed, seniors

died of covid-19. Now seniors are dying of natural causes again, right after being vaccinated. It won't be long before a surge in elderly deaths around the world is blamed on a new variant of SARS-CoV-2, with medical authorities calling for new vaccines, more doses, and mRNA updates. Isn't it suspicious that a deadly covid-variant became headline news suddenly after the vaccine rollout?

Norway deaths

Gibraltar isn't the only nation to report on the sudden spike in senior deaths. In Norway, twenty-nine senior citizens suddenly passed away in the first two weeks after the first dose of the vaccine. In the hours after vaccination, and sometimes minutes after, these seniors shared similar side effects, including but not limited to: persistent malaise and extreme exhaustion; severe allergic, including anaphylactic, reactions; multi-system inflammatory syndrome; psychological disturbances; seizures; convulsions; and paralysis, including Bell's Palsy. The Norwegian Medicines Agency declared that "all deaths are linked to this [Pfizer's] vaccine" because it was the only intervention that preceded the sudden elderly deaths.

<https://dreddymd.com/2021/02/18/elderly-population-suddenly-dying-off-for-unexplained-reasons-and-its-no-longer-coded-as-covid-19/>

That story coincides with a ***Mercola.com*** article titled, **Seniors Dying After COVID Vaccine Labeled as Natural Causes**. I want you to catch the irony in that title. Throughout the COVID-19 pandemic, nearly all elderly deaths, no matter what the actual cause of death were being called a COVID death. Now, after people are vaccinated and die suddenly and unexpectedly, the deaths are all being called "natural" or "unexplained."

From the article:

Around the world, reports are pouring in of people dying shortly after receiving the COVID-19 vaccine. In many cases, they die suddenly within hours of getting the shot. In others, death occurs within the span of a couple of weeks.

One notable case is baseball legend Hank Aaron, 86, who died January 22, 2021, 17 days after publicly getting vaccinated for COVID-19.^{1,2} He said at the time that he hoped other Blacks would follow his lead and get their vaccines too.

According to news reports, he died "peacefully in his sleep" and no cause of death had been announced. Aaron was famous for being the home-run king of baseball, and broke Babe Ruth's record when he hit homerun No. 715; he had hit 755 by the time he retired from the sport.

My comment: *Hank Aaron had been used by the media-pharmaceutical complex to promote that people get vaccinated with the experimental COVID-19 vaccines. As a role model for millions and especially the African American community, Aaron's endorsement carried a lot of weight. He was quoted as saying... "It makes me feel wonderful. I don't have any qualms about it at all ... I feel quite proud of myself for doing something like this ... It's just a small thing that can help zillions of people in this country."*

He was filmed getting his first dose as he encouraged minorities to join in and get the life-saving vaccine. He didn't make it to the next appointment for his second dose because he suddenly died "in his sleep" seventeen days after getting the first dose.

Vaccine Rollout Coincides with Outbreak

Other areas are also reporting “outbreaks” of COVID-19, resulting in increased death tolls, after the rollout of vaccinations. Case in point: In Auburn, New York, a COVID-19 outbreak began December 21, 2020, in a **Cayuga County nursing home**.^{8,9} Before this outbreak, no one in the nursing home had died from COVID-19. The next day, December 22, they started vaccinating residents and staff. The first death was reported December 29, 2020. Between December 22, 2020, and January 9, 2021, 193 residents (80%) received the vaccine, as did 113 staff members.

As of January 9, 2021, 137 residents had been infected and 24 had died. Forty-seven staff members had also tested positive for SARS-CoV-2 and one was on life-support.

Considering we’re also seeing cases in which healthy young and middle-aged individuals die within days of receiving the vaccine, it’s not inconceivable that the vaccine might have something to do with these dramatic rises in deaths among the elderly in various parts of the world. In fact, I’d expect it.

End of excerpts

<https://articles.mercola.com/sites/articles/archive/2021/02/02/covid-vaccine-death-seniors.aspx>

More resources

Want to learn more about the controversial subject of vaccines?

Check out my downloadable **eBook 1200 Studies- Truth will Prevail**. It is the most comprehensive expose ever on the subject. It is now at 737 pages, with excerpts and summaries from over 1,400 published studies authored by thousands of scientists and researchers, that contradict what the public is being told about the safety and efficacy of vaccines. It has easy search and navigation features with links directly to the article abstracts on PubMed, or the source journal. These features make it an invaluable research and reference tool. It can be downloaded at <https://1200studies.com>

Want to learn information about all things COVID-19 that you’ll never hear from the mainstream media?

Consider subscribing to my **Monthly 1200 Studies COVID-19 newsletter**. It will provide you with the stories, the research, the data and what the top experts from all over the world are saying about the virus, the lockdowns, the vaccines and the real numbers. You will learn information that doesn’t fit the mainstream media’s narrative and the information that certain factions do not want you to know. Now with all things COVID-19, as the 24/7 media drives hysteria and fear mongering, a new push for public compliance or even mandated vaccines is on. If you don’t have time to do all that homework yourself, let me do it for you. Subscribe at <https://www.wellnessdoc.com/science-and-news-monthly-newsletter/>