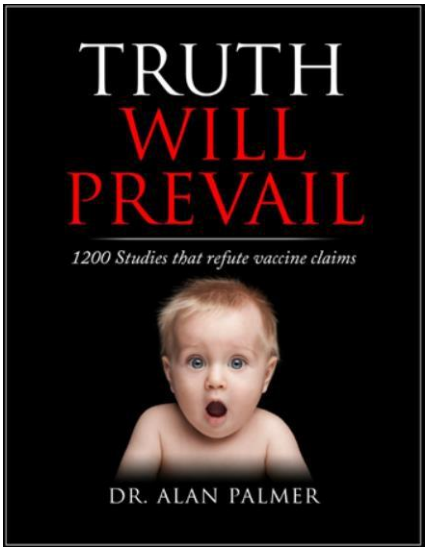
1200 Studies Update Newsletter July 1st, 2021



Welcome to *Issue 14* of the 1200 Studies Update Newsletter where the truth often flows against the mainstream narrative.

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

Please ask your friends and family to subscribe to this newsletter as these efforts have taken on a full-time job for me. And, as you will see in this issue, there is no other place that you can get such a variety of impactful evidence-based stories about these topics all in one place. More people need to know this information, especially in light of the unprecedented efforts to silence the truth and the treats of mandatory and coerced vaccination becoming the norm. They can subscribe here:
https://www.wellnessdoc.com/science-and-news-monthly-newsletter/

In addition to this vital information, I would encourage you to download and share my free 105-page ***COVID-19 Vaccine Critical Review***. I have recently updated it to include the latest information. You can access the full paper and a 2-page overview here: https://www.wellnessdoc.com/covid-19-vaccine-review-2/

Also, I have recently released my latest ***1200 Studies- Truth Will Prevail*** eBook update. It now contains excerpts from over 1,500 studies and is 950 pages in length. You can download it at https://www.wellnessdoc.com/1200studies/

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

any basis for it? Let's look at how they've handled previous variants.

- What percentage of the children under 18 in the U.S. have died from COVID-19?
- Inventor of Messenger RNA (mRNA) technology used by Pfizer and Moderna drops a bombshell about the COVID-19 vaccines in a must watch interview
- What are medical professionals saying about the adverse effects of the vaccines?
- An international coalition of doctors and scientists warn governments and regulatory agencies of the dangers of the COVID-19 vaccines
- New study in the New England Journal of Medicine looking at risks of COVID-19 shots in pregnancy, is under fire for glaring flaws that mis-represents the conclusions
- Tweet by HHS promoting COVID-19 vaccines in women who want to become pregnant
- COVID-19 vaccines may also have detrimental effects to the male reproductive system
- COVID-19 vaccines may have negative and risky immune effects for people that have previously had COVID-19
- At least some of the mainstream media is finally catching on
- Key players in the funding and research that has appeared to have led to the COVID-19 outbreak, participated in a conference two years before the outbreak
- Blatant misinformation from the World Health Organization (but then, who is really surprised?)
- WHO changes their position against vaccinating children in another embarrassing about face after external pressure
- One reason why children do better against SARS-CoV-2
- Evidence continues to show that transmission of the SARS-CoV-2 virus is

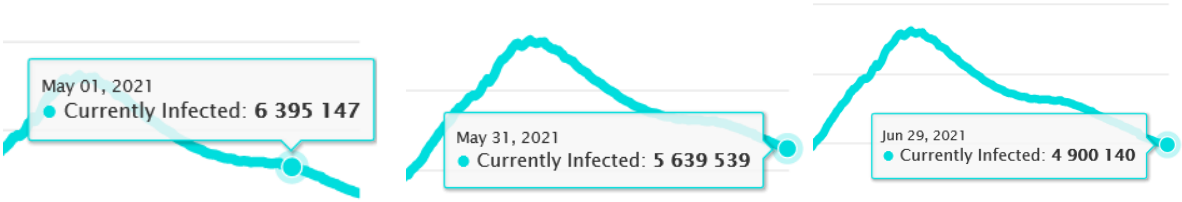
low in children and teachers after returning to in-person learning

- Two new studies provide more evidence of lasting immunity after infection with SARS-CoV-2
- A study looking at two dozen other studies examining cross-reactivity to other coronavirus infections that provide protection against SARS-CoV-2
- Infection with other viruses may have a neutralizing effect against SARS-CoV-2. Did public lockdown measures aid in the spread of SARS-CoV-2 and thus COVID-19 disease?
- Professor John Ioannidis from Stanford's great presentation summarizing what we now know about the lethality of the virus and the effects of the failed and damaging public health measures that were employed
- Legal updates-
- New PubMed article of the month-

  - **Health effects in vaccinated versus unvaccinated children, with covariates for breastfeeding status and type of birth**

Good news! The number of active cases continue to decline

U.S.A. May 1st | **U.S.A. May 31st** | **U.S.A. June 28th**



https://www.worldometers.info/coronavirus/country/us/

As you will see in this newsletter, cases are just one metric and not always a reliable one. More important if the number of people that are suffering severe illness of death from COVID-19. The great news is that those numbers are dropping precipitously. The powers that be are trying to scare people about the Delta Variant (formerly the Indian Variant). But even better news is that the Delta is the mildest form of all the variants thus far and much milder than the original Wuhan strain. But of course, the media will never tell you that. See more on all of this later in this issue.

COVID-19 trends in the U.S. – Testing and "Cases"

Testing and cases-

Reminder on the nuances of testing:

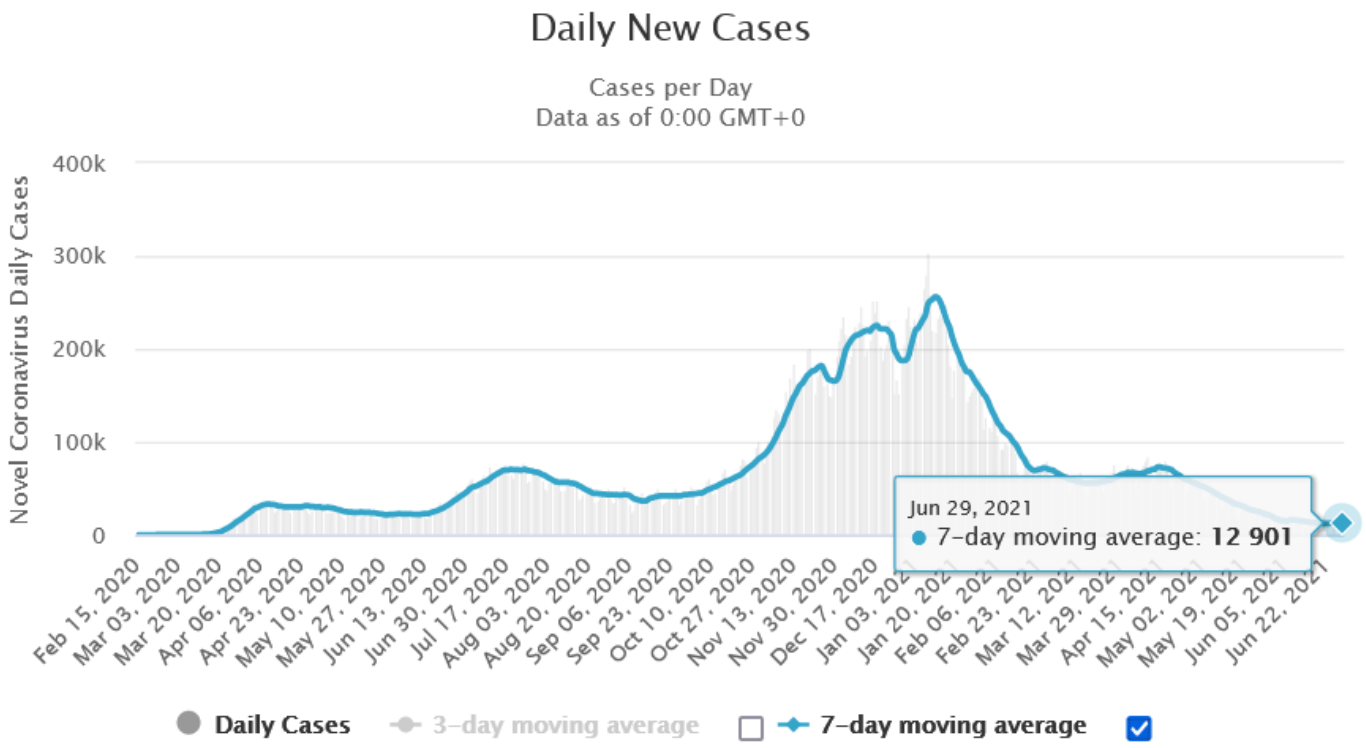
As you consider the case totals, bear in mind that cases are determined by PCR testing and not by combining PCR with a physician's clinical experience in properly evaluating a person based on history and examination. That is the way cases should be determined. The late Dr. Kary Mullis, the 1993 Nobel Prize in Chemistry Winner as the inventor of the Polymerase Chain Reaction (PCR) test was clear. The test is NOT appropriate for being used as a stand-alone diagnostic test for viral infection. He also made an interesting comment when talking about the AIDS epidemic. His comment mirrors many top scientist's feelings about the "case" numbers of COVID-19 that have and are being reported.

"Epidemic. The number of cases reported went up epidemically, exponentially because the number of tests that was done went up exponentially."

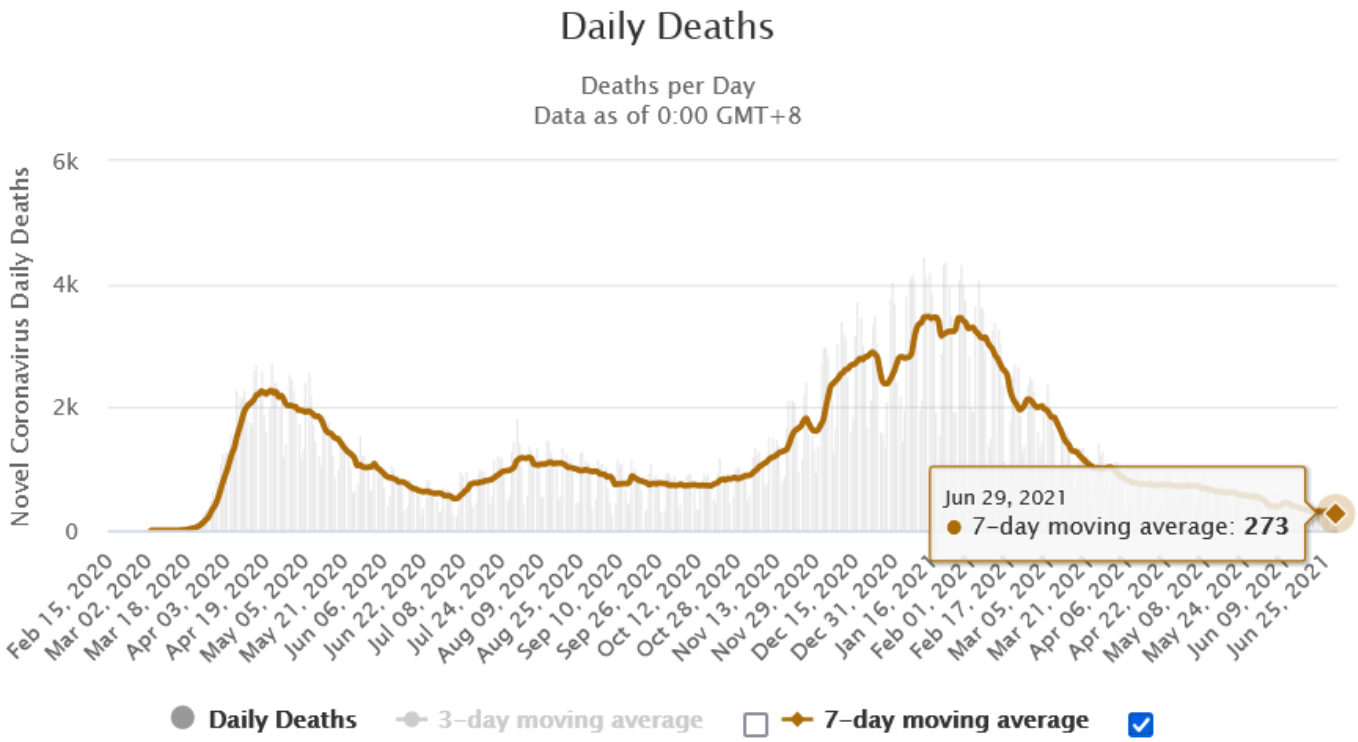
Therefore, more testing = more "cases". There is a major difference between infections and cases. If we stopped testing tomorrow and as a result "new cases" went to zero, would that mean that there are no more new people infected? Of course not. So, while it a metric that is driving public fear and policy decisions affecting all Americans, it is in no way the most important metric. This is not to mention that the reporting is fraught with inaccuracies, including some people being tested multiple times and each test being counted as a new test or new positive, as well as people that were never tested being called and informed that they tested positive! The PCR test also has significant rates of false positives (estimated at 30-50%) and false negatives (20% or so). And, despite the numbers that are discovered, the numbers of people that have been infected, been asymptomatic or had mild symptoms and never tested, are many multiples of the known positive case numbers (CDC says about 8X higher). Based on that estimation as of today it would mean that approximately 66% of all Americans have had the infection. Surely, we must be zeroing in on herd or population immunity and would expect the virus infection rate to decline.

7-day average of U.S. New Cases and Deaths- as of June 29th

Daily New Cases in the United States

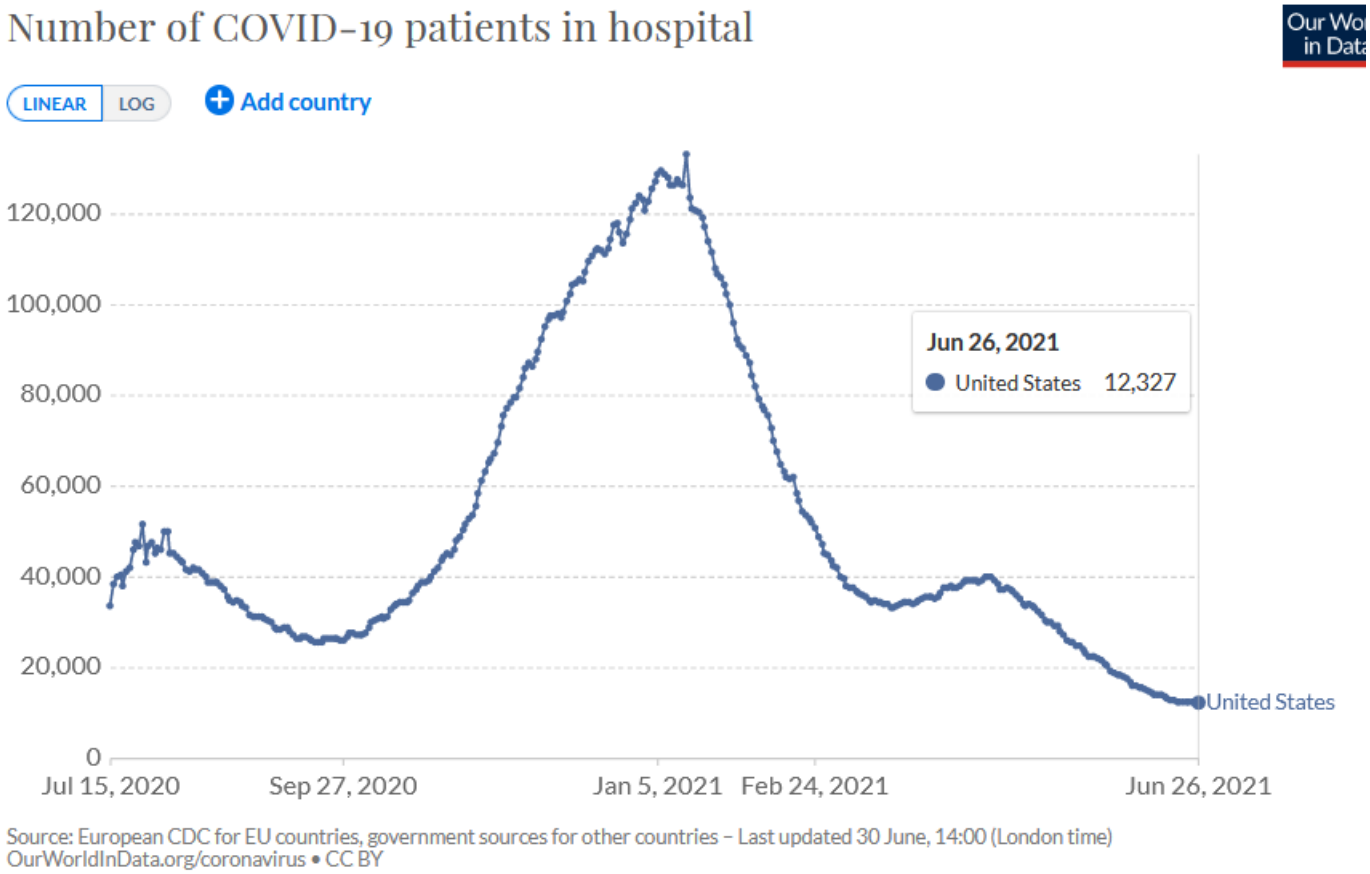


Daily New Deaths in the United States



https://www.worldometers.info/coronavirus/country/us/

COVID-19 patients in the hospital in the U.S.



Can we rely on the reported death numbers?

A footnote on deaths: We don't know what the actual number of deaths due to COVID-19 are, but all indicators are that it is GROSSLY inflated. Former Senator Dr. Scott Jensen a practicing physician from Minnesota has done an audit of deaths in Minnesota and found that they are 40% inflated due to incorrect assignment of cause of death on the death certificates.
https://www.washingtonexaminer.com/news/coronavirus-death-certificates-minnesota-inflated

And this does not even take into consideration the high rate of false positives of the PCR test! That is a whole additional category of people that died and were assigned to have died of COVID-19 on the death certificates. These may have appeared to be a legitimate COVID-19 death because of a similar presentation like pneumonia, acute respiratory distress syndrome, etc. (thus would pass the test the Minnesota team used), but may have had another respiratory illness (viral, bacterial, non-infectious pneumonia, etc.). If they pulled a positive COVID test but weren't tested for all the other pathogens…and the COVID test was truly a FALSE positive which again is common (estimated at 30%-90% depending on the source), that death is not a true COVID-19 death. How many of those were mislabeled? We may never know the number but suffice to say it would be a huge number!

One more consideration of deaths "with COVID-19". Of the CDC 576,688 reported deaths as of May 23rd,

2021, 332,402 of them were in people over the age of 75. That represents 58% of all the reported deaths. The 75 and over demographic in the U.S. is 6.8% of the population. So, in essence 6.8% of the population suffered 58% of the fatalities. (Once again considering the aforementioned qualifiers)

As proof of the justifiable concern over misrepresenting infectious disease death numbers, what is the CDC's track record on being accurate?

Consider this section from my November 2020 newsletter about the misidentification of deaths categorized as "flu" deaths….

Influenza is responsible for only a small percentage of hospitalizations and deaths from respiratory illness

The vast majority of hospitalized patients with respiratory infections, have infections from other microbes than the various strains of influenza virus, as reported in a highly touted 2015 study **published in the *New England Journal of Medicine*** titled, **Community-Acquired Pneumonia Requiring Hospitalization among U.S. Adults.** The study found that **only 6% of cases of pneumonia were caused by one of the influenza strains**. Remember the flu vaccine typically contains only 3 or 4 influenza strains. It is completely irresponsible and false to claim that between 50,000 and 80,000 people die annually of the flu, when according to one study only 6% of cases of pneumonia are influenza related! In fact, in the study pathogenic microbes were found in only 38% of confirmed cases of pneumonia. One or more viruses were found in 23%, with rhinovirus being the most common virus at 9% and bacterial microbes accounted for 11%.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6245375/pdf/idr-11-2321.pdf .

Respiratory viruses, bacteria and fungi causing pneumonia are equal opportunity killers and will all be reflected in those death numbers?
According to an October 03, 2012 article posted on the ***National Vaccine Information Center's*** web site (https://www.nvic.org/), supports my contention that the *CDC* lumps all pneumonia related and pulmonary deaths with influenza deaths. The article confirms that only a small percentage of pneumonia cases test positive for influenza. **The article says that "*CDC* now says that only 8.5 percent of all pneumonia and influenza deaths and only 2.1 percent of all respiratory and circulatory deaths are influenza related."**
https://www.nvic.org/NVIC-Vaccine-News/October-2012/Influenza-Deaths--The-Hype-vs--The-Evidence.aspx#_edn46

Since the CDC is aware of these facts, why the continued mixed messaging that supports the false narrative about deaths from influenza and the intentional use of that misinformation in the marketing of the flu vaccine every year?

Another consideration is ***hospital acquired infections***. The CDC estimates that there are 1.7 million hospital acquired infections annually and **99,000 people die from them**. So, the shocking reality is, that many people that die from pneumonia in the hospital actually contract their deadly infection there. They may have entered the hospital with influenza or influenza like illness (I.L.I.) from one of dozens of other viruses that they may have survived, but later died from a hospital acquired infection maybe even a bacterial caused pneumonia contracted while in the hospital. Because the assumption was made that they died from influenza, they are often misdiagnosed and categorized as "flu" deaths.

How has the United States fared compared to all of the other countries in the world with regard to deaths from COVID-19?

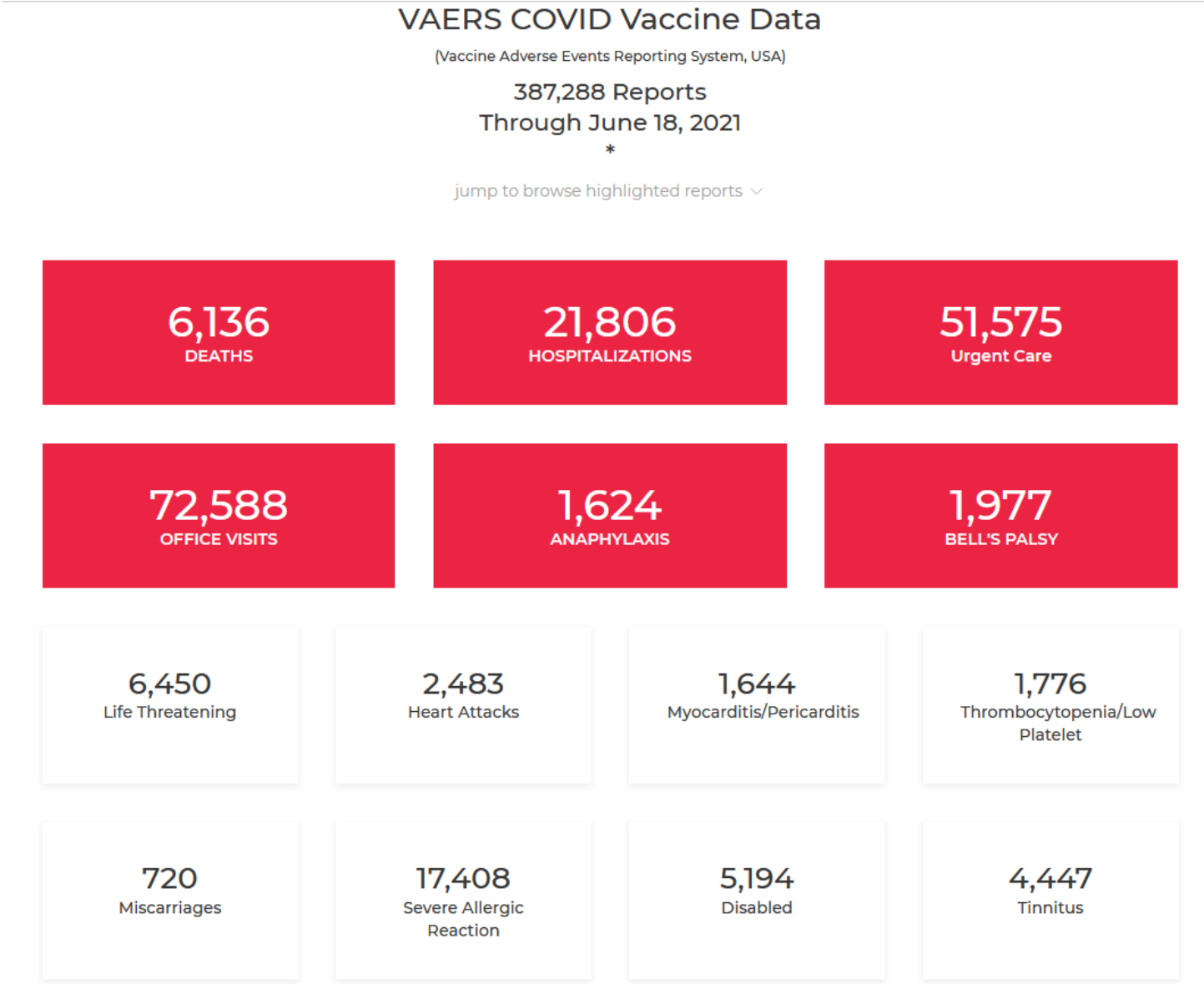
The chart on the next page shows the rankings of the worst countries in the world as it relates to deaths per million population from COVID-19. As you can see at 18th from the **WORST** in the world out of 220 countries! I've only shown the worst 57 countries to reduce space taken up by this story. The U.S. has one of the highest rates of obesity and chronic disease in the world (diabetes, cardiovascular disease including obstructive coronary artery disease, hypertension, chronic respiratory diseases and cancer). It's no wonder that so many people in our population had such a difficult time with the virus. The CDC has reported that people that died of COVID-19 had four co-morbid chronic diseases on average.

https://www.worldometers.info/coronavirus/#countries

See the next page…

#	Country, Other	Deaths/ 1M pop
1	Hungary	3,085
2	Bosnia and Herzegovina	2,836
3	Czechia	2,807
4	Gibraltar	2,791
5	San Marino	2,647
6	North Macedonia	2,598
7	Bulgaria	2,559
8	Montenegro	2,522
9	Slovakia	2,260
10	Brazil	2,160
11	Belgium	2,143
12	Slovenia	2,104
13	Italy	2,089
14	Peru	2,077
15	Croatia	1,966
16	Poland	1,950
17	UK	1,873
18	USA	1,832
19	Colombia	1,718
20	Mexico	1,717
21	Spain	1,709
22	Argentina	1,700
23	France	1,675
24	Portugal	1,674
25	Andorra	1,641
26	Lithuania	1,587
27	Romania	1,585
28	Chile	1,521
29	Liechtenstein	1,517
30	Moldova	1,517
31	Armenia	1,495
32	Panama	1,456
33	Sweden	1,419
34	Luxembourg	1,283
35	Latvia	1,273
36	Paraguay	1,259
37	Switzerland	1,241
38	Bolivia	1,225
39	Uruguay	1,209
40	Georgia	1,199
41	Austria	1,171
42	Greece	1,166
43	Ukraine	1,162
44	Ecuador	1,149
45	Lebanon	1,137
46	Germany	1,060
47	Tunisia	1,058
48	Netherlands	1,026
49	Aruba	998
50	Ireland	991
51	Malta	947
52	Estonia	943
53	Iran	943
54	South Africa	941
55	Jordan	919
56	Albania	853
57	Russia	832

Current VAERS reported COVID-19 vaccine injuries and deaths in the U.S.



https://www.openvaers.com/covid-data

As reported many times before, but important for any new readers that are not aware of the extreme under-reporting of adverse events to the VAERS system. For those that have seen this information feel free to scroll on past.

The U.S. government funded a Harvard study that found that less than 1% of adverse reactions to vaccines are reported to VAERS

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., 613,600 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 61,360 thus far. The next logical question would have to be, “how many is too many?”

And as we all know by now, the vaccine makers are completely liability free for any damages caused by their products. You assume ALL risk and costs for damages.

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."

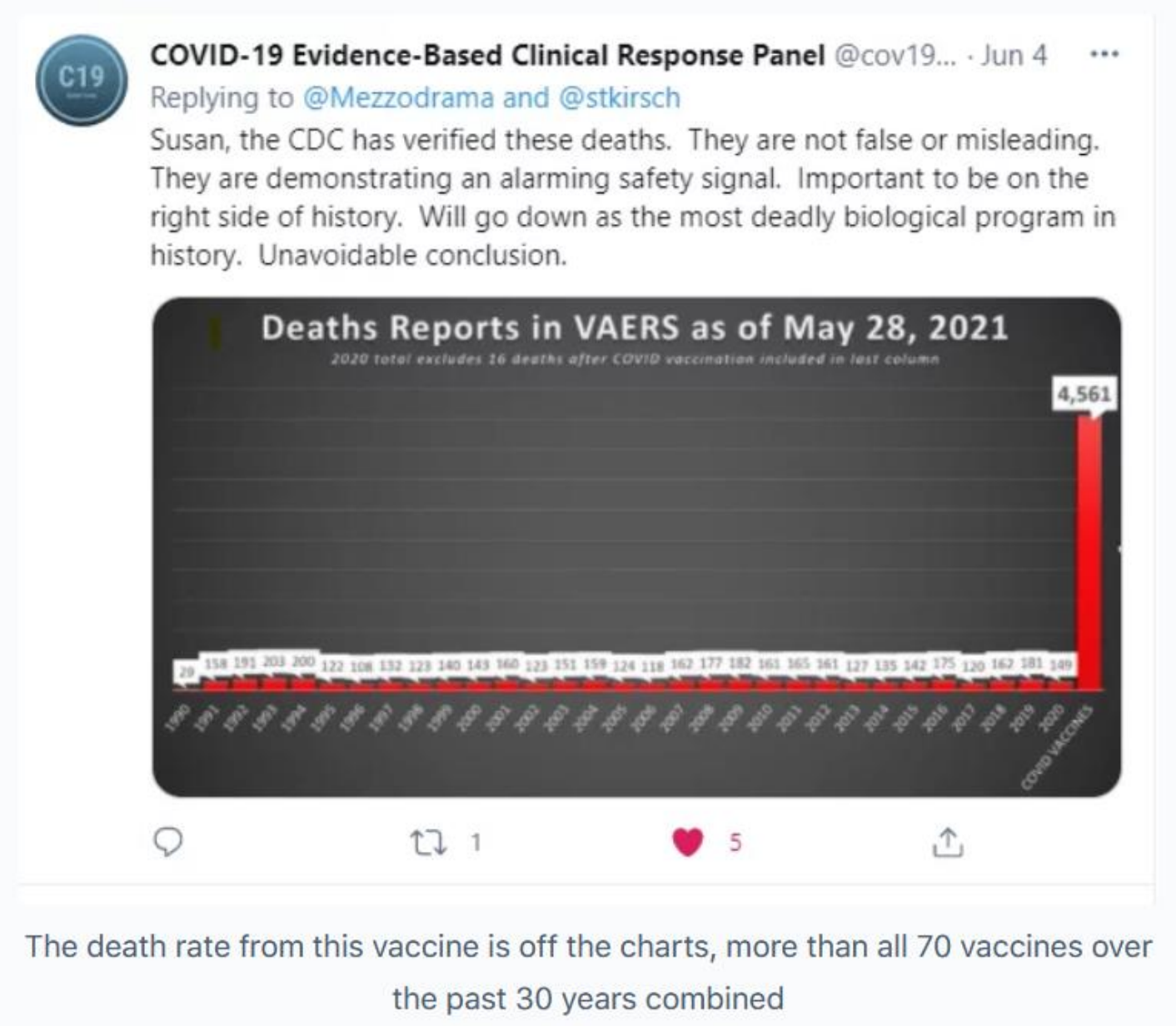
Dividing 1.4 million doses between 376,452 people is an average of 3.72 doses per person. And, if there were 35,570 reactions in 1.4 million doses given, that is one adverse reaction for every 39.4 doses. Perhaps what is most striking here is that if each person reacting experienced on adverse reaction 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."

Despite the under-reporting of deaths and serious adverse reactions to the COVID-19 vaccines, our public health authorities and public health agencies remain silent and even ignore the pleas of the many injured people. Senator Ron Johnson of Wisconsin held a press conference earlier this week and invited some of the victims to tell their stories because they have been ignored. https://informedchoicewa.org/news/senator-ron-johnson-milwaukee-news-conference-covid-19-vax-injuries/

Unfortunately, this is not unprecedented as tens of thousands of families have been ignored by our federal government after they or their children have been injured throughout the years. I have chronicled and investigated the science being vaccine injury and reported it in my eBook titled, 1200 Studies- Truth Will Prevail. It is now over 900 pages in length and contains excerpts from over 1,500 studies that contradict the public narrative about the safety and effectiveness of vaccines. It is available online at https://1200studies.com

Check out this graphic to see how the death rates from the COVID-19 vaccines compare to all the other vaccines combined for the last 30 years. And that was from over a month ago. When the new updates come out the first week of July the reported death toll will now be nearly 7,000.



https://trialsitenews.com/should-you-get-vaccinated/

The CDC's weekly cause of death tally shows a consistent uptick in an "unspecified" category since the start of administration of the COVID-19 vaccine

The CDC maintains a database called the **Weekly Provisional Counts of Deaths by State and Select Causes, 2020-2021.** It shows the cause of death in columns for each week. There is one column that is listed as "Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)". That column has seen an unprecedented increase since the start of the COVID-19 vaccination program that began on December 14th, 2020.

This table shows the R00-R99 category from January 2020 and the increase after the COVID-19 vaccine program began December 14th 2021. (you can increase the magnification of the page to read it easier).

https://data.cdc.gov/NCHS/Weekly-Provisional-Counts-of-Deaths-by-State-and-S/muzy-jte6

	Jurisdictio	MMWR	MMV	Week Ending	All Cause	Natural Ca	Septice	Malignant	Diabetes n	Alzheimer	Influenza a	Chronic lo	Other dise	Nephritis,	Symptoms, signs and abnormal c	Diseases	Cerebrova	COVID-19 (UC	COVID-19 (UC
2	United Sta	2020	1	1/4/2020	60,173	55,014	844	11,566	1,830	2,536	1,560	3,502	1,068	1,094	639	14,202	3,109	0	0
3	United Sta	2020	2	1/11/2020	60,735	55,754	863	11,960	1,943	2,566	1,529	3,709	1,036	1,092	651	13,912	3,189	1	1
4	United Sta	2020	3	1/18/2020	59,364	54,522	831	11,705	1,820	2,490	1,484	3,526	993	1,121	620	13,592	3,258	3	2
5	United Sta	2020	4	1/25/2020	59,171	54,407	830	11,882	1,865	2,517	1,488	3,403	979	1,107	646	13,612	3,185	2	1
6	United Sta	2020	5	2/1/2020	58,833	54,004	813	11,963	1,828	2,480	1,412	3,314	981	1,074	624	13,467	3,084	1	0
7	United Sta	2020	6	2/8/2020	59,482	54,412	809	11,709	1,957	2,515	1,464	3,413	974	1,136	604	14,004	3,057	3	2
8	United Sta	2020	7	2/15/2020	58,812	53,969	794	11,814	1,845	2,537	1,514	3,479	978	1,070	623	13,639	3,087	2	0
9	United Sta	2020	8	2/22/2020	58,912	53,989	782	11,783	1,880	2,515	1,462	3,454	968	1,058	618	13,628	3,083	6	6
10	United Sta	2020	9	2/29/2020	59,342	54,322	820	11,790	1,830	2,519	1,507	3,460	1,011	1,092	688	13,715	3,127	9	9
11	United Sta	2020	10	3/7/2020	59,694	54,391	815	11,712	1,867	2,511	1,610	3,471	1,003	1,071	667	13,688	3,096	37	33
12	United Sta	2020	11	3/14/2020	58,672	53,531	759	11,571	1,743	2,445	1,641	3,390	993	1,078	649	13,442	3,167	58	54
13	United Sta	2020	12	3/21/2020	59,218	54,306	843	11,735	1,835	2,515	1,742	3,384	1,022	1,105	626	13,200	3,069	584	546
14	United Sta	2020	13	3/28/2020	63,046	58,258	851	11,784	2,046	2,749	1,789	3,520	1,064	1,027	648	13,722	3,067	3,203	3,024
15	United Sta	2020	14	4/4/2020	72,295	67,451	954	11,597	2,301	2,871	1,856	3,537	1,029	1,037	704	14,956	3,165	10,116	9,619
16	United Sta	2020	15	4/11/2020	79,092	74,008	836	11,552	2,358	2,964	1,628	3,441	1,020	1,119	677	15,768	3,192	16,302	15,488
17	United Sta	2020	16	4/18/2020	76,807	71,896	751	11,209	2,271	2,900	1,245	3,196	916	1,099	676	14,578	3,205	17,183	16,276
18	United Sta	2020	17	4/25/2020	73,910	68,749	739	11,363	2,086	2,804	1,147	2,995	889	987	689	13,875	3,059	15,545	14,647
19	United Sta	2020	18	5/2/2020	69,320	63,942	741	11,099	1,935	2,727	1,013	2,930	852	961	563	13,009	3,042	13,212	12,429
20	United Sta	2020	19	5/9/2020	66,811	61,190	722	11,018	1,971	2,498	865	2,807	858	937	617	13,167	2,855	11,229	10,454
21	United Sta	2020	20	5/16/2020	64,478	58,996	681	11,268	1,968	2,432	863	2,771	786	976	590	12,740	2,962	9,223	8,478
22	United Sta	2020	21	5/23/2020	61,628	56,021	715	11,118	1,835	2,417	806	2,678	744	919	596	12,782	2,827	7,243	6,588
23	United Sta	2020	22	5/30/2020	59,692	54,021	653	10,905	1,814	2,261	754	2,634	761	893	610	12,462	2,855	6,170	5,585
24	United Sta	2020	23	6/6/2020	58,918	52,951	733	11,084	1,728	2,302	701	2,565	780	905	576	12,480	2,791	5,053	4,515
25	United Sta	2020	24	6/13/2020	58,033	52,295	694	11,131	1,741	2,327	700	2,502	737	924	610	12,411	2,843	4,229	3,726
26	United Sta	2020	25	6/20/2020	57,997	52,220	686	11,159	1,792	2,362	756	2,563	762	932	634	12,406	2,925	3,845	3,351
27	United Sta	2020	26	6/27/2020	58,506	52,654	721	11,360	1,768	2,289	723	2,538	775	952	600	12,513	2,962	3,839	3,327
28	United Sta	2020	27	7/4/2020	59,840	53,830	686	11,298	1,931	2,362	656	2,625	780	986	624	12,878	2,835	4,548	4,047
29	United Sta	2020	28	7/11/2020	61,939	55,854	767	11,329	1,956	2,471	741	2,615	753	916	698	13,022	2,921	5,783	5,232
30	United Sta	2020	29	7/18/2020	63,169	57,160	711	11,376	1,889	2,501	767	2,646	712	985	702	12,867	2,984	7,190	6,524
31	United Sta	2020	30	7/25/2020	64,246	58,399	687	11,558	1,956	2,510	782	2,560	732	969	702	12,928	2,913	8,238	7,519
32	United Sta	2020	31	8/1/2020	64,229	58,289	693	11,512	1,989	2,502	759	2,737	782	961	659	12,826	2,991	8,300	7,606
33	United Sta	2020	32	8/8/2020	63,716	57,849	786	11,530	1,798	2,435	782	2,594	730	910	705	12,817	3,036	7,863	7,176
34	United Sta	2020	33	8/15/2020	63,641	57,770	740	11,702	1,895	2,528	756	2,657	798	968	682	12,841	2,950	7,257	6,557
35	United Sta	2020	34	8/22/2020	62,578	56,631	738	11,519	1,935	2,567	697	2,644	784	967	664	12,768	2,933	6,379	5,747
36	United Sta	2020	35	8/29/2020	61,101	55,354	728	11,575	1,882	2,430	680	2,560	747	984	657	12,473	2,992	5,741	5,142
37	United Sta	2020	36	9/5/2020	60,241	54,269	704	11,376	1,838	2,506	737	2,553	801	929	611	12,508	2,864	5,010	4,424
38	United Sta	2020	37	9/12/2020	59,660	53,970	698	11,468	1,894	2,330	681	2,560	748	928	657	12,350	3,046	4,624	4,078
39	United Sta	2020	38	9/19/2020	59,732	54,164	751	11,628	1,860	2,373	718	2,519	779	920	680	12,688	2,949	4,269	3,759
40	United Sta	2020	39	9/26/2020	60,610	55,080	769	11,864	1,843	2,500	724	2,672	790	923	627	12,706	3,079	4,298	3,786
41	United Sta	2020	40	10/3/2020	59,803	54,142	724	11,424	1,896	2,414	763	2,578	719	945	708	12,653	2,885	4,241	3,694
42	United Sta	2020	41	10/10/2020	61,778	55,978	759	11,829	1,895	2,516	725	2,615	800	959	690	12,800	3,125	4,817	4,272
43	United Sta	2020	42	10/17/2020	60,638	55,243	777	11,321	1,845	2,538	724	2,598	814	1,023	675	12,571	3,038	5,193	4,587
44	United Sta	2020	43	10/24/2020	62,207	56,903	732	11,677	1,838	2,572	766	2,700	796	944	673	12,869	3,082	5,988	5,320
45	United Sta	2020	44	10/31/2020	63,420	58,099	703	11,529	1,941	2,460	795	2,570	831	923	638	13,154	3,103	7,015	6,248
46	United Sta	2020	45	11/7/2020	67,599	61,791	771	11,809	1,963	2,664	802	2,898	814	1,028	740	13,675	3,160	8,753	7,837
47	United Sta	2020	46	11/14/2020	68,815	63,251	796	11,740	2,024	2,735	849	2,751	859	1,023	672	13,453	3,174	10,638	9,572
48	United Sta	2020	47	11/21/2020	71,662	66,277	824	11,634	2,119	2,657	833	2,818	858	1,032	753	13,628	3,215	13,352	12,062
49	United Sta	2020	48	11/28/2020	73,286	67,950	777	11,392	2,153	2,774	810	2,755	863	1,043	769	13,545	3,127	15,608	14,120
50	United Sta	2020	49	12/5/2020	77,406	72,018	851	11,353	2,216	2,846	919	2,834	902	1,034	797	14,295	3,312	18,546	16,836
51	United Sta	2020	50	12/12/2020	81,980	76,458	835	11,902	2,298	2,935	953	3,032	973	1,088	816	14,549	3,482	20,908	19,050
52	United Sta	2020	51	12/19/2020	82,916	77,581	842	11,782	2,351	3,059	949	2,947	921	1,022	Health care workers get 1st shots 838	14,749	3,466	22,301	20,393
53	United Sta	2020	52	12/26/2020	84,324	78,756	860	11,692	2,329	2,979	979	2,861	924	1,124	896	14,825	3,388	23,343	21,319
54	United Sta	2020	53	1/2/2021	86,842	81,049	896	11,672	2,439	3,066	1,019	3,055	904	1,108	874	15,208	3,502	24,767	22,649
55	United Sta	2021	1	1/9/2021	86,421	80,864	856	11,282	2,345	2,937	1,031	2,942	938	1,148	986	14,947	3,356	25,737	23,692
56	United Sta	2021	2	1/16/2021	86,243	80,775	821	11,736	2,415	2,954	999	2,898	948	1,226	1,039	14,764	3,501	25,286	23,132
57	United Sta	2021	3	1/23/2021	82,465	77,190	831	11,434	2,172	2,888	923	2,782	892	1,180	1,036	14,371	3,411	23,241	21,225
58	United Sta	2021	4	1/30/2021	78,718	73,511	782	11,641	2,153	2,641	914	2,769	950	1,168	1,061	14,132	3,272	20,133	18,232
59	United Sta	2021	5	2/6/2021	74,326	68,940	804	11,291	2,021	2,499	827	2,791	902	1,104	1,180	13,993	3,225	16,461	14,741
60	United Sta	2021	6	2/13/2021	69,060	63,984	804	11,152	1,998	2,309	837	2,565	869	1,078	1,150	13,443	3,271	12,954	11,501
61	United Sta	2021	7	2/20/2021	67,255	62,224	796	11,051	2,211	2,424	850	2,615	830	1,034	1,214	13,698	3,072	10,399	9,149
62	United Sta	2021	8	2/27/2021	64,646	59,453	848	11,276	1,910	2,409	773	2,543	863	1,040	1,219	13,113	3,115	8,308	7,220
63	United Sta	2021	9	3/6/2021	61,565	56,474	763	11,036	1,887	2,234	812	2,493	786	1,040	1,293	12,771	3,074	6,498	5,580
64	United Sta	2021	10	3/13/2021	59,790	54,922	812	11,044	1,829	2,213	748	2,542	828	981	1,441	12,619	2,999	5,549	4,664
65	United Sta	2021	11	3/20/2021	58,230	53,306	736	10,943	1,876	2,111	726	2,459	814	945	1,676	12,134	2,961	4,786	4,018
66	United Sta	2021	12	3/27/2021	58,416	53,685	694	10,969	1,791	2,147	664	2,576	813	979	1,802	12,438	3,002	4,357	3,694
67	United Sta	2021	13	4/3/2021	56,152	51,649	664	10,637	1,816	1,970	659	2,389	812	963	2,091	11,764	2,826	4,090	3,440
68	United Sta	2021	14	4/10/2021	58,148	53,404	673	11,075	1,756	2,076	700	2,477	740	984	2,377	12,112	2,924	4,177	3,543
69	United Sta	2021	15	4/17/2021	56,129	51,906	639	10,862	1,653	1,878	645	2,345	729	919	2,384	11,844	2,951	4,304	3,671
70	United Sta	2021	16	4/24/2021	57,200	53,084	691	11,047	1,739	1,949	658	2,437	822	931	2,596	11,975	2,933	4,419	3,805
71	United Sta	2021	17	5/1/2021	56,286	52,500	678	10,997	1,718	2,024	631	2,451	784	942	2,717	11,697	2,791	3,997	3,460
72	United Sta	2021	18	5/8/2021	54,695	51,111	649	10,666	1,655	1,979	642	2,390	781	834	3,046	11,327	2,786	3,754	3,239
73	United Sta	2021	19	5/15/2021	53,739	50,492	631	10,734	1,632	1,884	617	2,319	770	888	3,134	10,979	2,755	3,457	2,980
74	United Sta	2021	20	5/22/2021	52,895	49,726	637	10,720	1,446	1,992	584	2,369	804	871	3,252	10,687	2,700	2,943	2,509
75	United Sta	2021	21	5/29/2021	49,172	46,498	612	10,041	1,455	1,792	567	2,224	716	849	3,166	10,243	2,589	2,389	2,000
76	United Sta	2021	22	6/5/2021	44,698	42,399	533	9,441	1,221	1,675	489	2,030	636	759	3,143	9,277	2,324	1,828	1,567
77	United Sta	2021	23	6/12/2021	32,665	31,470	362	7,020	926	1,392	377	1,574	483	550	2,491	6,908	1,761	1,151	952
78															48,102				
79																			
80	Alabama	2020	1	1/4/2020	1,082	1,009	15	196	25	54	28	86	13	25	25	268	81	0	0
81	Alabama	2020	2	1/11/2020	1,127	1,060	25	197	17	41	27	72	20	23	34	274	68	0	0

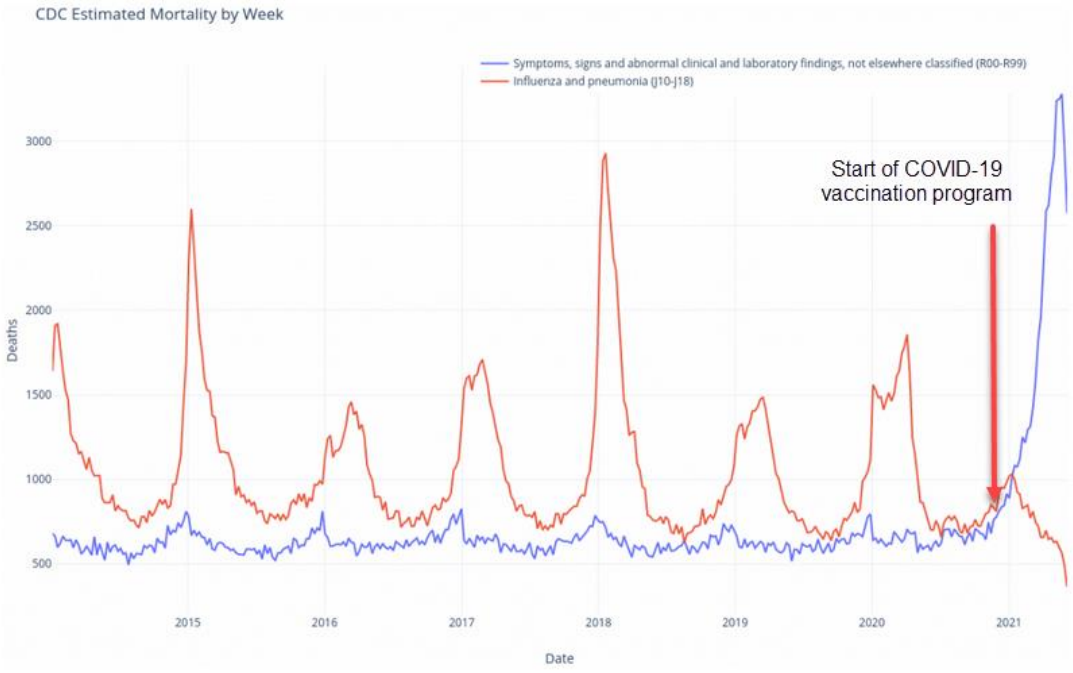
https://data.cdc.gov/NCHS/Weekly-Provisional-Counts-of-Deaths-by-State-and-S/muzy-jte6

The total of 48,102 at the bottom of that column is the total of deaths classified with that code from the onset of the mass vaccination program. The average baseline weekly amount for that code BEFORE the vax program is 660.88 (661). Backing out 661 per week since the start of the vax program accounts for 17,186 of the 48,102 deaths categorized with that code since the program started. Subtracting 17,186 from 48,102 leaves 30,916 deaths over the baseline. This is speculation, but it could explain the vaccine deaths where cause of death after the vaccines was never determined (i.e., heart attack, brain aneurism, etc.). As has been widely reported, many people that have passed away after getting the shots never have an autopsy to determine the cause of death. Is it possible that this is a category where they are showing up?

Check out this next graphic. (I've added the arrow showing the date of the start of the vax program)

*The print is small, but the orange is the influenza and pneumonia deaths, and the blue is the R00-R99 code.

(Addition June 16, 2021) To really make it clear how well outside of normal this is, we look at historic CDC data we can see a dramatic spike in the R00-R94 codes – from 2014 through today June 2021.

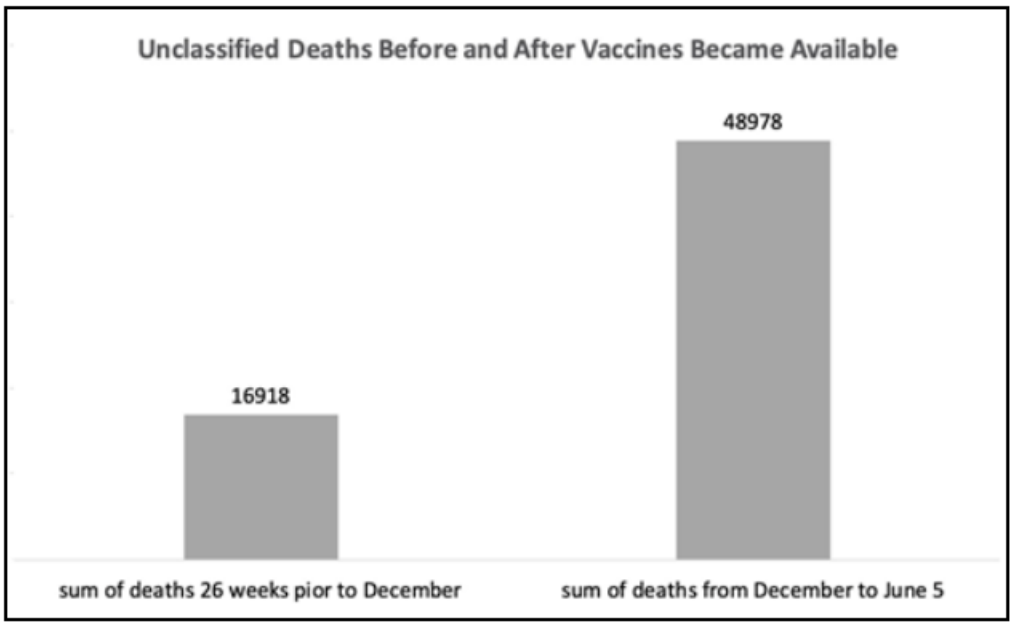


(Addition June 22, 2021) It's important to note the R00-R99 codes will adjust later, i.e. re-attributed to COVID-19 or diseases of heart deaths. I do a bit of an analysis into that topic in a follow up article, Changes in the CDC Counts of Deaths by State and Select Cause. Yes, the R00-R99 are increasing over time. This is counter intuitive as the rate should be decreasing as there are fewer cases of COVID-19. In addition, it appears there are an increasing number of R00-R99 deaths being re-attributed to diseases of heart (see follow up article). That being said, it is still early and the data is unclear until the numbers stabilize in the next 6-8 weeks (at time of writing).

https://austingwalters.com/covid19-vaccine-risks/

One more graph with another perspective on the next page…

If values prior to December (left bar in Graph 3) are subtracted from values December to June (right bar in Graph 3), the number of excess "unclassified" deaths is 32,060. This is comparable to Steve Kirsch's difference of 25,800 (My calculation may be higher because I downloaded the data a few days after Kirsch posted the video).



Graph3: Total "unclassified" deaths before and after vaccine availability. Death rates were provided the CDC's "Weekly Provisional Counts of Deaths by State and Select Causes."

https://www.americanthinker.com/blog/2021/06/what_is_the_true_number_of_vaccinerelated_deaths.html

Explosive new report blows the lid off of the claims of efficacy and safety of the COVID-19 vaccines

A June 24th, 2021 article published in the journal ***Vaccine*** titled, **The Safety of COVID-19 Vaccinations—We Should Rethink the Policy**, reveals devastating statistics on the COVID-19 vaccines. It finds greater than a 1 in 25,000 death rate and that between 200 and 700 people would need to be vaccinated to prevent one person from getting COVID-19. As bad as the numbers are in this study, it must be recognized that like the VAERS system here in the U.S., the number of adverse reactions and deaths are likely grossly under-reported.

Abstract

Background: COVID-19 vaccines have had expedited reviews without sufficient safety data. We wanted to compare risks and benefits.

Method: We calculated the number needed to vaccinate (NNTV) from a large Israeli field study to prevent one death. We accessed the Adverse Drug Reactions (ADR) database of the European Medicines Agency and of the Dutch National Register (lareb.nl) to extract the number of cases reporting severe side effects and the number

of cases with fatal side effects.

Result: The NNTV is between 200–700 to prevent one case of COVID-19 for them RNA vaccine marketed by Pfizer, while the NNTV to prevent one death is between 9000 and 50,000 (95% confidence interval), with 16,000 as a point estimate. The number of cases experiencing adverse reactions has been reported to be 700 per 100,000 vaccinations. Currently, we see 16 serious side effects per 100,000 vaccinations, and the number of fatal side effects is at 4.11/100,000 vaccinations. For three deaths prevented by vaccination we have to accept two inflicted by vaccination.

Conclusions: This lack of clear benefit should cause governments to rethink their vaccination policy.

From the article

Table 1. Risk differences and number needed to vaccinate (NNTV) to prevent one infection, one case of symptomatic illness, and one death from COVID-19. Data from Dagan et al. [6], $N = 596{,}618$ in each group.

	Documented Infection		Symptomatic Illness		Death from COVID-19	
Period	Risk Difference (No./1000 Persons) (95% CI)	NNTV (95% CI)	Risk Difference (No./1000 Persons) (95% CI)	NNTV (95% CI)	Risk Difference (No./1000 Persons) (95% CI)	NNTV (95% CI)
14–20 days after first dose	2.06 (1.70–2.40)	486 (417–589)	1.54 (1.28–1.80)	650 (556–782)	0.03 (0.01–0.07)	33,334 (14,286–100,000)
21–27 days after first dose	2.31 (1.96–2.69)	433 (372–511)	1.34 (1.09–1.62)	747 (618–918)	0.06 (0.02–0.11)	16,667 (9091–50,000)
7 days after second dose to end of follow-up	8.58 (6.22–11.18)	117 (90–161)	4.61 (3.29–6.53)	217 (154–304)	NA	NA

Data taken from Table 2 in Dagan et al.'s work. NNTV = 1/risk difference.

Table 2. Number needed to vaccinate (NNTV) calculated from pivotal phase 3 regulatory trials of the SARS-CoV2 mRNA vaccines of Moderna, BioNTech/Pfizer, and Sputnik (the vector vaccine of Astra-Zeneca is not contained here, as the study [9] was active-controlled and not placebo-controlled).

Vaccine	*N* Participants Vaccine Group	*N* Participants Placebo Group	CoV2 Positive End of Trial Vaccine Group	CoV2 Positive End of Trial Placebo Group	Absolute Risk Difference (ARD)	Number Needed to Vaccinate 1/ARR
Moderna [5] $	15,181(14,550 *)	15,170 (14,598 *)	19 (0.13%) [1]	269 (1.77%) [1]	0.0165	61
Comirnaty (BioNTech/Pfizer) [4] $	18,860	18,846	8 (0.042%) [2]	162 (0.86%) [2]	0.00817	123
Sputnik V [7] §	14,964	4902	13 (0.087%) **,[3]	47 (1%) **,[3]	0.0091	110

* Modified intention to treat-population—basis for calculation; ** taken from the publication because of slightly different case numbers; $ outcome was a symptomatic COVID-19 case; § outcome was a confirmed infection by PCR-test; [1] after 6 weeks; [2] after 4 weeks; [3] after 3 weeks.

Table 3. Individual case safety reports for the most widely distributed COVID-19 vaccines according to the Dutch side effects register (www.lareb.nl/coronameldingen (accessed on 29 May 2021)), the absolute numbers per vaccine, and standardization per 100,000 vaccinations.

	General Number of Reports (1)	Serious Side Effects (1)	Deaths (2)	Number of Vaccinations According to (3)	Number of Vaccinations According to ECDC (4)
Comirnaty (Pfizer)	21,321	864	280	5,946,031	6,004,808
Moderna	6390	114	35	531,449	540,862
Vaxzevria (AstraZeneca)	29,865	411	31	1,837,407	1,852,996
Janssen	2596	7	-	142,069	143,525
Unknown	129	15	5	-	540
Total	60,301	1.411	351	8,456,956	8,542,731
Per 100,000 vaccinations according to Dutch data	**713.03**	**16.68**	**4.15**		
Per 100,000 vaccinations according to ECDC	**705.87**	**16.52**	**4.11**		

(1) https://www.lareb.nl/coronameldingen. (2) https://www.lareb.nl/pages/update-van-bijwerkingen. (3) https://coronadashboard.rijksoverheid.nl/landelijk/vaccinaties. (4) https://www.ecdc.europa.eu/en/publications-data/data-covid-19-vaccination-eu-eea. All sites accessed on 27 May 2021. The Dutch government reported two numbers; we took the calculated amounts.

Thus, we need to accept that around 16 cases will develop severe adverse reactions from COVID-19 vaccines per 100,000 vaccinations delivered, and approximately four people will die from the consequences of being vaccinated per 100,000 vaccinations de-livered. Adopting the point estimate of NNTV = 16,000 (95% CI, 9000–50,000) to prevent one COVID-19-related death, for every six (95% CI, 2–11) deaths prevented by vaccination, we may incur four deaths as a consequence of or associated with the vaccination. Simply put: As we prevent three deaths by vaccinating, we incur two deaths.

The risk–benefit ratio looks better if we accept the stronger effect sizes from the phase3 trials. Using Cunningham's estimate of NNTV = 12,300, which stems from a non-peer reviewed comment, we arrived at eight deaths prevented per 100,000 vaccinations and, in the best case, 33 deaths prevented by 100,000 vaccinations. Thus, in the optimum case, we risk four deaths to prevent 33 deaths, a risk–benefit ratio of 1:8. The risk–benefit ratio in terms of deaths prevented and deaths incurred thus ranges from 2:3 to 1:8, although real-life data also support ratios as high as 2:1, i.e., twice as high a risk of death from the vaccination compared to COVID-19, within the 95% confidence limit.

A recent experimental study showed that the SARS-CoV2 spike protein is sufficient to produce endothelial damage [23]. This provides a potential causal rationale for the most serious and most frequent side effects, namely, vascular problems such as thrombotic events. The vector-based COVID-19 vaccines can produce soluble spike proteins, which multiply the potential damage sites [24]. The spike protein also contains domains that may bind to cholinergic receptors, thereby compromising the cholinergic anti-inflammatory pathways, enhancing inflammatory processes [25]. A recent review listed several other potential side effects of COVID-19 mRNA vaccines that may also emerge later than in the observation periods covered here [26].

Is this a few or many? This is difficult to say, and the answer is dependent on one's view of how severe the pandemic is and whether the common assumption that there is hardly any innate immunological defense or cross-reactional immunity is true. Some argue that we can assume cross-reactivity of antibodies to conventional coronaviruses in 30–50%of the population [13–16]. This might explain why children and younger

people are rarely afflicted by SARS-CoV2 [17–19]. An innate immune reaction is difficult to gauge. Thus, low seroprevalence figures [20–22] may not only reflect a lack of herd immunity, but also a mix of undetected cross-reactivity of antibodies to other coronaviruses, as well as clearing of infection by innate immunity.

However, one should consider the simple legal fact that a death associated with a vaccination is different in kind and legal status from a death suffered as a consequence of an incidental infection.

End of excerpts

https://www.mdpi.com/2076-393X/9/7/693/htm

Notice of liability for harm served on all members of the European Parliament

NOTICE OF LIABILITY

May 18, 2021

This Notice of Liability has been SERVED to you personally.

You may be held personally liable for harm and death caused by LEGISLATION, which is designed to coerce widespread acceptance of EXPERIMENTAL VACCINATION OF CHILDREN. If you take further action supporting such LEGISLATION, and if you take no steps to mitigate your past actions supporting such LEGISLATION, you may be held personally liable for resulting harm and death.

Severe illness and death in children and young adults caused by SARS-CoV-2 is extremely rare. It is absurd to claim that any measure can or will protect against a danger that does not exist. The claims that these experimental vaccinations induce production of protective antibodies are fundamentally flawed. Antibodies in the blood cannot prevent entry of air-borne viruses into cells of the lower respiratory tract. Secretory IgA antibodies are also known to be unable to efficiently prevent viral pneumonia. Severe adverse effects occur at high frequency following application of all gene-based agents. Children have already joined the tragic list of victims.

Attached as appendices and as integral parts of this Notice of Liability are the documents: Urgent Open Letter from Doctors and Scientists to the European Medicines Agency Regarding COVID-19 Vaccine Safety Concerns; Reply from the European Medicines Agency to Doctors for Covid Ethics; Doctors and Scientists Accuse Medical Regulator of Downplaying COVID-19 Vaccine Dangers; Rebuttal Letter to European Medicines Agency from Doctors for Covid Ethics; Doctors for Covid Ethics Signatories; COVID Vaccines: Necessity, Efficacy and Safety.

Furthermore, you may be held personally responsible for supporting CRIMES AGAINST HUMANITY, defined as acts that are purposely committed as part of a widespread or systematic policy, directed against civilians, committed in furtherance of state policy.

Please respond to this NOTICE OF LIABILITY within 14 days from the DATE OF SERVICE to:

DOCTORS FOR COVID ETHICS ***Doctors4CovidEthics@protonmail.com***

Cc: Rechtsanwaltskanzlei Dr. Reiner Fuellmich

Appendices

1. **Urgent Open Letter from Doctors and Scientists to the European Medicines Agency Regarding COVID-19 Vaccine Safety Concerns**

2. **Reply from the European Medicines Agency to Doctors for Covid Ethics**

3. **Doctors and Scientists Accuse Medical Regulator of Downplaying COVID-19 Vaccine Dangers**

4. **Rebuttal Letter to European Medicines Agency from Doctors for Covid Ethics**

5. **Doctors and Scientists Write to the European Medicines Agency, Warning of COVID-19 Vaccine Dangers for a Third Time**

6. **Doctors for Covid Ethics Signatories**

7. **COVID Vaccines: Necessity, Efficacy and Safety**

Doctors for Covid Ethics
We are doctors and scientists from 30 countries, seeking to uphold medical ethics, patient safety and human rights in response to COVID-19. t: @Drs4CovidEthics

https://doctors4covidethics.medium.com/notice-of-liability-for-harm-and-death-to-children-served-on-all-members-of-the-european-parliament-fe42ffdbf400

COVID vaccines for children- We had better think again! A letter from a consortium of U.K. medical specialists calling for a halt

COVID-19 child vaccination: safety and ethical concerns

May 20, 2021

An open letter from UK doctors to Dr June Raine, Chief Executive, MHRA

Lead signatory Dr Ros Jones- Retired Consultant Paediatrician

We wish to notify you of our grave concerns regarding all proposals to administer COVID-19 vaccines to children. Recently leaked Government documents suggested that a COVID-19 vaccine rollout in children over 12 years old is already planned for September 2021, and the possibility of children as young as 5 years old being vaccinated in the summer in a worst-case scenario.[1]

We have been deeply disturbed to hear several Government and SAGE representatives calling in the media for the COVID-19 vaccine rollout to be “turning to children as fast as we can”.[2] Teaching materials circulated to London schools contain emotionally loaded questions and inaccuracies[3]. In addition, there has been disturbing language used by teaching union leaders, implying that coercion of children to accept the COVID-19 vaccines through peer pressure in schools was to be encouraged, despite the fact that coercion to accept a

medical treatment is against UK and International Laws and Declarations.[4] Rhetoric such as this is irresponsible and unethical, and encourages the public to demand the vaccination of minors with a product still at the research stage and about which no medium- or long-term effects are known, against a disease which presents no material risk to them. A summary of our reasons is given below and a more detailed fully referenced explanation is available.[5]

Risks and benefits in medical treatments

Vaccines, like any other medical treatment, come with varied risks and benefits. Therefore, we must consider each product, individually, on its merits, and specifically for which patients or sections of the population is the risk/benefit ratio acceptable. For COVID-19 vaccines, the potential benefits are clear for the elderly and vulnerable, however, for children, the balance of benefit and risk would be quite different. We are raising these concerns as part of an informed debate, which is a vital part of the proper, scientific process. We must ensure that there is no repeat of any past tragedies which have occurred especially when vaccines are rushed to market. For example, the swine flu vaccine, Pandemrix, rolled out following the pandemic of 2010, resulted in over one thousand cases of narcolepsy, a devastating brain injury, in children and teenagers, before being withdrawn.[6] Dengvaxia, a new vaccine against Dengue, was also rolled out to children ahead of the full trial outcomes, and 19 children died of possible antibody dependent enhancement (ADE) before the vaccine was withdrawn.[7] We must not risk a repeat of this with the COVID-19 vaccines, which would not only impact on the children and families affected, but would also have a hugely damaging effect on vaccination uptake in general.

No medical intervention should be introduced on a 'one size fits all' basis, but instead should be fully assessed for suitability according to the characteristics of the age cohort and of the individuals concerned, weighing up the risk versus benefit profile for each cohort and the individuals within a group. This approach was outlined last October, by the head of the Government Vaccine Task Force, Kate Bingham, who said "We just need to vaccinate everyone at risk. There's going to be no vaccination of people under 18. It's an adult-only vaccine, for people over 50, focusing on health workers and care home workers and the vulnerable."[8]

Children do not need vaccination for their own protection

Healthy children are at almost no risk from COVID-19, with risk of death as low as 1 in 2.5 million[9]. No previously healthy child under the age of 15 died during the pandemic in the UK and admissions to hospital or intensive care are exceedingly rare[10] with most children having no or very mild symptoms. Although Long-Covid has been cited as a reason for vaccinating children, there is little hard data. It appears less common and much shorter-lived than in adults and none of the vaccine trials have studied this outcome[11 12]. The inflammatory condition, PIMS, was listed as a potential adverse effect in the Oxford AstraZeneca children's trial[13]. Naturally acquired immunity will give broader and better lasting immunity than vaccination[14]. Indeed, many children will already be immune[15]. Individual children at very high risk can already receive vaccination on compassionate grounds[16].

Children do not need vaccination to support herd immunity

Already, two thirds of the adult population have received at least one dose of a COVID-19 vaccine[17]. Models that assume vaccination of children is required to reach herd immunity have failed to account for the proportion who had immunity prior to March 2020 and those who have acquired it naturally[18]. Recent modelling suggested that the UK had achieved the required herd immunity threshold on 12 April 2021.[19]

Children do not transmit SARS-CoV-2 as readily as adults, moreover adults living or working with young

children are at lower risk of severe COVID-19[20]. Schools have not been shown to be the focus on spread to the community, teachers have a lower risk of COVID-19 than other working age adults[21].

Short-term safety concerns

As of 13th May, the MHRA[22] has received a total of 224,544 adverse events, including 1,145 deaths in association with SARS-CoV-2 vaccines. Reports of strokes due to cerebral venous thromboses were initially in low numbers but as awareness increased, many more reports led to the conclusion that AstraZeneca vaccine should not be used for adults under 40 years of age and this unpredicted finding has also led to the suspension of the Oxford AstraZeneca children's trial.

Similar events have been noted with Pfizer & Moderna vaccines on the US adverse reporting system (VAERS)[23] and it is likely that this is a class effect related to production of spike protein. New UK guidelines on managing Vaccine-Induced Thrombotic Thrombocytopenia (VITT)[24] include all COVID-19 vaccines in their advice. The possibility of further unexpected safety issues cannot be ruled out. In Israel, where the vaccines have been widely rolled out to young people and teenagers, the Pfizer vaccine has been linked to several cases of myocarditis in young men[25] and concerns have been raised about reports of altered menstrual cycles and abnormal bleeding in young women following the vaccine.[26]

Most concerning with regard to possible vaccination of children, is that there have now been a number of deaths associated with vaccination reported to VAERS in the US, despite the vaccines only being given to children within trials and a very recent rollout to 16-17 year olds[27].

Long-term safety concerns

All Phase 3 COVID-19 vaccine trials are ongoing and not due to conclude until late 2022/early 2023. The vaccines are, therefore, currently experimental with only limited short-term and no long-term adult safety data available. In addition, many are using a completely new mRNA vaccine technology, which has never previously been approved for use in humans[28]. The mRNA is effectively a pro-drug and it is not known how much spike protein any individual will produce. Potential late-onset effects can take months or years to become apparent. The limited children's trials undertaken to date are totally underpowered to rule out uncommon but severe side effects.

Children have a lifetime ahead of them, and their immunological and neurological systems are still in development, making them potentially more vulnerable to adverse effects than adults. A number of specific concerns have been raised already, including autoimmune disease and possible effects on placentation and fertility.[29] A recently published paper raised the possibility that mRNA COVID-19 vaccines could trigger prion-based, neurodegenerative disease[30]. All potential risks, known and unknown, must be balanced against risks of COVID-19 itself, so a very different benefit/risk balance will apply to children than to adults.

Conclusion

There is important wisdom in the Hippocratic Oath which states, "First do no harm". All medical interventions carry a risk of harm, so we have a duty to act with caution and proportionality. This is particularly the case when considering mass intervention in a healthy population, in which situation there must be firm evidence of benefits far greater than harms. The current, available evidence clearly shows that the risk versus benefit calculation does NOT support administering rushed and experimental COVID-19 vaccines to children, who have virtually no risk from COVID-19, yet face known and unknown risks from the vaccines. The Declaration of the Rights of the Child states that, "the child, by reason of his physical and mental immaturity, needs special

safeguards and care, including appropriate legal protection".[31] As adults we have a duty of care to protect children from unnecessary and foreseeable harm.

We conclude that it is irresponsible, unethical and indeed, unnecessary, to include children under 18 years in the national COVID-19 vaccine rollout. Clinical trials in children also pose huge ethical dilemmas, in light of the lack of potential benefit to trial participants and the unknown risks. The end of the current Phase 3 trials should be awaited as well as several years of safety data in adults, to rule out, or quantify, all potential adverse effects.

We call upon our governments and the regulators not to repeat mistakes from history, and to reject the calls to vaccinate children against COVID-19. Extreme caution has been exercised over many aspects of the pandemic, but surely now is the most important time to exercise true caution – we must not be the generation of adults that, through unnecessary haste and fear, risks the health of children.

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Cases of myocarditis making the news are just the tip of the iceberg. FDA adding warning labels

FDA Notice:

Today, the FDA is announcing revisions to the patient and provider fact sheets for the Moderna and Pfizer-BioNTech COVID-19 vaccines regarding the suggested increased risks of myocarditis (inflammation of the heart muscle) and pericarditis (inflammation of the tissue surrounding the heart) following vaccination. For each vaccine, the Fact Sheet for Healthcare Providers Administering Vaccine (Vaccination Providers) has been revised to include a warning about myocarditis and pericarditis and the Fact Sheet for Recipients and Caregivers has been revised to include information about myocarditis and pericarditis. … The warning in the Fact Sheets for Healthcare Providers Administering Vaccines notes that **reports of adverse events suggest increased risks of myocarditis and pericarditis, particularly following the second dose and with onset of**

symptoms within a few days after vaccination. Additionally, the Fact Sheets for Recipients and Caregivers for these vaccines **note that vaccine recipients should seek medical attention right away if they have chest pain, shortness of breath, or feelings of having a fast-beating, fluttering, or pounding heart after vaccination."**

See: https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-june-25-2021

Myocarditis is much more serious than the CDC and the media have been portraying

In an excellent ***Highwire*** interview by Del Bigtree of Dr. Roger Hodkinson, a highly credentialled Canadian pathologist. Dr. Hodkinson makes it clear that the potential damage to the heart can be not only life-threatening, but life-altering for a lifetime.

Dr. Hodkinson is the former President of the ***Alberta Society of Laboratory Physicians***, holds two different fellowships, is the CEO of a large laboratory specializing in infectious and viral diseases, has held many local and national public positions in Canadian Medicine. He talks extensively on the myocarditis problem that is impacting so many young people after the COVID-19 vaccines. He speaks to the ridiculous downplaying of the severe nature of myocarditis and the lasting consequences that these young people may face in the future. Here is the link. https://thehighwire.com/videos/episode-220-dirty-deeds/ If you want to go directly to the interview, fast forward to the interview go to the 1 hour and 5-minute mark.

Not only are the vaccines risky, but the vaccinated don't appear to be as protected as the unvaccinated against variants

A May 29th article in the Telegraph titled, **Fully vaccinated people who catch Covid variants may pass virus on, study finds**, pulls back the curtain on the effectiveness of the COVID-19 vaccines against variants. It also appears to suggest that people who have been vaccinated can still carry high viral loads making them infectious to others.

Study shows post-jab cases more likely to be infected with virus strains that have emerged in recent months
By Anne Gulland, Global Health Security Deputy Editor 29 May 2021 • 6:00pm

Fully vaccinated people infected with Covid variants may be likely to pass the virus on, researchers have said. No vaccine is 100 per cent effective, and while the number of people who contract Covid after vaccination – known as post-vaccine breakthrough cases – is tiny, a growing number of studies show that these cases are more likely to be infected with variants that have emerged in recent months.

Researchers at the University of Washington in the United States sequenced samples from 20 health workers who went on to contract Covid after receiving both doses of either the Pfizer or Moderna vaccine.

The study showed that all 20 were infected with variants of concern that have been driving second waves of Covid in many parts of the world – eight had the UK variant, one the South African variant, 10 had one of the two California variants and one had the Brazilian variant.

The researchers then compared the samples collected from this group with samples collected from 5,174 non-vaccinated individuals who had Covid.

While everyone in the vaccinated group had a variant of concern, only 67 per cent of non-vaccinated individuals did. **The study also showed that the vaccinated individuals infected with Covid had high viral loads.**
Dr Pavitra Roychoudhury, the lead author of the study, said the "prevailing understanding" was that while vaccine breakthrough cases would occur, they would be mild.

"But in contrast to that, what we saw among our 20 samples was that a number of them actually had quite robust viral loads. That was concerning in the sense that there was definitely enough virus to sequence, and potentially there might be enough virus to transmit," she said.

None of the 20 patients studied were hospitalised and it is not known whether they passed the disease to others, said Dr Roychoudhury.

A recent study by the US Centers for Disease Control and Prevention also showed that vaccinated individuals who contracted the disease were also likely to be infected with variants.

Data released earlier this week showed that, as of April 30, there were 10,262 cases of post-vaccination infection among the 101 million people that had been fully vaccinated.

My comment: It is certain that there have many more cases than that. Because the vaccines may reduce the symptoms of COVID-19, it is likely that most people that contract it after being vaccinated have mild to moderate symptoms and may never go to be tested.

Some 555 of these 10,000 samples were sequenced and researchers found that 356 were identified as variants of concern. Of these, more than half were the UK variant, 33 per cent were one of the two California variants, eight per cent were the Brazilian variant and four per cent were the South African variant.
Dr Roychoudhury said the finding of high viral loads showed that it was important to monitor breakthrough cases and highlighted the importance of continuing self-isolation.

She added that monitoring breakthrough cases would help vaccine manufacturers who are currently looking at booster shots, saying: "It can help us identify a potential redesign of the booster shots and improve them."
However, Dr Roychoudhury said the findings of her study did not indicate that the current vaccines were not effective.

"A lot of the antibody responses are pretty broad. The vaccines are not designed to be super specific so they will be able to target the variants," she said. She added that, as more people are vaccinated, the number of vaccination breakthrough cases is likely to come down as infection levels reduce in the wider population.

End of excerpts

https://www.telegraph.co.uk/global-health/science-and-disease/fully-vaccinated-people-catch-covid-variants-may-pass-virus/

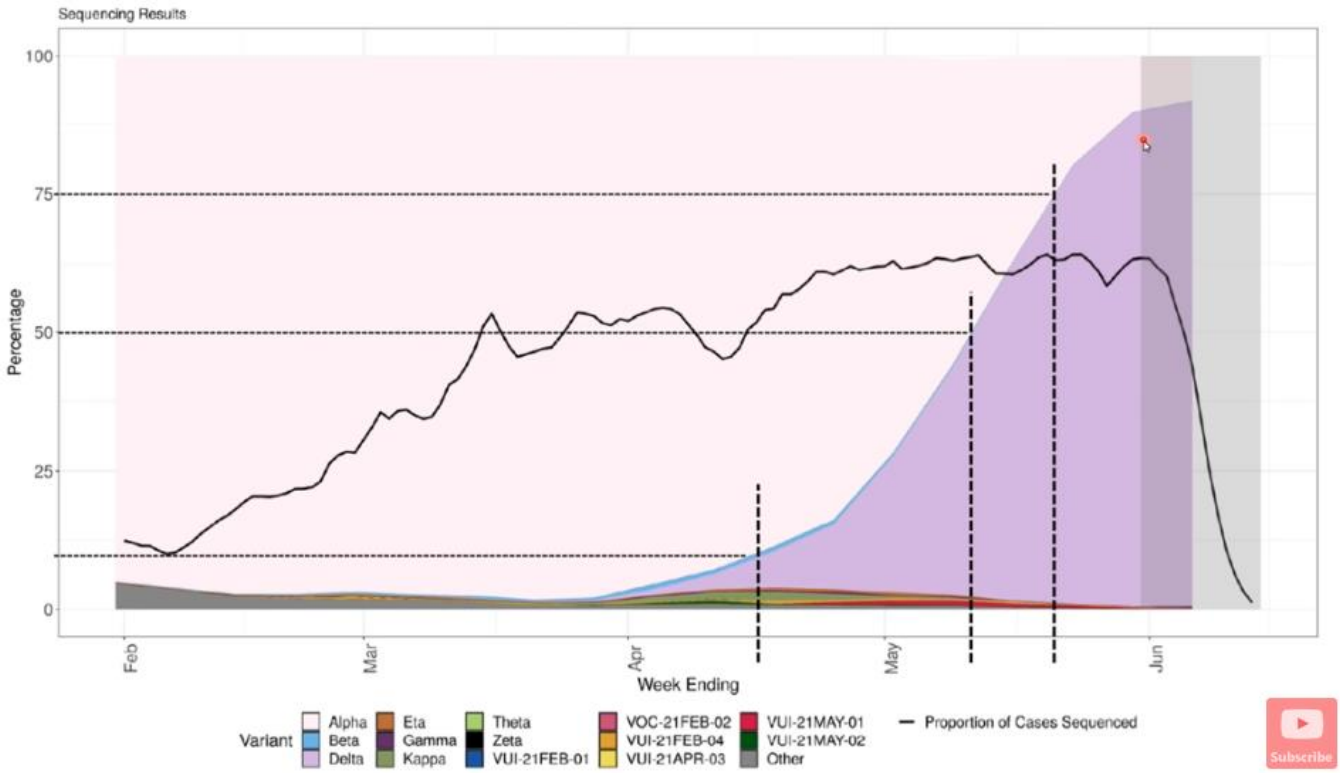
Speaking of variants, is the Delta Variant the scary boogieman that people are being told it is?

Mid-June the UK announced another 30 days of lockdowns- (at least)

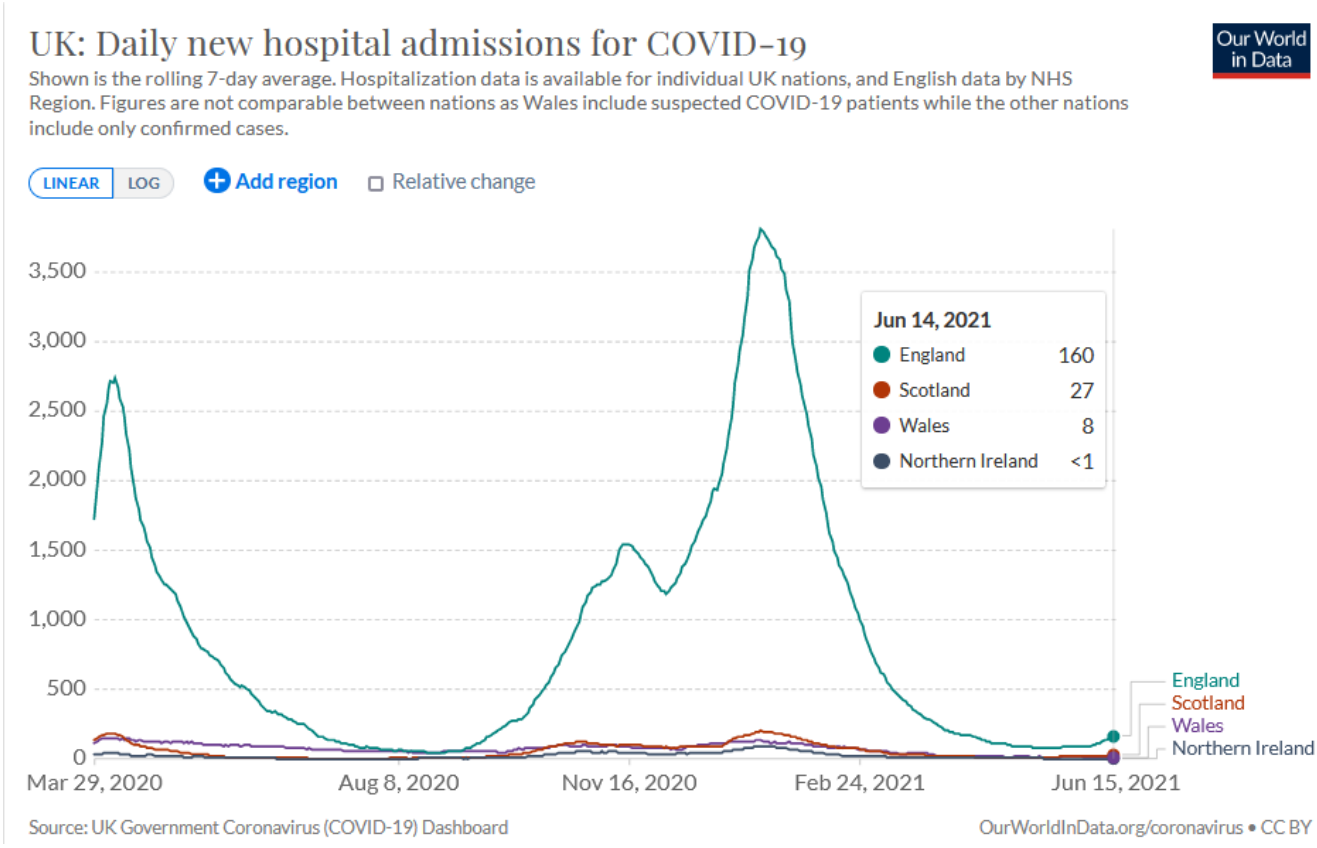
On the next page is the real-world data from England.

The purple is the Delta Variant, which as you can see has taken over >90% of the cases.

Figure 3. Variant prevalence for all England available sequenced cases from 1 February 2021 as of 14 June 2021 (excluding 48 cases where the specimen date was unknown). (Find accessible data used in this graph in underlying data).



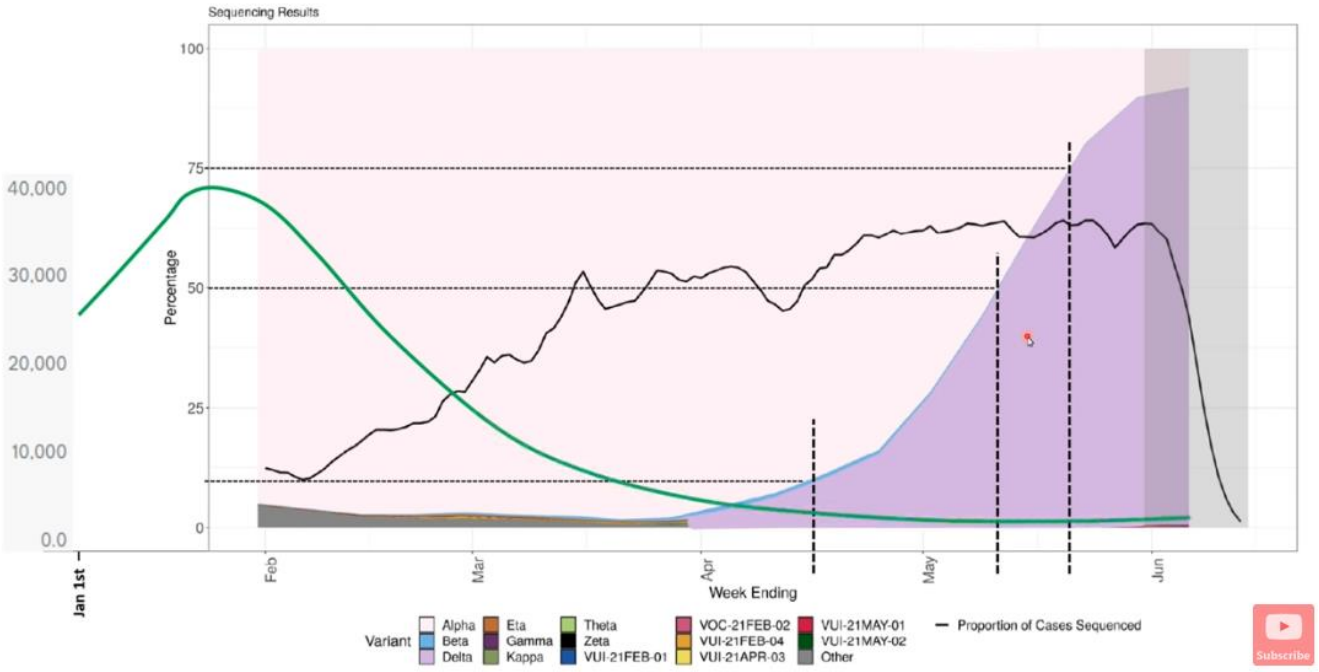
But what are the real-world effects on hospitalizations and deaths? Here is a graph looking at that…



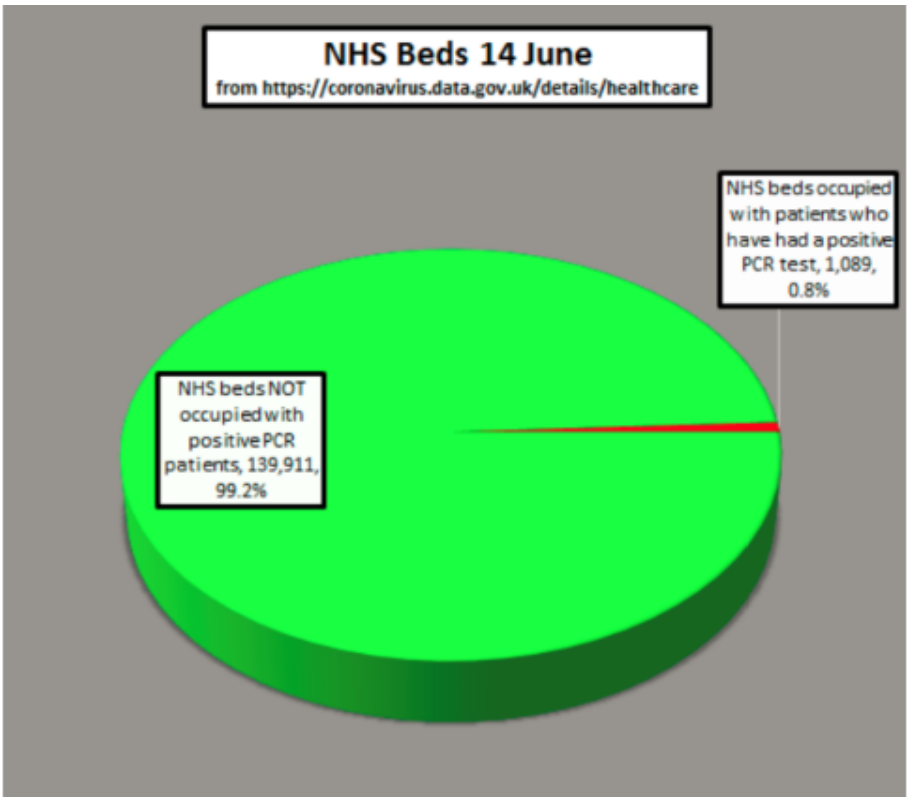
As you can see, zilch, nada, nothing to be panicked about.

And here the green line representing the hospitalizations is superimposed on the graph showing the dominant Delta Variant.

Figure 3. Variant prevalence for all England available sequenced cases from 1 February 2021 as of 14 June 2021
(excluding 48 cases where the specimen date was unknown). (Find accessible data used in this graph in underlying data).



Here is another look at the availability of hospital beds across the U.K. as of June 14th when the decision to announce another 30 days of lockdown "due to the Delta Variant."



My understanding is that throughout the natural evolution of virus mutation, they become more contagious but less virulent and that is what the Delta Variant is demonstrating. And the vaccines are driving the virus to shapeshift or evolve into variants and more high amplification cycle PCR testing driven cases, which are then being co-opted by the profiteers that want to peddle more fear and compliance with the narrative to keep this going as long as possible.

Case in point. The UK locking down for at least another 30 days under the guise of the Delta Variant which has had no impact on the health care system. Welcome to totalitarianism!

Credit to Ivor Cummins, AKA the Fat Emperor Podcast for much of this information.
https://www.youtube.com/watch?v=TtOu7jx3snQ

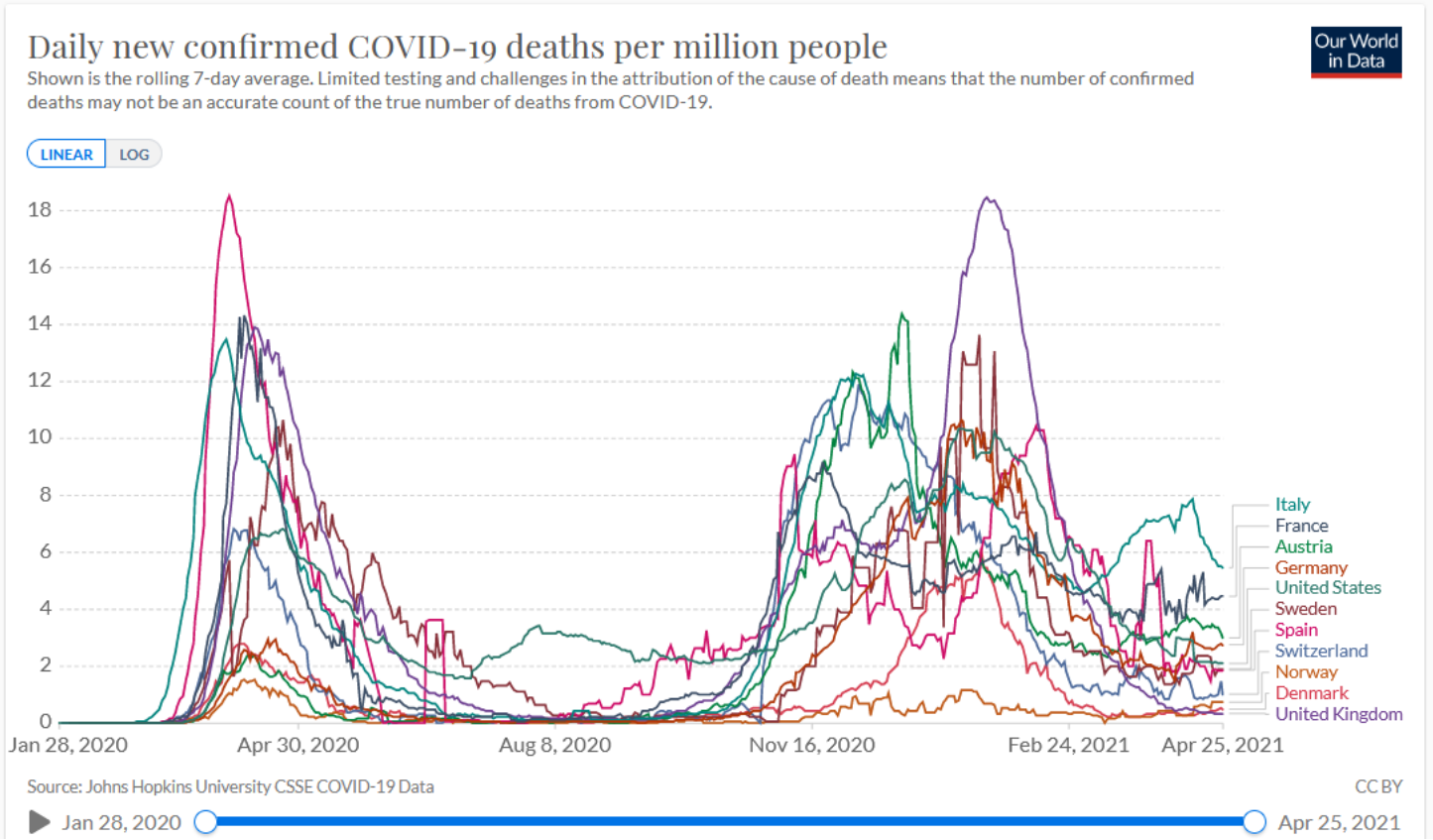
Although the Delta Variant may be a nothing burger when it comes to increasing severe COVID-19 and deaths, there is one strain we should all be on the lookout for. See that warning on the next page…

Since Delta IS the Indian Variant and India was hit hard this spring, shouldn't we be concerned?

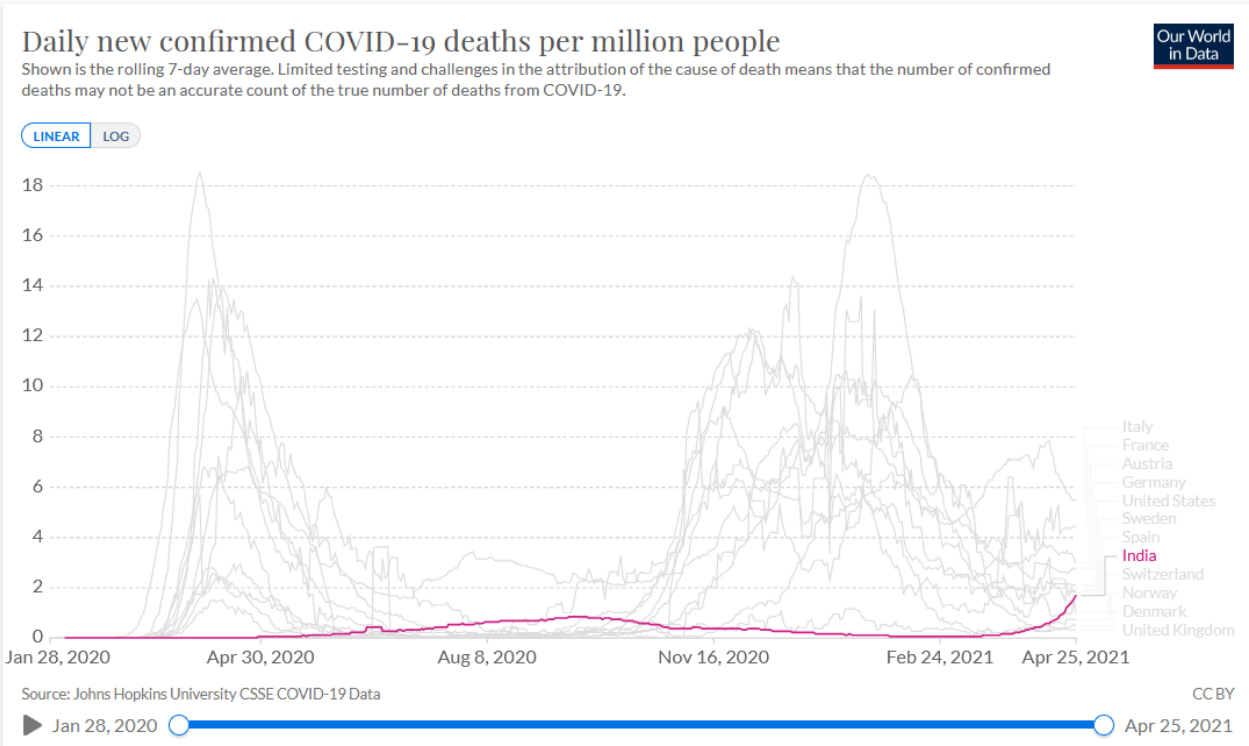
Not so fast. I reported in the May issue, the reasons why India was hit hard is that they had managed to avoid endemic spread previously.

See the dramatic visual proof on the next page…

I showed this graph showing the deaths per 1 million people in many major European countries and the U.S.



Then I showed India superimosed over the other countries.



As you can clearly see, India has skated through the pandemic almost unscathed compared to most of the rest

of the world. But, as has been said many times, you cannot hide from a virus. And earlier this year India was seeing an uptick. BUT, does the evidence you can see above with your very own eyes support the sensationalized headlines, hysteria and graphic displays of apocalyptic proportions we saw in the media? It appeared as the western nations were calming down, the media had found another way to scare the people they have been traumatizing in the developed world for a year now into more fear. And, as the alt-media reporting shows that fewer people are buying into the vaccine plan, you can certainly expect more of the same fear mongering from pharma's marketing puppets. And now the Delta Variant. Wait until you see what I have

And a post from someone on the ground in India during the hysteria created over it in the west.

Gagan Si 32 minutes ago (edited)

Reporting from the ground here:

The situation is mainly tense in Delhi. All arrangements made by the state government last year just disappeared weeks before the pandemic. Nobody is asking where did all those beds go! Those stadiums, hotels etc that were set up as "Covid facilities" have all just disappeared.
We are a population of 1.4 Billion (Europe x 2 , US x 4, UK x 15).
Objectively speaking, the COVID patient load is tiny and manageable, but there are signs posted outside the hospitals in Delhi - "No beds, No oxygen, No admission". But why? A city of 22 Million people cannot handle 1000 patients a day??
Where the hell did all that preparation go?

Not saying the situation is not serious. People have died and died unnecessarily. But the images being shown on TV are so so exaggerated and misleading. The Australian media is describing it as "Apocalypse"! Really? 3 million people die of heart attacks in India.
There are weddings happening in my hometown (200kms from Delhi).

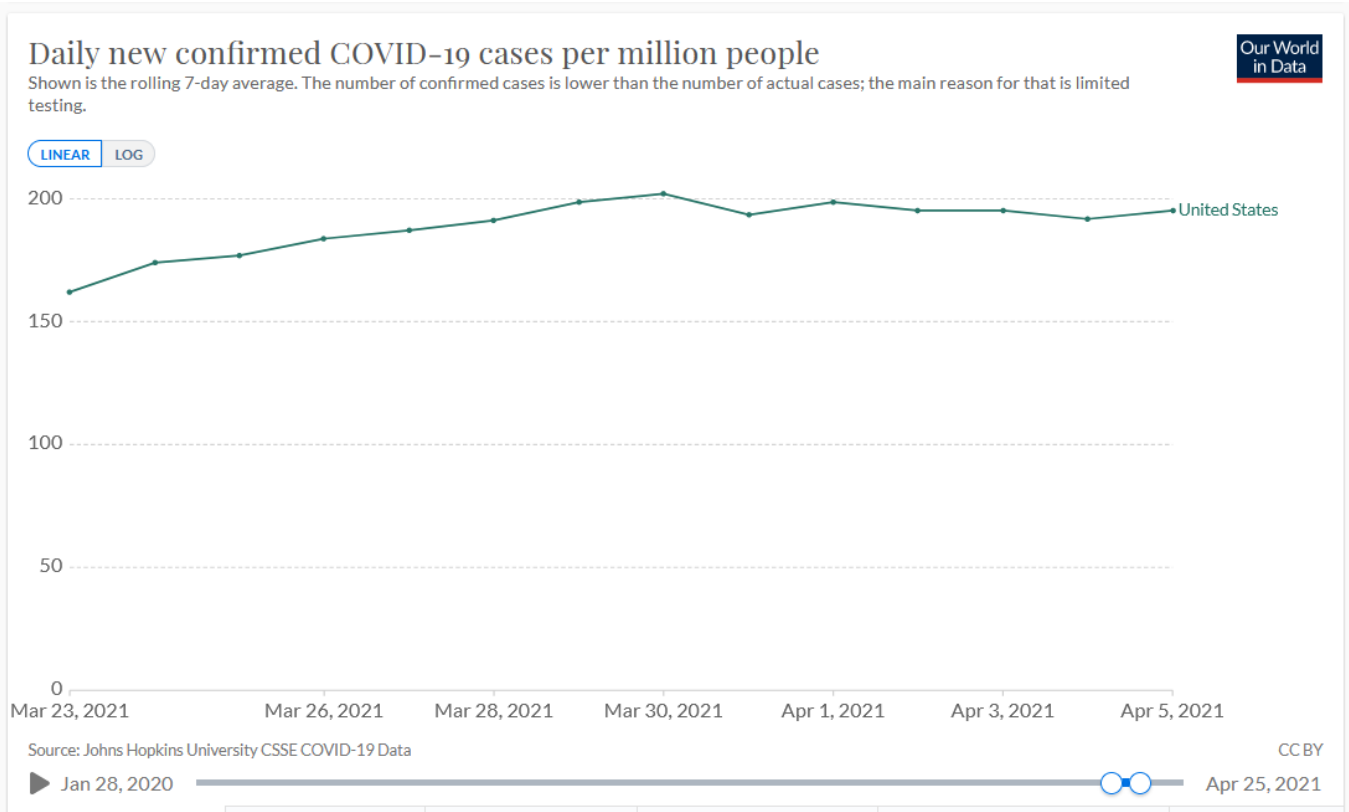
Temples, churches and mosques opened up to full capacity last year in late September. Why would it take 6 months for a wave to build up?
All in all, the fear machine is firing on all cylinders, but not asking any questions of the government

How about the mainstream media's sensationalized reporting? Is there any basis for it? Let's look at how they've handled previous variants.

We have seen this play before. A couple of months ago, ***ABC Good Morning America*** video report (see the link below). They reported on a "double mutant variant"….."this as COVID cases across the country climb. And fears of a fourth wave are growing."….."The nation's daily case average up nearly 20% in the last 2-weeks. Experts fearing the spread of variants will only accelerate it. Like in Massachusetts, where are more cases of the Brazilian Variant than anywhere else in the country." Pretty scary right?
https://abcnews.go.com/International/india-sees-alarming-rate-growth-covid-19-cases/story?id=76874838

But what does the data really look like? See below…

Here is the 2-week period that they reported on with the near “20% rise in cases.” There was a slight uptick, bet followed by a flattening. You would never get that from the way they reported it.



At the same time death rates plummeted across the U.S. Now as the Delta variant becomes more predominant in many countries around the world, we are seeing the same trend, more cases mostly mild and fewer hospitalizations and deaths. But none of that matters, because fear sells vaccines.

What percentage of the children under 18 in the U.S. have died from COVID-19?

When we are talking about giving a new, never before tested in children experimental gene therapy biologic technology, we really need to ask the question…”How dangerous is COVID-19 to children anyway?”

One calculation that can be looked at is the percentage of all children under the age of 18 in the U.S. that have died from COVID-19 according to the CDC. I have borrowed this from ***Children’s Health Defense*** Citizen Petition you will read in this document, but it bears repeating over and over.

There are 74 million children in the United States. That is 74,000,000 in numeric form. So far, 282 have died "involving Covid." Two hundred eighty-two in 74 million is a rate of 0.00038%. While many children may not have been exposed to COVID, CDC estimated that 22.2 million children aged 5-17 had had COVID and 127 had died, at the May 12, 2021 meeting of the Advisory Committee on Immunization Practices, or 0.00057%.44 Available evidence strongly suggests that the vaccine is much more dangerous to children than the disease.

It’s an abomination that we are going to subject children in this country with an unknown health risk when they are about as close to zero risk from COVID as it can get. And don’t give me the “we have to vaccinate the kids to get to herd immunity” BULL S_ _ _. They are grasping at straws and they know it. Kids do not readily

spread the infections and even more pertinent is that you cannot reach herd immunity with a product that cannot prevent infection OR stop transmission. So, once again stop the B.S.! Ask doctors and nurses in the field what they are seeing now. A high percentage of people testing positive and showing up at hospitals now have been vaccinated. Many reports estimate as high as 60%. You will see reports of that in this issue. It's time to stop the charade. Leave the kids alone.

I would encourage you to check out the **Legal Updates** section of this newsletter to learn about and support the legal challenges underway the team at the ***Informed Consent Action Network (ICAN) by Robet F. Kennedy Jr. with his legal team at Children's Health Defense*** and with ***America's Frontline Doctors headed up by doctor and attorney Simon Gold M.D.*** to stop the madness of moving forward with vaccinating children, adolescents and teens. We are already seeing an unacceptable toll of injuries and fatalities just in the small numbers that have been vaccinated thus far.

Inventor of Messenger RNA (mRNA) technology used by Pfizer and Moderna drops a bombshell about the COVID-19 vaccines in a must watch interview

In an amazing interview on the ***Dark Horse Podcast***, **Dr. Robert Malone** the creator of mRNA vaccine technology, said the COVID vaccine lipid nanoparticles which transport the spike protein into people's cells so that they can then kick out copies of the spike protein at high levels leave the injection site in large amounts and accumulate in organs and tissues. The two areas that these particles accumulate are especially in the ovaries by multiple factors, followed by the bone marrow, a very concerning revelation (others as well).

Here are some of Dr. Malone's credentials.

Dr. Malone is the discoverer of in-vitro and in-vivo RNA transfection and the inventor of mRNA vaccines, while he was at the Salk Institute in 1988. His research was continued at Vical in 1989, where the first in-vivo mammalian experiments were designed by him. The mRNA, constructs, reagents were developed at the Salk institute and Vical by Dr. Malone. The initial patent disclosures were written by Dr. Malone in 1988-1989. **Dr. Malone was also an inventor of DNA vaccines in 1988 and 1989**. **This work results in over 10 patents and numerous publications, yielding about 7000 citations for this work. Dr. Malone has extensive research and development experience in the areas of pre-clinical discovery research, clinical trials, vaccines, gene therapy, bio-defense, and immunology. He has over twenty years of management and leadership experience in academia, pharmaceutical and biotechnology industries, as well as in governmental and non-governmental organizations.**

Dr. Malone specializes in clinical research, medical affairs, regulatory affairs, project management, proposal management (large grants and contracts), vaccines and biodefense. This includes writing, developing, reviewing and managing vaccine, bio-threat and biologics clinical trials and clinical development strategies. **He has been involved in developing, designing, and providing oversight of approximately forty phase 1 clinical trials and twenty phase 2 clinical trials, as well as five phase 3 clinical trials. He has served as medical director/medical monitor on approximately forty phase 1 clinical trials, and on twenty phase 2 clinical trials, including those run at vaccine-focused Clinical Research Organizations**. His proposal development work has yielded clients billions of dollars.

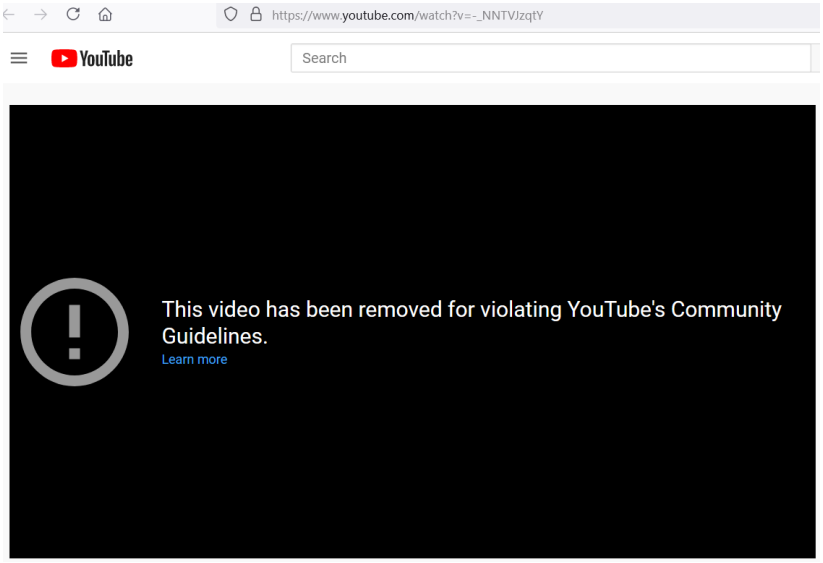
Scientifically trained at UC Davis, UC San Diego, and at the Salk Institute Molecular Biology and Virology laboratories, **Dr. Malone is an internationally recognized scientist (virology, immunology, molecular biology) and is known as one of the original inventors of mRNA vaccination and DNA Vaccination. His discoveries in**

mRNA non viral delivery systems are considered the key to the current COVID-19 vaccine strategies. Dr. Malone holds numerous fundamental domestic and foreign patents in the fields of gene delivery, delivery formulations, and vaccines.

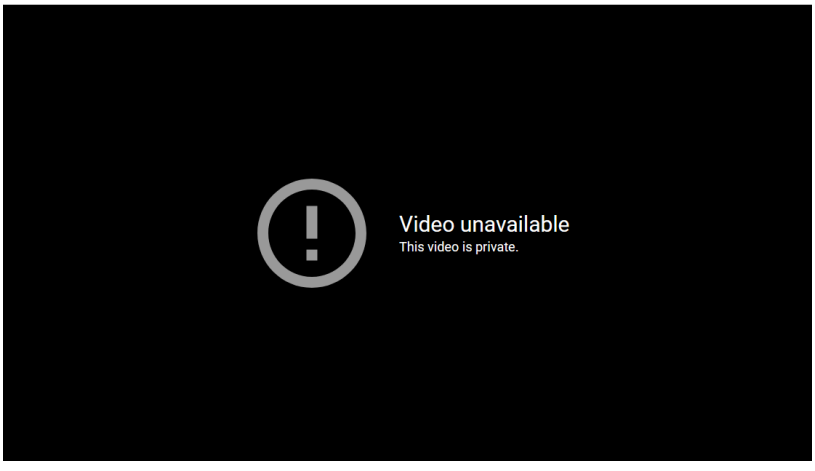
He received his medical training at Northwestern University (MD) and Harvard University (Clinical Research Post Graduate) medical school, and in Pathology at UC Davis.

Dr. Malone has close to 100 peer-reviewed publications and published abstracts and has over 11,477 citations of his peer reviewed publications, as verified by Google Scholar. His google scholar ranking is "outstanding" for impact factors. **He has been an invited speaker at over 50 conferences, has chaired numerous conferences and he has sat on or served as chairperson on numerous NIAID and DoD study sections.**

When following the link from ***Children's Health Defense*** website resulted in this from YouTube.



Interestingly, You Tube must have felt uneasy about censoring the inventor of the technology and have changed the censor flag to say this.



Since then, I have been able to access this critical section on YouTube here:
https://www.youtube.com/watch?v=Du2wm5nhTXY

Thankfully, there are platforms that allow debate and free speech, and you can see that part of the interview

here and it IS A MUST WATCH! https://www.bitchute.com/video/ZXIz7NCD7tnm/

Another backup link

https://odysee.com/@BretWeinstein:f/how-to-save-the-world,-in-three easy:0?r=FuWwFotRbicqY9GHyWBqDdTNNHpaTgC9 The 15 minutes I am referring to is from to

Details…

In case you don't have the time to watch the interview, the following is an excellent article by Megan Redshaw from ***The Defender*** publication of the ***Children's Health Defense.***

On June 10, Dr. Robert Malone, creator of mRNA vaccine technology, joined evolutionary biologist Bret Weinstein, Ph.D., for a 3-hour conversation on the "Dark Horse Podcast" to discuss multiple safety concerns related to the Pfizer and Moderna vaccines.

In this short outtake (this link now censored as I showed by the graphics above) from the full podcast, Malone, Weinstein and tech entrepreneur Steve Kirsch touch on the implications of the controversial Japanese Pfizer biodistribution study. The study was made public earlier this month by Dr. Byram Bridle, a viral immunologist.

They also discuss the lack of proper animal studies for the new mRNA vaccines, and the theory, espoused by virologist Geert Vanden Bossche, Ph.D., that mass vaccination with the mRNA vaccines could produce ever more transmissible and potentially deadly variants.

As The Defender reported June 3, Bridle received a copy of a Japanese biodistribution study — which had been kept from the public — as a result of a freedom of information request made to the Japanese government for Pfizer data.

Prior to the study's disclosure, the public was led to believe by regulators and vaccine developers that the spike protein produced by mRNA COVID vaccines stayed in the shoulder where it was injected and was not biologically active — even though regulators around the world had a copy of the study which showed otherwise.

The biodistribution study obtained by Bridle showed lipid nanoparticles from the vaccine did not stay in the deltoid muscle where they were injected as the vaccine's developers claimed would happen, but circulated throughout the body and accumulated in large concentrations in organs and tissues, including the spleen, bone marrow, liver, adrenal glands and — in "quite high concentrations" — in the ovaries.

The mRNA — or messenger RNA — is what tells the body to manufacture the spike protein. The lipid nanoparticles are like the "boxes" the mRNA is shipped in, according to Malone. "If you find lipid nanoparticles in an organ or tissue, that tells you the drug got to that location," Malone explained.

According to the data in the Japanese study, lipid nanoparticles were found in the whole blood circulating throughout the body within four hours, and then settled in large concentrations in the ovaries, bone marrow and lymph nodes.

Malone said there needed to be monitoring of vaccine recipients for leukemia and lymphomas as there were concentrations of lipid nanoparticles in the bone marrow and lymph nodes. But those signals often don't show up for six months to three or nine years down the road, he said.

Usually, signals like this are picked up in animal studies and long-term clinical trials, but this didn't happen

with mRNA vaccines, Malone said.

Malone said there are two adverse event signals that are becoming apparent to the U.S. Food and Drug Administration (FDA). One of them is thrombocytopenia — not having enough platelets, which are manufactured in the bone marrow. The other is reactivation of latent viruses.

Malone found the ovarian signal perplexing because there is no accumulation in the testes.

Malone said the original data packages contained this biodistribution information. "This data has been out there a long time" within the protected, non-disclosed, purview of the regulators across the world, he said.

According to Malone, the FDA knew the COVID spike protein was biologically active and could travel from the injection site and cause adverse events, and that the spike protein, if biologically active, is very dangerous.

In fact, Malone was one of many scientists to warn the FDA about the dangers of the free spike protein.

Malone suggested autoimmune issues may be related to free-circulating spike protein which developers assured would not happen. To pick up autoimmune issues, a 2- to 3- year follow-up period in phase 3 patients would be required to monitor for potential autoimmune consequences from vaccines — but that monitoring didn't happen with the Pfizer and Moderna vaccines.

Pfizer and Moderna also didn't conduct proper animal studies, Weinstein said. What the animal models give us is a signal that alerts us to what we need to follow up on in humans.

Weinstein said:

"We've got very alarming short-term stuff. We've got short-term stuff that is alarming on the basis of where we find these lipids, where we find the spike proteins — those things are reasons for concern because it wasn't supposed to be this way. We've also got an alarming signal in terms of the hazards and deaths or the harms and the deaths that are reported in the system and there are reasons to think they are dramatic under-reports."

Vaden Bossche got it right

One of the potential harms from the vaccines, Weinstein said, was made famous by Vanden Bossche, a vaccinologist who worked with GSK Biologicals, Novartis Vaccines, Solvay Biologicals, Bill & Melinda Gates Foundation's Global Health Discovery team in Seattle, and Global Alliance for Vaccines and Immunization in Geneva.

Earlier this year, Vanden Bossche put out a call to the World Health Organization, supported by a 12-page document, that described the "uncontrollable monster" that a global mass vaccination campaign could potentially unleash.

Vanden Bossche said a combination of lockdowns, and extreme selection pressure on the virus induced by the intense global mass vaccination program, might diminish the number of cases, hospitalizations and deaths in the short-term, but ultimately, will induce the creation of more mutants of concern. This is what Vanden Bossche calls "immune escape" (i.e. incomplete sterilization of the virus by the human immune system, even following vaccine administration).

Immune escape will in turn trigger vaccine companies to further refine vaccines that will add, not reduce, the

selection pressure, producing ever more transmissible and potentially deadly variants.

The selection pressure will cause greater convergence in mutations that affect the critical spike protein of the virus that is responsible for breaking through the mucosal surfaces of our airways, the route used by the virus to enter the human body.

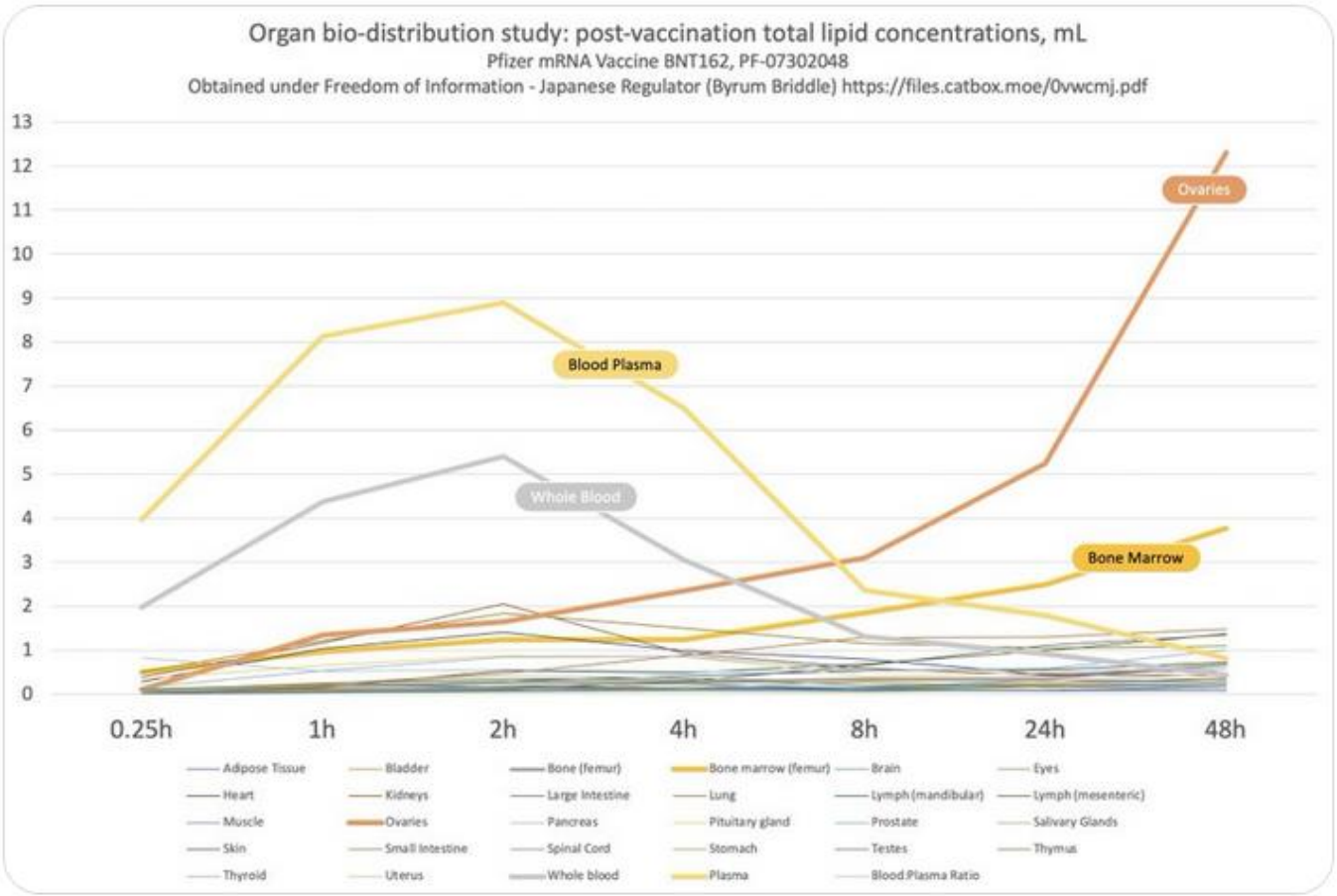
The virus will effectively outsmart the highly specific antigen-based vaccines being used and tweaked, depending on the circulating variants. All of this could lead to a hockey stick-like increase in serious and potentially lethal cases — in effect, an out-of-control pandemic.

Malone said:

"Vanden Bossche's concern is not theoretical. It is real and we have the data. We're stuck with this virus or its downstream variants pretty much for the rest of our lives and it's going to become more like the flu. We will have continuing evolution and circulation of variants, and that is an escape."

My comment: This is another highly respected and qualified scientist that warns that we have made a grave mistake by forcing evolutionary mutational pressure on a virus by mass vaccinating for it during the middle of an outbreak.

Graphs from the Japanese Biodistribution study



2.6.5.5B. PHARMACOKINETICS: ORGAN DISTRIBUTION CONTINUED

Test Article: [^{3}H]-Labelled LNP-mRNA formulation containing ALC-0315 and ALC-0159
Report Number: 185350

Sample	Total Lipid concentration (µg lipid equivalent/g [or mL]) (males and females combined)							% of Administered Dose (males and females combined)						
	0.25 h	1 h	2 h	4 h	8 h	24 h	48 h	0.25 h	1 h	2 h	4 h	8 h	24 h	48 h
Lymph node (mandibular)	0.064	0.189	0.290	0.408	0.534	0.554	0.727	--	--	--	--	--	--	--
Lymph node (mesenteric)	0.050	0.146	0.530	0.489	0.689	0.985	1.37	--	--	--	--	--	--	--
Muscle	0.021	0.061	0.084	0.103	0.096	0.095	0.192	--	--	--	--	--	--	--
Ovaries (females)	0.104	1.34	1.64	2.34	3.09	5.24	12.3	0.001	0.009	0.008	0.016	0.025	0.037	0.095
Pancreas	0.081	0.207	0.414	0.380	0.294	0.358	0.599	0.003	0.007	0.014	0.015	0.015	0.011	0.019
Pituitary gland	0.339	0.645	0.868	0.854	0.405	0.478	0.694	0.000	0.001	0.001	0.001	0.000	0.000	0.001
Prostate	0.061	0.091	0.128	0.157	0.150	0.183	0.170	0.001	0.001	0.002	0.003	0.003	0.004	0.003

This second table shows some other organs with high biodistribution that are not included in the graph above.

Sample	Mean total lipid concentration (µg lipid equivalent/g (or mL) (males and females combined)							% of administered dose (males and females combined)						
	0.25 h	1 h	2 h	4 h	8 h	24 h	48 h	0.25 h	1 h	2 h	4 h	8 h	24 h	48 h
Adipose tissue	0.057	0.100	0.126	0.128	0.093	0.084	0.181	--	--	--	--	--	--	--
Adrenal glands	0.271	1.48	2.72	2.89	6.80	13.8	18.2	0.001	0.007	0.010	0.015	0.035	0.066	0.106
Bladder	0.041	0.130	0.146	0.167	0.148	0.247	0.365	0.000	0.001	0.001	0.001	0.001	0.002	0.002
Bone (femur)	0.091	0.195	0.266	0.276	0.340	0.342	0.687	--	--	--	--	--	--	--
Bone marrow (femur)	0.479	0.960	1.24	1.24	1.84	2.49	3.77	--	--	--	--	--	--	--
Brain	0.045	0.100	0.138	0.115	0.073	0.069	0.068	0.007	0.013	0.020	0.016	0.011	0.010	0.009
Eyes	0.010	0.035	0.052	0.067	0.059	0.091	0.112	0.000	0.001	0.001	0.002	0.002	0.002	0.003
Heart	0.282	1.03	1.40	0.987	0.790	0.451	0.546	0.018	0.056	0.084	0.060	0.042	0.027	0.030
Injection site	128	394	311	338	213	195	165	19.9	52.6	31.6	28.4	21.9	29.1	24.6
Kidneys	0.391	1.16	2.05	0.924	0.590	0.426	0.425	0.050	0.124	0.211	0.109	0.075	0.054	0.057
Large intestine	0.013	0.048	0.093	0.287	0.649	1.10	1.34	0.008	0.025	0.065	0.192	0.405	0.692	0.762
Liver	0.737	4.63	11.0	16.5	26.5	19.2	24.3	0.602	2.87	7.33	11.9	18.1	15.4	16.2
Lung	0.492	1.21	1.83	1.50	1.15	1.04	1.09	0.052	0.101	0.178	0.169	0.122	0.101	0.101

See the links to these tables in the biodistribution link above from the ***Children's Health Defense*** article. It will take you to the study which is in Japanese, however the tables are in English.

WOW! This is not only unexpected as Dr. Malone said, it in-and-of itself should be sufficient reason to stop the vaccine program immediately. As mentioned in the interview, these biodistribution studies are typically done in animals prior to testing on humans and this was never done in the United States. And as Dr. Michael Yeadon has said, toxicology studies on the spike protein these gene therapy agents instruct our cells to make were never done before the Emergency Use Authorizations were given. Now, unleashed on millions soon to be billions of people in the world we are learning a very bitter lesson; you cannot shortcut safety steps in the scientific method.

Another outstanding interview with Dr. Malone was done on the Highwire by Del Bigtree.

Del does a great job of discussing the many concerns that Dr. Malone has about the COVID-19 vaccines and the ethical issues surrounding the way they are being promoted, including the bribery, coercion, threatened

segregation and loss of human rights surrounding the freedom of choice. One of the most revealing interview you will see on this topic by someone who checks all the credibility and expertise boxes.

https://thehighwire.com/videos/mrna-vaccine-inventor-calls-for-stop-of-covid-vax/

To view that whole ***Highwire*** episode click here… https://thehighwire.com/watch/#latest-episodes

What are medical professionals saying about the adverse effects of the vaccines?

Medscape is a popular web site that offers medical advice on just about any topic you could imagine. It is considered quite mainstream in the medical world. As of June 22nd, 2021, they have had 644 comments and the vast majority of them relate personal stories and stories of what they are seeing in the field. With this many doctors, nurses and other health care professionals relating these first-hand accounts, why aren't our regulatory agencies taking notice and acting on these dangerous vaccines?

One of the physicians weighing in is Dr. Peter McCullough who has been very visible and expressing his frustrations with the suppression of early, inexpensive and effective treatments for COVID-19 like hydroxychloroquine and zinc, Ivermectin, Budesonide and others. He has also been critical of the expedited vaccines and the shortcuts that have occurred in the safety trials. Here is what he had to say on the Medscape blog.

Dr. Peter McCullough| Cardiology, General 3 days ago

June 12, 2021, Multiple medical authorities have called for termination of the COVID-19 mass vaccination program due to safety concerns and the lack of independent critical event, data safety monitoring, and human ethics committees:

1) Bruno et al, 57 authors from 17 countries indicate the program should be halted unless safety mechanisms are immediately installed and risk mitigation initiated.
https://www.authorea.com/users/414448/articles/522499-sars-cov-2-mass-vaccination-urgent-questions-on-vaccine-safety-that-demand-answers-from-international-health-agencies-regulatory-authorities-governments-and-vaccine-developers

2) Lawrie et al, Evidence Based Medicine Consultancy calls upon the MHRA to terminate the COVID-19 vaccination program "vaccines not safe for human use". https://drive.google.com/file/d/1pH0Y3jvHtgaEwcDR9QGTB2f90IaPbcRW/view

3) McCullough PA, calls for halt of vaccination of < 30 year olds for no clinical benefit and safety concerns. https://rumble.com/vif52d-evidence-builds-for-early-treatment-natural-immunity-and-pause-on-vaccinati.html

4) Wastila, et al, letter to FDA calling for non-approval of COVID-19 vaccines based on safety concerns. https://www.regulations.gov/commenton/FDA-2021-P-0521-0001
Based on VAERS as of May 28, 2021, there were 5,165 deaths reported and over 17,619 hospitalizations reported. By comparison, from July 1, 1997, until December 31, 2013, VAERS received 666 adult death reports for all vaccines.[1]

[1]Pedro L. Moro, Jorge Arana, Mria Cano, Paige Lewis, and Tom T. Shimabukuro, Deaths Reported to the

Vaccine Adverse Event Reporting System, United States, 1997-2013, VACCINES, CID 2015:61 (September 2015).

Log on and sample what others are saying (if Medscape hasn't taken it down yet).

https://www.medscape.com/sites/public/covid-19/vaccine-insights/how-concerned-are-you-about-vaccine-related-adverse-events

An international coalition of doctors and scientists warn governments and regulatory agencies of the dangers of the COVID-19 vaccines

An article published May 24th, 2021 on ***Authorea*** titled **SARS-CoV-2 mass vaccination: Urgent questions on vaccine safety that demand answers from international health agencies, regulatory authorities, governments and vaccine developers**, serves as a wake-up call and urges an immediate pause followed by "opening an urgent pluralistic, critical, and scientifically-based dialogue on SARS-CoV-2 vaccination among scientists, medical doctors, international health agencies, regulatory authorities, governments, and vaccine developers" to address the many concerns about the vaccines and policies surrounding their promotion and use.

Abstract

Since the start of the COVID-19 outbreak, the race for testing new platforms designed to confer immunity against SARS-CoV-2, has been rampant and unprecedented, leading to conditional emergency authorization of various vaccines. Despite progress on early multidrug therapy for COVID-19 patients, the current mandate is to immunize the world population as quickly as possible. The lack of thorough testing in animals prior to clinical trials, and authorization based on safety data generated during trials that lasted less than 3.5 months, raise questions regarding vaccine safety. The recently identified role of SARS-CoV-2 Spike glycoprotein for inducing endothelial damage characteristic of COVID-19, even in absence of infection, is extremely relevant given that most of the authorized vaccines induce endogenous production of Spike. Given the high rate of occurrence of adverse effects that have been reported to date, as well as the potential for vaccine-driven disease enhancement, Th2-immunopathology, autoimmunity, and immune evasion, there is a need for a better understanding of the benefits and risks of mass vaccination, particularly in groups excluded from clinical trials. Despite calls for caution, the risks of SARS-CoV-2 vaccination have been minimized or ignored by health organizations and government authorities. As for any investigational biomedical program, data safety monitoring boards (DSMB) and event adjudication committees (EAC), should be enacting risk mitigation. If DSMBs and EACs do not do so, we will call for a pause in mass vaccination. If DSMBs and EACs do not exist, then vaccination should be halted immediately, in particular for demographic groups at highest risk of vaccine-associated death or serious adverse effects, during such time as it takes to assemble these boards and commence critical and independent assessments. We urge for pluralistic dialogue in the context of health policies, emphasizing critical questions that require urgent answers, particularly if we wish to avoid a global erosion of public confidence in science and public health

Discussion

The risks outlined here are a major obstacle to continuing global SARS-CoV-2 vaccination. Evidence on the safety of all SARS-CoV-2 vaccines is needed before exposing more people to the risk of these experiments, since releasing a candidate vaccine without time to fully understand the resulting impact on health could lead to an exacerbation of the current global crisis [41]. Risk-stratification of vaccine recipients is essential.

According to the UK government, people below 60 years of age have an extremely low risk of dying fromCOVID-19[1]. However, according to ***Eudravigillance***, most of the serious adverse effects following SARS-CoV-2 vaccination occur in people aged 18-64. Of particular concern is the planned vaccination schedule for children aged 6 years and older in the United States and the UK. Dr. Anthony Fauci recently anticipated that teenagers across the country will be vaccinated in the autumn and younger children in early 2022, and the UK is awaiting trial results to commence vaccination of 11 million children under 18. There is a lack of scientific justification for subjecting healthy children to experimental vaccines, given that the Centers for Disease Control and Prevention estimates that they have a 99.997% survival rate if infected with SARS-CoV-2. Not only is COVID-19 irrelevant as a threat to this age group, but there is no reliable evidence to support vaccine efficacy or effectiveness in this population or to rule out harmful side effects of these experimental vaccines. In this sense, when physicians advise patients on the elective administration of COVID-19 vaccination, there is a great need to better understand the benefits and risk of administration, particularly in understudied groups.

In conclusion, in the context of the rushed emergency-use-authorization of SARS-CoV-2 vaccines, and the current gaps in our understanding of their safety, the following questions must be raised:

*Is it known whether cross-reactive antibodies from previous coronavirus infections or vaccine-induced antibodies may influence the risk of unintended pathogenesis following vaccination with COVID-19?

*Has the specific risk of ADE, immunopathology, autoimmunity, and serious adverse reactions been clearly disclosed to vaccine recipients to meet the medical ethics standard of patient understanding for informed consent? If not, what are the reasons, and how could it be implemented?

*What is the rationale for administering the vaccine to every individual when the risk of dying fromCOVID-19 is not equal across age groups and clinical conditions and when the phase 3 trials excluded the elderly, children and frequent specific conditions?

*What are the legal rights of patients if they are harmed by a SARS-CoV-2 vaccine? Who will cover the costs of medical treatment? If claims were to be settled with public money, has the public been made aware that the vaccine manufacturers have been granted immunity, and their responsibility to compensate those harmed by the vaccine has been transferred to the tax-payers?

If vaccination programs worldwide do not institute independent data safety monitoring boards (DSMB), event adjudication committees (EAC), and enact risk mitigation, we will call for a pause in the mass vaccination program. If DSMBs and EACs do not exist currently, as would be imperative for any investigational biomedical program, then vaccination should be immediately halted for those demographic groups at highest risk of vaccine-associated death or serious adverse effects, during the time it takes to assemble these boards and committees and commence their assessments.

In the context of these concerns, we propose opening an urgent pluralistic, critical, and scientifically-based dialogue on SARS-CoV-2 vaccination among scientists, medical doctors, international health agencies, regulatory authorities, governments, and vaccine developers. This is the only way to bridge the current gap between scientific evidence and public health policy regarding the SARS-CoV-2 vaccines. We are convinced that humanity deserves a deeper understanding of the risks than what is currently touted as the official position. An open scientific dialogue is urgent and indispensable to avoid erosion of public confidence in science and public health and to ensure that the WHO and national health authorities protect the interests of humanity during the current pandemic. Returning public health policy to evidence-based medicine, relying on a careful evaluation of the relevant scientific research, is urgent. It is imperative to follow the science.

https://www.authorea.com/users/414448/articles/522499-sars-cov-2-mass-vaccination-urgent-questions-on-vaccine-safety-that-demand-answers-from-international-health-agencies-regulatory-authorities-governments-and-vaccine-developers

This paper has 41 references.

Speaking of dangers…Check out this next story!

New study in the New England Journal of Medicine looking at risks of COVID-19 shots in pregnancy is under fire for glaring flaws that mis-represent the conclusion

A June 17th study published in the ***New England Journal of Medicine*** titled, **Preliminary Findings of mRNA Covid-19 Vaccine Safety in Pregnant Persons** concluded that there were no safety signals related to spontaneous abortions in women getting the COVID-19 vaccines. But stop the press! An independent analysis of the data found some glaring flaws that completely change the narrative that the study authors were apparently attempting to provide.

There were some interesting findings and statements throughout the study that leads me to believe they recognized some of the issues with their conclusion which says this

From the Conclusion

"Preliminary findings did not show obvious safety signals among pregnant persons who received mRNA Covid-19 vaccines."

They did say that further follow-up with larger cohorts are needed especially in women vaccinated earlier in pregnancy, but they did make a couple very large and critically important miscalculations in the data that was reported.

Here are some those interesting sections from the study.

Among 827 participants who had a completed pregnancy, the pregnancy resulted in a live birth in 712 (86.1%), in a spontaneous abortion in 104 (12.6%), in stillbirth in 1 (0.1%), and in other outcomes (induced abortion and ectopic pregnancy) in 10 (1.2%). A total of 96 of 104 spontaneous abortions (92.3%) occurred before 13 weeks of gestation (Table 4), and 700 of 712 pregnancies that resulted in a live birth (98.3%) were among persons who received their first eligible vaccine dose in the third trimester.

https://www.nejm.org/doi/full/10.1056/NEJMoa2104983

In a letter to the editor, it was pointed out that there are at least two glaring flaws in this study.

1. The range used population wide stillbirths used a higher end range that represented clinically-unrecognized pregnancies, which does not reflect the clinically-recognized pregnancies of this cohort

and should be removed according to the authors.

2. The intent of the study was to evaluate the COVID-19 vaccines for adverse pregnancy events including spontaneous abortion (death prior to 20 weeks gestation), or still birth (death between 21 weeks and full term). It is well documented that the fetus is most susceptible to toxins and spontaneous abortion if the mother is vaccinated or exposed to other toxins in the first trimester of pregnancy. The number of vaccinated women in the study by the authors also included women who were vaccinated in the last trimester of pregnancy.

   After the authors of the letter to the editor adjusted for the above variables of using the rate of fetal deaths in **known pregnancies** and removed those who were vaccinated in the third trimester of their pregnancy from the cohort, they came up with a **greater than 82% rate of spontaneous abortion** in those vaccinated in the first trimester!

Here is the Letter to the Editor

Letter to Editor – Comment on "mRNA Covid-19 Vaccine Safety in Pregnant Persons", Shimabukuro et al. (NEJM Apr 2021)

TO THE EDITOR

The article by Shimabukuro et al. 2021 presents preliminary safety results of coronavirus 2019 mRNA vaccines used in pregnant women from the V-Safe Registry.1 These findings are of particular importance, as pregnant women were excluded from the phase III trials assessing mRNA vaccines.

In table 4, the authors report a rate of spontaneous abortions <20 weeks (SA) of 12.5% (104 abortions/827 completed pregnancies). However, this rate should be based on the number of women who were at risk of an SA due to vaccine receipt and should exclude the 700 women who were vaccinated in their third-trimester (104/127 = 82%). We acknowledge this rate will likely decrease as the pregnancies of women who were vaccinated <20 weeks complete but believe the rate will be higher than 12.5%. However, given the importance of these findings we feel it important to report these rates accurately. Additionally, the authors indicate that the rate of SAs in the published literature is between 10% and 26%.3-5 However, the upper cited rate includes clinically-unrecognized pregnancies,3 which does not reflect the clinically-recognized pregnancies of this cohort and should be removed.

NOTE: I'm going to insert the table from the study itself prior to the table the authors of this letter provide to make it easier to see the contrast from what the study authors showed as compared to the authors of the letter to the editor.

Table 4. Pregnancy Loss and Neonatal Outcomes in Published Studies and V-safe Pregnancy Registry Participants.

Participant-Reported Outcome	Published Incidence*	V-safe Pregnancy Registry†
	%	*no./total no. (%)*
Pregnancy loss among participants with a completed pregnancy		
Spontaneous abortion: <20 wk[15-17]	10–26	104/827 (12.6)‡
Stillbirth: ≥ 20 wk[18-20]	<1	1/725 (0.1)§
Neonatal outcome among live-born infants		
Preterm birth: <37 wk[21,22]	8–15	60/636 (9.4)¶
Small size for gestational age[23,24]‖	3.5	23/724 (3.2)
Congenital anomalies[25]**	3	16/724 (2.2)
Neonatal death[26]††	<1	0/724

From the Letter to the Editor

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Neonatal outcome among live-born infants		
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Neonatal death[26]††	<1	0/724

* The populations from which these rates are derived are not matched to the current study population for age, race and ethnic group, or other demographic and clinical factors.

† Data on pregnancy loss are based on 827 participants in the v-safe pregnancy registry who received an mRNA Covid-19 vaccine (BNT162b2 [Pfizer–BioNTech] or mRNA-1273 [Moderna]) from December 14, 2020, to February 28, 2021, and who reported a completed pregnancy. **A total of 700 participants (84.6%) received their first eligible dose in the third trimester. Data on neonatal outcomes are based on 724 live-born infants, including 12 sets of multiples.**

‡ A total of 96 of 104 spontaneous abortions (92.3%) occurred before 13 weeks of gestation.

§ The denominator includes live-born infants and stillbirths.

¶ The denominator includes only participants vaccinated before 37 weeks of gestation.

‖ Small size for gestational age indicates a birthweight below the 10th percentile for gestational age and infant sex ac- cording to INTERGROWTH-21st growth standards (http://intergrowth21.ndog.ox.ac.uk). These standards draw from an international sample including both low-income and high-income countries but exclude children with coexisting conditions and malnutrition. They can be used as a standard for healthy children growing under optimal conditions.

Letter to Editor – Comment on “mRNA Covid-19 Vaccine Safety in Pregnant Persons”, Shimabukuro et al. (NEJM Apr 2021)

** Values include only major congenital anomalies in accordance with the Metropolitan Atlanta Congenital Defects Pro- gram 6-Digit Code Defect List (www.cdc.gov/ncbddd/birthdefects/macdp.html); all pregnancies with major congeni- tal anomalies were exposed to Covid-19 vaccines only in the third trimester of pregnancy (i.e., well after the period of organogenesis).
†† Neonatal death indicates death within the first 28 days after delivery.

Kind Regards,

Deanna, McLeod, HBSc, Principal at Kaleidoscope Strategic Inc, Toronto, ON deanna@kstrategic.com
Ira Bernstein, MD, CCFP, FCFP, University of Toronto, Toronto, ON, irabernstein@bell.net
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No potential conflict of interest relevant to this letter was reported.

1. Shimabukuro TT, Kim SY, Myers TR, Moro PL, Oduyebo T, Panagiotakopoulos L, Marquez PL, Olson CK, Liu R, Chang KT. Preliminary Findings of mRNA Covid-19 Vaccine Safety in Pregnant Persons. *New England Journal of Medicine* 2021.
2. Devis P, Knuttinen MG. Deep venous thrombosis in pregnancy: incidence, pathogenesis and endovascular management. *Cardiovascular diagnosis and therapy* 2017;7:S309.
3. Dugas C, Slane VH. Miscarriage. *StatPearls [Internet]* 2020.
4. Obstetricians ACo, Gynecologists. ACOG practice bulletin no. 200: Early pregnancy loss. *Obstetrics and gynecology* 2018;132:e197-e207.
5. Medicine PCotASfR. Evaluation and treatment of recurrent pregnancy loss: a committee opinion. *Fertility and sterility* 2012;98:1103-11.

https://www.skirsch.com/covid/Vaccine_safety_in_preg_NEJM_May_28_2021.pdf

Another beef I have with this study, is with the title. See if you can pick it out.

Preliminary Findings of mRNA Covid-19 Vaccine Safety in Pregnant Persons

You may have different feelings about this, but I am so sick of the woke culture. To use the term “pregnant persons” rather than women is an obvious surrender to wokeness. This is particularly egregious coming from one of the top medical journals in the world, whose authors and peer reviewers ought to know the biological difference between men and women with regard to the capability of childbirth. Until someone can demonstrate to me that men are having children by natural means, this is completely ridiculous! I'll probably get cancelled for this biological truth. That is just another sign of the sick and twisted times we live in.

IMPORTANT UPDATE: As of Tuesday June 29th, the NEJM has removed this letter to the editor. Another example of scientific censorship? What normally happens if there is disagreement by some in the scientific community or the journal regarding the content or conclusions of a letter to the editor, other doctors or researchers will write their response to that letter and give their arguments against what the writer or writers of the letter to the editor have said. That is healthy scientific debate. But apparently those days are long gone.

BREAKING NEWS as of July 1st: (I had to squeeze this in prior to releasing this newsletter)

A story in ***Science*** on Sciencemag.org titled, **Scientists quit journal board, protesting 'grossly irresponsible' study claiming COVID-19 vaccines kill**, reports on an exodus from the editorial board of the journal ***Vaccine***.

From the story

Several reputed virologists and vaccinologists have resigned as editors of the journal ***Vaccine*** to protest its 24 June publication of a **peer-reviewed article** that misuses data to conclude that "for three deaths prevented by [COVID-19] vaccination, we have to accept two inflicted by vaccination."

Since Friday, at least six scientists have resigned positions as associate or section editors with *Vaccines*, including Florian Krammer, a virologist at the Icahn School of Medicine at Mount Sinai, and Katie Ewer, an immunologist at the Jenner Institute at the University of Oxford who was on the team that developed the Oxford-AstraZeneca COVID-19 vaccine.

https://www.sciencemag.org/news/2021/07/scientists-quit-journal-board-protesting-grossly-irresponsible-study-claiming-covid-19

My comment: Isn't it interesting that Katie Ewer, a developer of the AstraZeneca vaccine was one of the editors jumping ship. So, the narrative is that they resigned in protest of the article saying it "misuses" data, but is it really that, or is it that they are upset that the journal had the integrity to publish the results and expose the dangers of the vaccine? It will be interesting to continue to follow this story.

Considering the risk found in pregnant woman as demonstrated by this story, look at how these shots are being marketed to women wanting to get pregnant…

Tweet by HHS promoting COVID-19 vaccines in women who want to become pregnant

Health and Human Services (HHS) has put out a video June 8th in a Tweet designed to encourage women desiring or planning to get pregnant containing some false and deceptive statements. The person speaking in the video is Sara Whetstone M.D. https://twitter.com/hhsgov/status/1402340632807415809?s=11

This is the full script, which I will take point by point.

1. "We don't have any data that suggests that COVID-19 vaccines affects fertility."
   This is debatable as many world-renowned scientists and medical specialists have come forward expressing legitimate concerns and asking for a pause in vaccinations until these concerns can be addressed. In addition, we have seen many adverse wide-ranging effects to menstrual cycles of women who have been vaccinated. And aside from all that, reading that statement again is the exact point that people advocating for safe vaccines are making. WE DON'T HAVE ANY DATA about short, moderate or long-range effects of these experimental vaccines on fertility. We now know thanks to a Japanese study discussed in this newsletter, that the Lipid nanoparticles that carry the spike protein used by our cells to manufacture trillions of copies of spike protein accumulate in the ovaries in quantities several times greater than any other organ or tissue. The inventor of mRNA technology that is being used by the Pfizer ND Moderna vaccines expressed grave concerns about this very issue. You would have been able to see it on YouTube initially, but this is what I found when I first tried.

2. "It's not a live vaccine."
   This statement is a non-relevant statement, so in essence a distraction. No, it is not a live vaccine. It is an engineered spike protein never used in humans before, in a delivery system that has never been used in humans before. And, with very short trials in limited numbers and demographics before unleashing it on the public. So, their statement that is not a live vaccine is basically saying "why worry?"

3. "The sort of proteins that are used in the vaccine do not alter anyone's DNA or genetic material."
   That is still up for debate, but one thing that isn't, is that they do instruct your cells to manufacture a genetically modified spike protein that has now shown in several studies to act as a toxin in the body and is now thought to be responsible for the catastrophic numbers of casualties in vaccinated people.

4. "So, we don't have any evidence that makes us worry that this vaccine could affect fertility."
   Could that be because these vaccines weren't studied as they should have been and tested in a small number of women who were then followed for two to three years to see if they were able to conceive as compared to the rest of the population? And, based on the previous report it would be logical to suggest that the possibility exists.

5. "And we know, we have lots of vaccines in the past, that we give out, you know, to people that desire to get pregnant as a way to protect them in pregnancy."
   The only two vaccines that the CDC recommends in pregnant women are the flu vaccine and the T-dap. What she means by "lots of vaccines" I'm not exactly sure. And even these two vaccines have been shown in many studies to be problematic. Download and read my **1200 Studies- Truth Will Prevail** (https://1200studies.com) and you will see extensive evidence to support that statement.

6. "So, in general, we think that vaccines are safe prior to pregnancy. And in some cases, we encourage people to get vaccinated before pregnancy for certain viruses."

   "We think"? That's reassuring. Especially considering the findings in the Japanese Pfizer biodistribution study as discussed by the inventor of messenger RNA technology Dr. Robert Malone. See that story in this newsletter.

COVID-19 vaccines may also have detrimental effects to the male reproductive system

A study published in the ***World Journal of Men's Health*** November 2020 titled, **Histopathology and Ultrastructural Findings of Fatal COVID-19 Infections on Testis** presents some very concerning findings.

Conclusion from the abstract

The novel COVID-19 has an affinity for ACE-2 receptors. Since ACE-2 receptor expression is high in the testes, we hypothesized that COVID-19 is prevalent in testes tissue of infected patients. This study suggests the male reproductive tract, specifically the testes, may be targets of COVID-19 infection. We found an inverse association between ACE-2 receptor levels and spermatogenesis, suggesting a possible mechanism of how COVID-19 can cause infertility.

From the study

As our understanding of the virus grew, it became apparent that the virus additionally affects other organs of the human body, such as the liver, kidneys, and gastrointestinal tract. There is a male preponderance for the virus and early studies showed worse disease severity and duration in men compared to women. This preponderance has resulted in an increased incidence of the disease and morbidity rate in men that is double that of women [2]. The 2005 SARS-CoV virus, a respiratory virus part of the same family as the SARS-CoV-2 virus, was also investigated regarding its effects on testes tissue. Xu et al [3] found that all six patients who died of SARS-CoV displayed widespread germ cell destruction with few to no spermatozoon, thickened seminiferous tubule basement membranes, as well as lymphocyte and macrophage infiltration. They suggested orchitis is a complication of SARS-CoV.

Pathological studies have shown that the primary target organ of COVID-19 is the lungs. It is believed that this is due to an increased expression of angiotensin- converting enzyme 2 (ACE-2) receptors in lung tissue, of which COVID-19 has a high affinity of binding and subsequent entry [8-10]. Studies have shown the potential risk of COVID-19 impacting and damaging other organs that express ACE-2 receptors, including the heart, kidneys, bladder, oral cavity, esophagus, and ileum [9,11,12]. Interestingly, the ACE-2 receptor is widely expressed in the testes [13]. It has been found that in prior to viral entry *via* ACE-2 the SARS-CoV-2 viral spike proteins must be primed *via* the transmembrane protease, serine 2 (TMPRSS2). Androgens *via* the androgen receptor are the only known transcription promoters for the TMPRSS2 gene [14,15]. Since both ACE-2 as well as TMPRSS2 have been shown to be expressed in testis tissue, *via* single-cell and single nucleus RNA-seq studies, we believe the high androgen environment of the testes will allow for viral entry [16].

In addition, multiple studies have reported that the use of renin-angiotensin system inhibitors has neither been shown to confer any protective effects, nor impact testing positive rates or mortality [17-19].

Additionally, it has been shown that viruses, such as human immunodeficiency virus, hepatitis B virus, and mumps, can cross the blood-testis barrier and cause viral orchitis resulting in infertility and cancer [20]. In this study we hypothesized that the SARS-CoV-2 virus can be present in the testis and impact spermatogenesis. We also evaluated the association between ACE-2 receptor levels and impact on spermatogenesis.

The presence of SARS-CoV-2 viral particles in the testicular tissue fills a fundamental gap in knowledge of the affected organs and possible sequalae of COVID-19 in men. The findings of this study could be the first step in discovering impacts to fertility or the possibility of sexual transmission of the virus. On the basis of these preliminary findings, we believe that COVID-19 can penetrate the blood-testis barrier and enter the testis in some men. Presence of the virus can still be identified in the testis after patients have seroconverted. ACE-2 receptor density in testis tissue may be a factor influencing the extent of damage to cells responsible for spermatogenesis, with higher ACE-2 expression possibly leading to poorer spermatogenesis. However, further experiments are needed to validate this association. The relationship between possible visual viral particles on TEM and leukocyte infiltration suggests the COVID-19 virus may enter the testis and potentially cause orchitis. Further studies need to be undertaken to better understand the effects of this virus on reproductive organs.

Since the vaccines trigger our cells to make the spike protein and as the story I reported in this newsletter about the Japanese biodistribution study showed, these nanoparticles travel throughout the body. They seem to have a greater affinity for then ovaries than the testis, but what about the billions of free spike proteins released by the cells which have also been shown to travel throughout the body? Since the testis have high levels of ACE-2 receptors (the target for the spike protein) and TMPRSS2 expression as discussed above, it is reasonable to be concerned about the vaccine's effect on male reproduction. Since hundreds of millions of males are now experimental test subjects, I guess we will see in two to three years.

https://pubmed.ncbi.nlm.nih.gov/33151050/

COVID-19 vaccines may have negative and risky immune effects for people that have previously had COVID-19

A February 2021 study from Italy and published on ***medRxiv*** as a preprint titled, **A cautionary note on recall vaccination in ex-COVID-19 subjects** warns of some disastrous unintended consequences to the vaccines.

From the Abstract

Here, we tested the antibody response developed after the first dose of the mRNA-based vaccine encoding the SARS-CoV-2 full-length spike protein (BNT162b2) in 124 healthcare professionals of which 57 had a previous history of COVID-19 (ExCOVID). Post-vaccine antibodies in ExCOVID individuals increase exponentially within 7-15 days after the first dose compared to naïve subjects (p<0.0001). We developed a multivariate Linear Regression (LR) model with l2 regularization to predict the IgG response for SARS-COV-2 vaccine. We found that the antibody response of ExCOVID patients depends on the IgG pre-vaccine titer and on the symptoms that they developed during the disorder, with anosmia/dysgeusia and gastrointestinal disorders being the most significantly positively correlated in the LR. Thus, one vaccine dose is sufficient to induce a good antibody response in ExCOVID subjects. **On the contrary, a second dose might switch-off the immune response due to antigen exhaustion, which occurs in response to several viruses or drive the development of low-affinity antibodies for SARS-CoV-2 which may foster an antibody dependent enhancement (ADE) reaction when re-exposed to the virus. These results question whether a second shot in ExCOVID subjects is indeed required and suggest to post-pone it while monitoring antibody response longevity.**

https://www.medrxiv.org/content/10.1101/2021.02.01.21250923v1

At least some of the mainstream media is finally catching on

For quite some time, we have seen excellent monologs and interviews by Tucker Carlson and Laura Ingraham from Fox News covering various stories about the pandemic public health response, recently the origins of the virus and bringing to light the risks of the COVID shots. Add the Wall Street Journal to the list of honest journalism.

Recently they have reported on the lab origins…

The Science Suggests a Wuhan Lab Leak - The Covid-19 pathogen has a genetic footprint that has never been observed in a natural coronavirus.

https://www.wsj.com/articles/the-science-suggests-a-wuhan-lab-leak-11622995184

and now this from the WSJ…

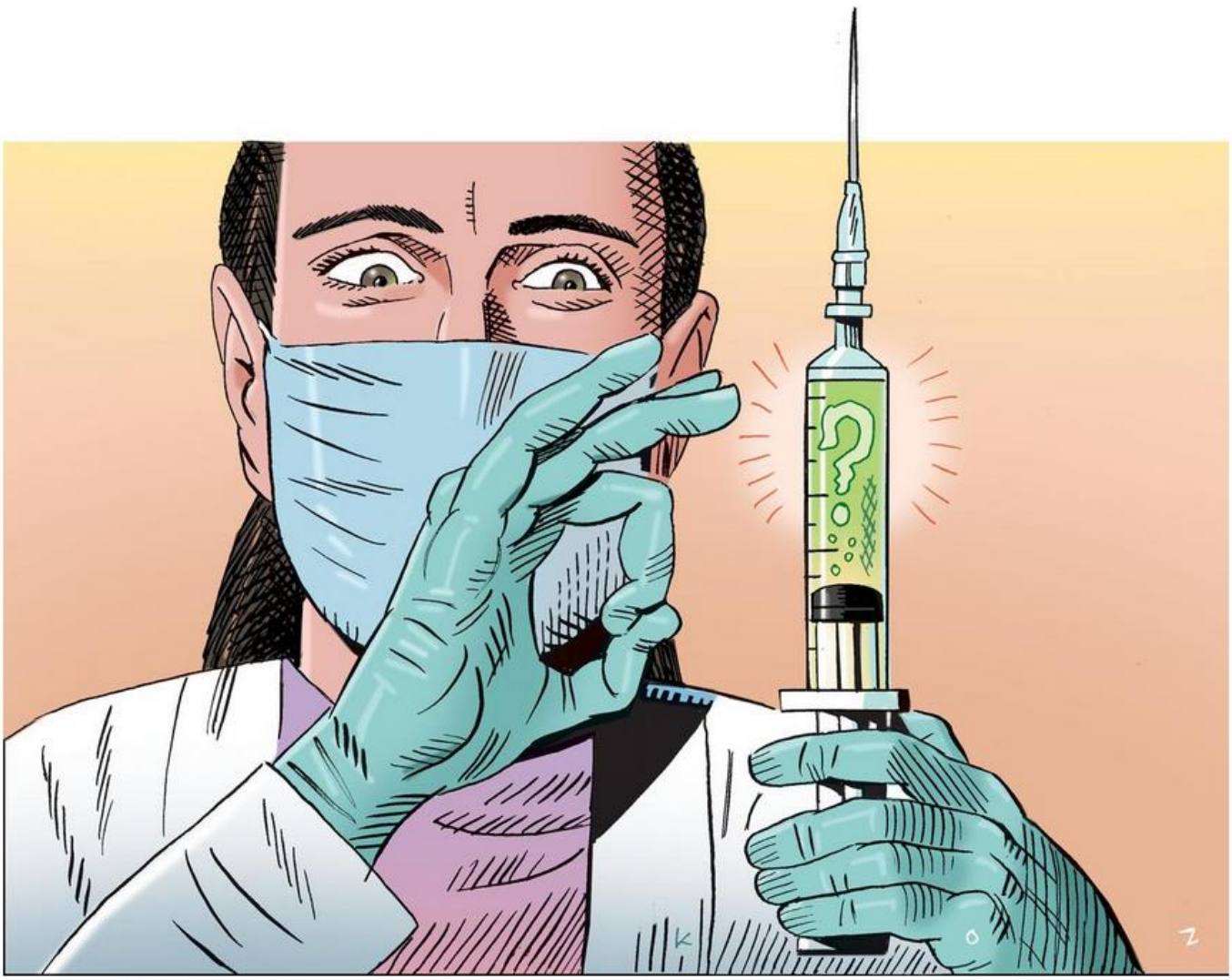


ILLUSTRATION: MARTIN KOZLOWSKI

The op-ed featured in the WSJ June 22nd, 2021 titled **Are Covid Vaccines Riskier Than Advertised?** - **There are concerning trends on blood clots and low platelets, not that the authorities will tell you** was submitted by Joseph Ladapo, M.D., Ph.D., associate professor of medicine at ***UCLA's David Geffen School of Medicine***, and Harvey Risch, M.D., Ph.D., a professor of epidemiology at ***Yale School of Public Health*** wrote while "some scientists have raised concerns that the safety risks of Covid-19 vaccines have been underestimated … the politics of vaccination has relegated their concerns to the outskirts of scientific thinking."

In discussing the numbers of adverse reports after the vaccines, they said that they felt that "The true number of cases is almost certainly higher. This tendency of underreporting is consistent with our clinical experience."

In addition, they said "The implication is that the risks of a COVID-19 vaccine may outweigh the benefits for certain low-risk populations, such as children, young adults and people who have recovered from COVID-19. This is especially true in regions with low levels of community spread, since the likelihood of illness depends on exposure risk. And while you would never know it from listening to public health officials, not a single published study has demonstrated that patients with a prior infection benefit from COVID-19 vaccination. That this isn't readily acknowledged by the CDC or Anthony Fauci is an indication of how deeply entangled pandemic politics is in science."

"Analyses to confirm or dismiss these findings should be performed using large data sets of health-insurance

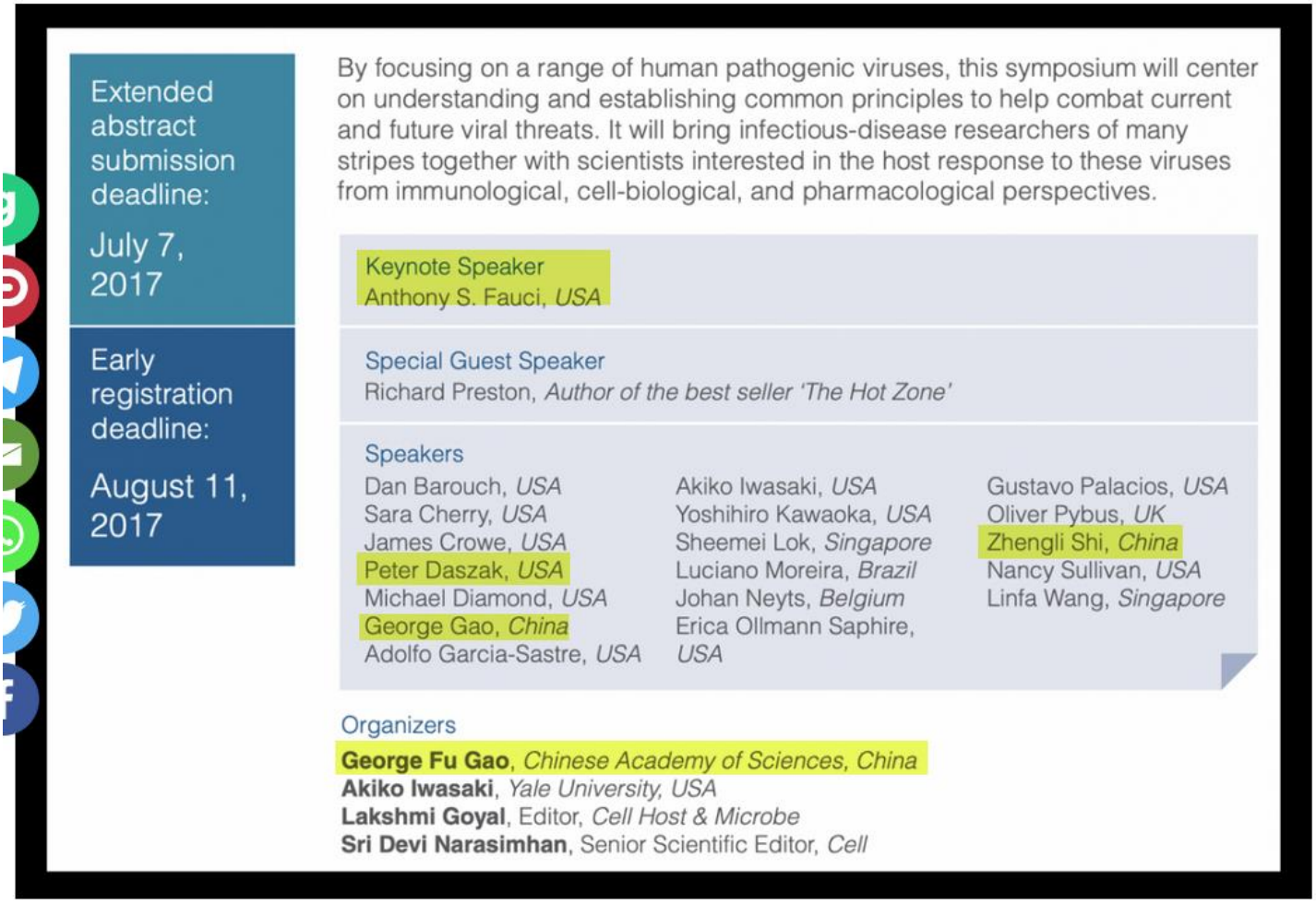
companies and healthcare organizations. The CDC and FDA are surely aware of these data patterns, yet neither agency has acknowledged the trend."

https://www.wsj.com/articles/are-covid-vaccines-riskier-than-advertised-11624381749

Key players in the funding and research that has appeared to have led to the COVID-19 outbreak, participated in a conference two years before the outbreak

A June 9th, 2021 article in the ***National Pulse*** titled, **EXPOSED: Fauci Headlined Conference With 'Bat Lady' and EcoHealth's Daszak Despite Distancing Himself from Wuhan** connects some very interesting dots.

In the Anthony Fauci email dump, ***China's Centers for Disease Control and Prevention (CDC)*** Director George Gao – emailed Dr. Fauci to thank him for publicly dismissing the ***Wuhan Institute of Virology's*** role in creating COVID-19. Dr. Gao was responsible for organizing an October 1-3, 2017 ***Cell Symposia*** conference in Arlington Virginia titled, **Emerging and Re-emerging Viruses** where Dr. Fauci was the keynote speaker and Peter Daszak of ***Ecohealth Alliance*** and ***Wuhan Institute of Virology Center for Emerging Infectious Diseases*** **Director** Shi Zhengli. Isn't it interesting that all the major players in the funding and research of the ***Wuhan Institute of Virology's*** gain-of-function research were all participating?

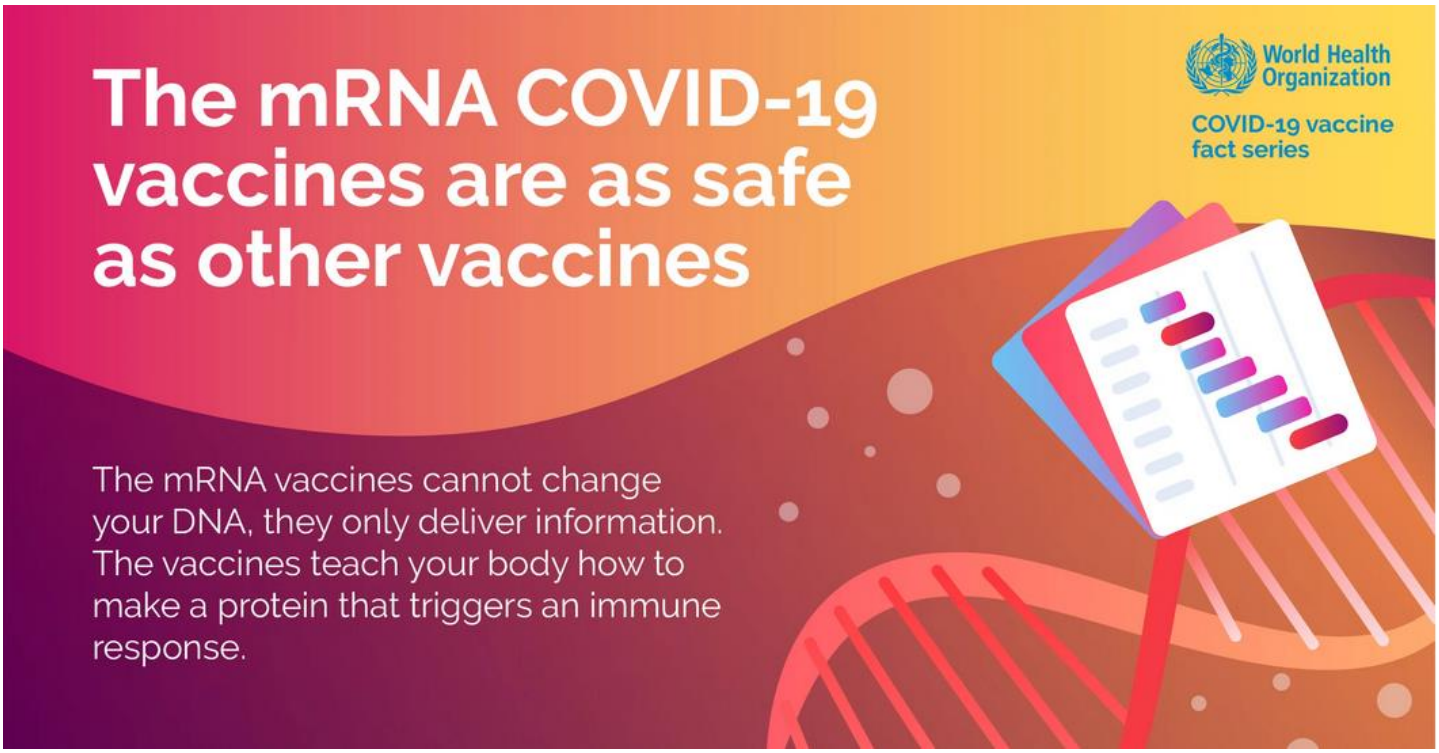


https://thenationalpulse.com/exclusive/fauci-headlined-conference-with-shi-and-daszak/

The argument could be made that these people run in the same circles because of connections with research that is being done and thus may speak at and attend conferences together. But the more evidence like this which puts all the key players together in common collaborative efforts, the more Dr. Fauci's denials of his and NIAID's involvement with gain of function research seem less legitimate.

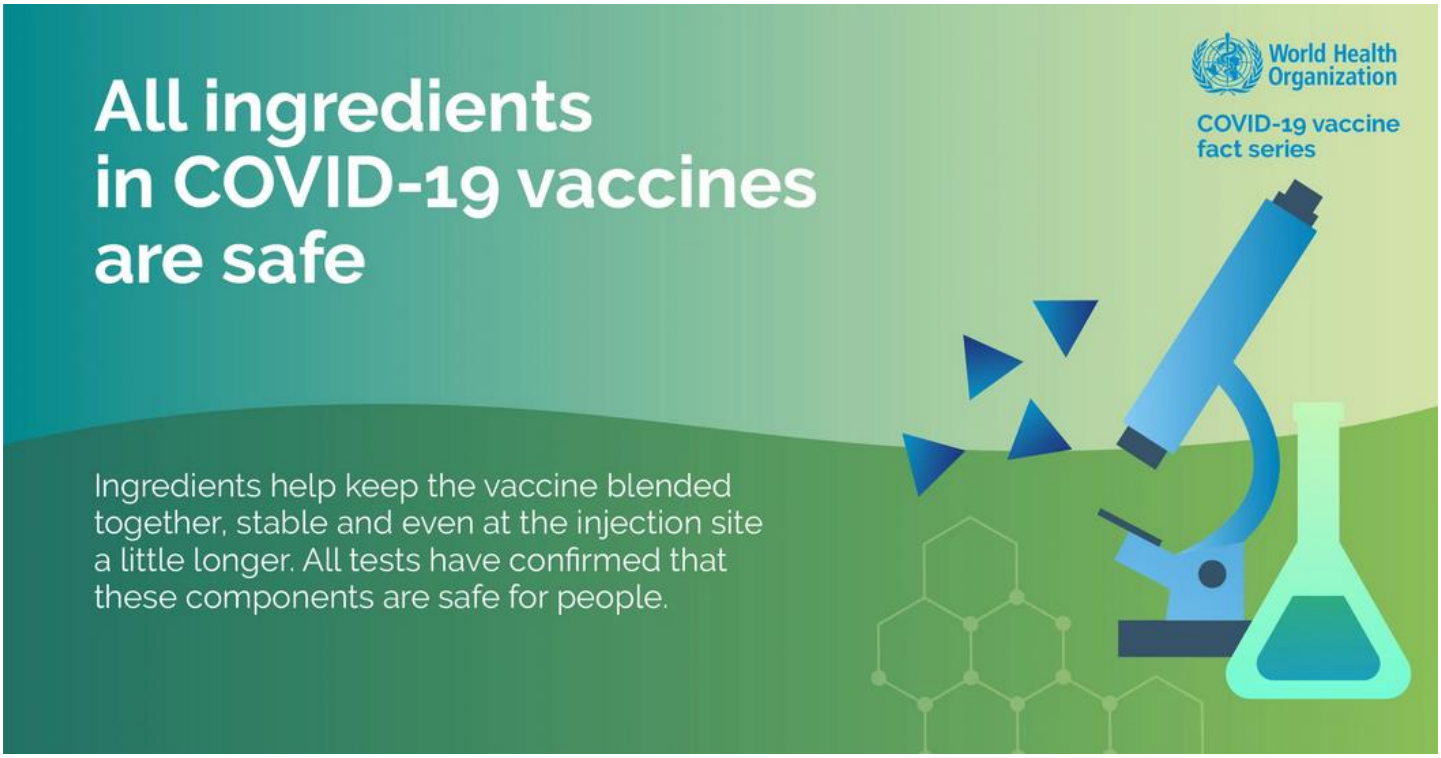
Blatant misinformation from the World Health Organization (but then, who is really surprised?)

In a series of infographics on the COVID vaccines found on the World Health organization's website, I found seven of the nine to contain blatant misinformation. See if you can pick them out yourself.



As safe as other vaccines? Just check the VAERS reports (which we know are highly under-reported) and read the MedScape medical professional comments from the link found in this newsletter. Then tell me what you think about this egregious statement.

Continued next page…



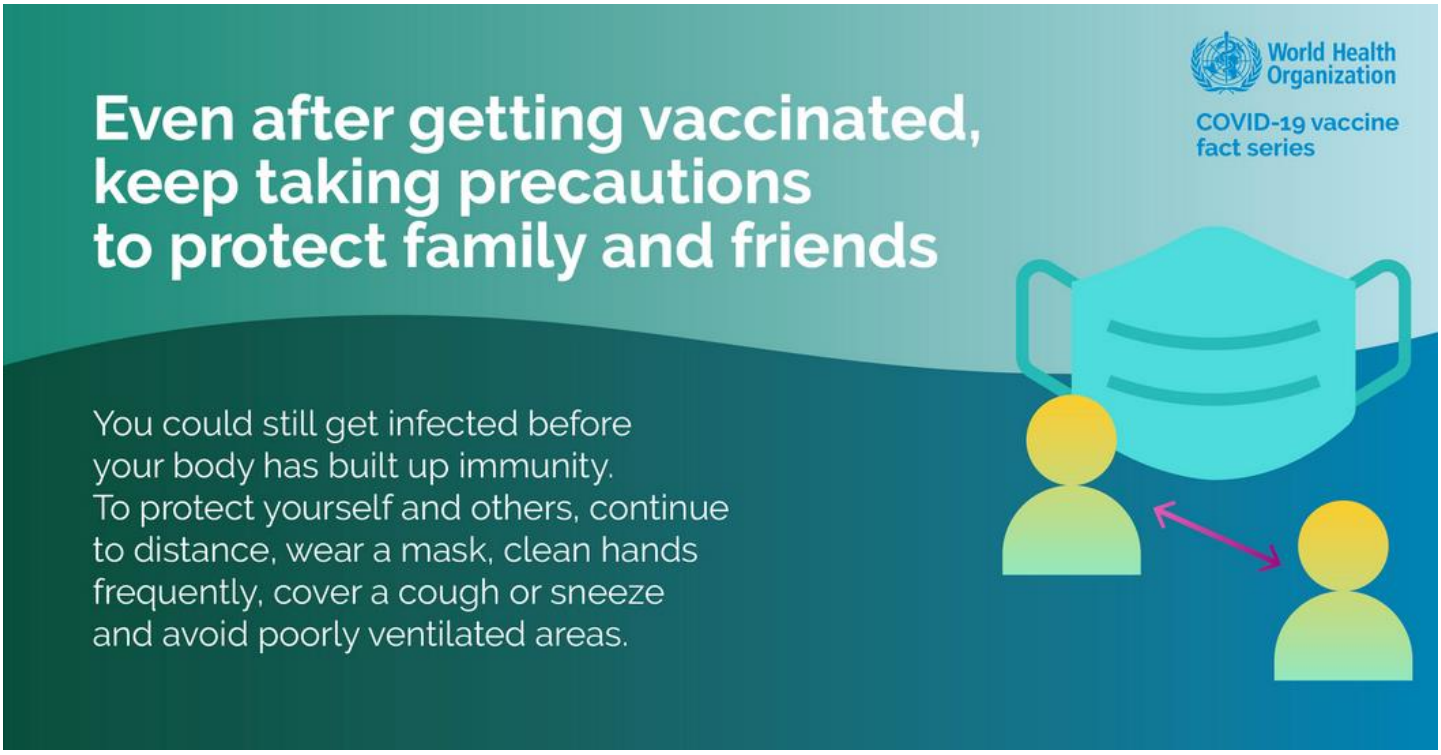
See my comment above. In addition, the Pfizer biodistribution study from Japan that I report on in this newsletter clearly shows that these ingredients distribute throughout the human body and do not stay at or near the injection site.

This statement is a joke! We know from numerous studies many of which I've covered in previous newsletters and some of them in this newsletter, that natural immunity is far superior to vaccine immunity. Those who have been vaccinated are at far greater risk of becoming infected by mutant strains. This is becoming clearly evident all around the world. One of the key reasons is that their immune system only recognizes the spike

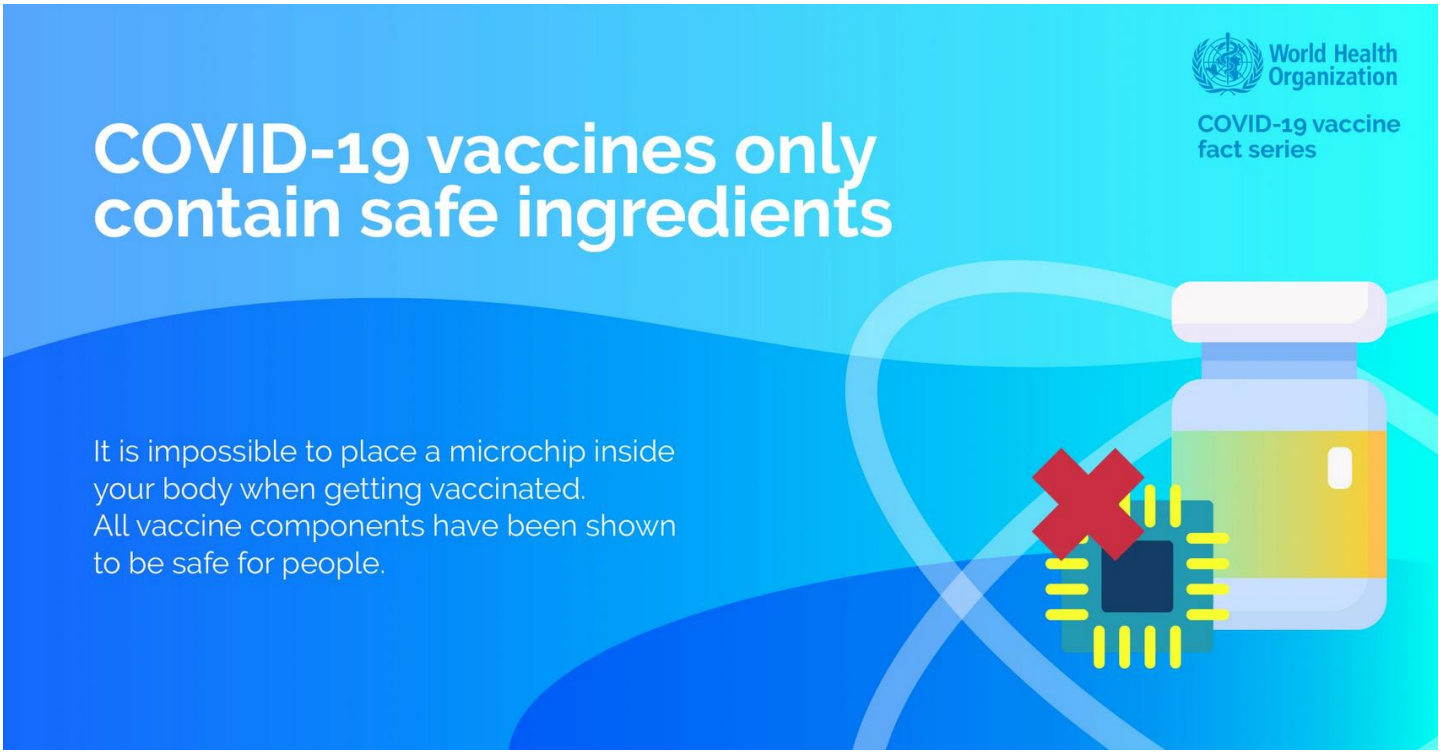
protein. Once mutations occur in the spike protein it reduces the immune system's ability to recognize it and mount an attack. Whereas natural infection trains the immune system to recognize the whole virus in all of the proteins not just the single S1 protein. In all of this is withstanding the fact that 99.8 percent of the people under the age of 60 have very little risk of death from this virus, especially those who do not have co-morbidities. For them the risk is far lower. That is definitely a risk reward part of the equation that leans towards more risk from the vaccine and one that those individuals need to make without force or coercion.

Serious side effects are rare? Really? For those of you that have been reading my monthly newsletters, you know this is a boldface lie. And looking at the statistics posted this month, recognizing that they may represent only 1% of the total numbers will quickly make you realize the magnitude of this lie. The same thing is being reported throughout the European reporting system.

Continued next page…



This statement infers that you can't get infected after your body builds up immunity post-vaccination. Making a reassuring statement like that which is untrue, is a deceptive lie. Once again, many reports are that as high as 60 to 70% of COVID-19 infections and hospitalizations are now in vaccinated people.



To continue to repeat this lie is truly nauseating. Many people have the risk of severe anaphylaxis and death from the polyethylene glycol in the Pfizer and Moderna vaccines. The spike protein in the vaccines force the body to make, what are now being recognized as a toxin and its actions in many people are leading to serious illness, hospitalizations, and death (this includes the Johnson and Johnson and AstraZeneca vaccines). The

spike protein that begins that cascade of events in the body, is in the vaccine lipid nanoparticles. Therefore, the spike proteins which are an incredibly dangerous toxin in the body, is an unsafe ingredient in the vaccine. Dr. Michael Yeadon the former vice president of Pfizer respiratory division, clearly states this in the interview that I've posted the link for in this newsletter. Additionally, Dr. Robert Malone the inventor of the messenger RNA (mRNA) technology echoed the same concerns, including the fact that researchers developing the vaccines did not expect the lipid nanoparticles carrying the spike protein to be so widely distributed throughout the body. That distribution appears to be greatest in the ovaries, but also high in the liver, adrenals and bone marrow. This is an incredibly disturbing revelation.

Link to WHO graphics

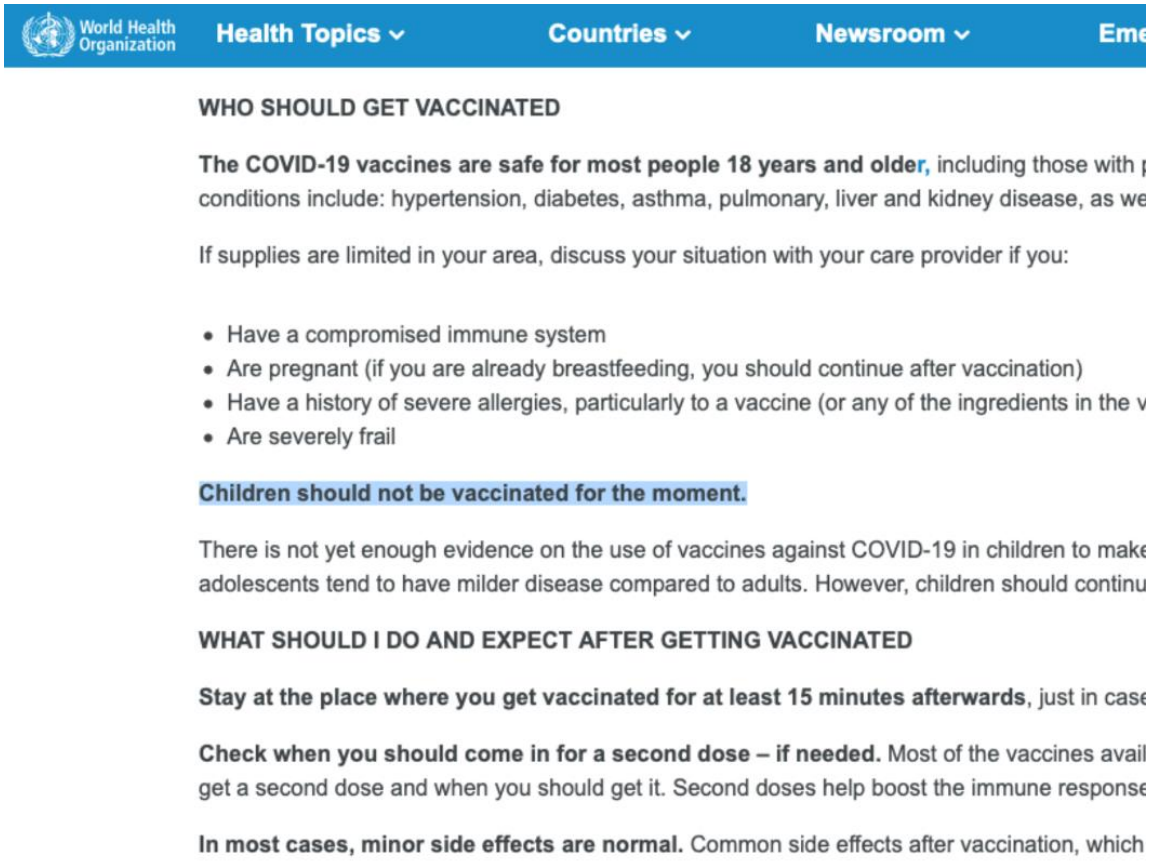
https://www.who.int/emergencies/diseases/novel-coronavirus-2019/covid-19-vaccines/advice

The tragic thing is that our own CDC and FDA parrot many if these same claims on their websites and official communications.

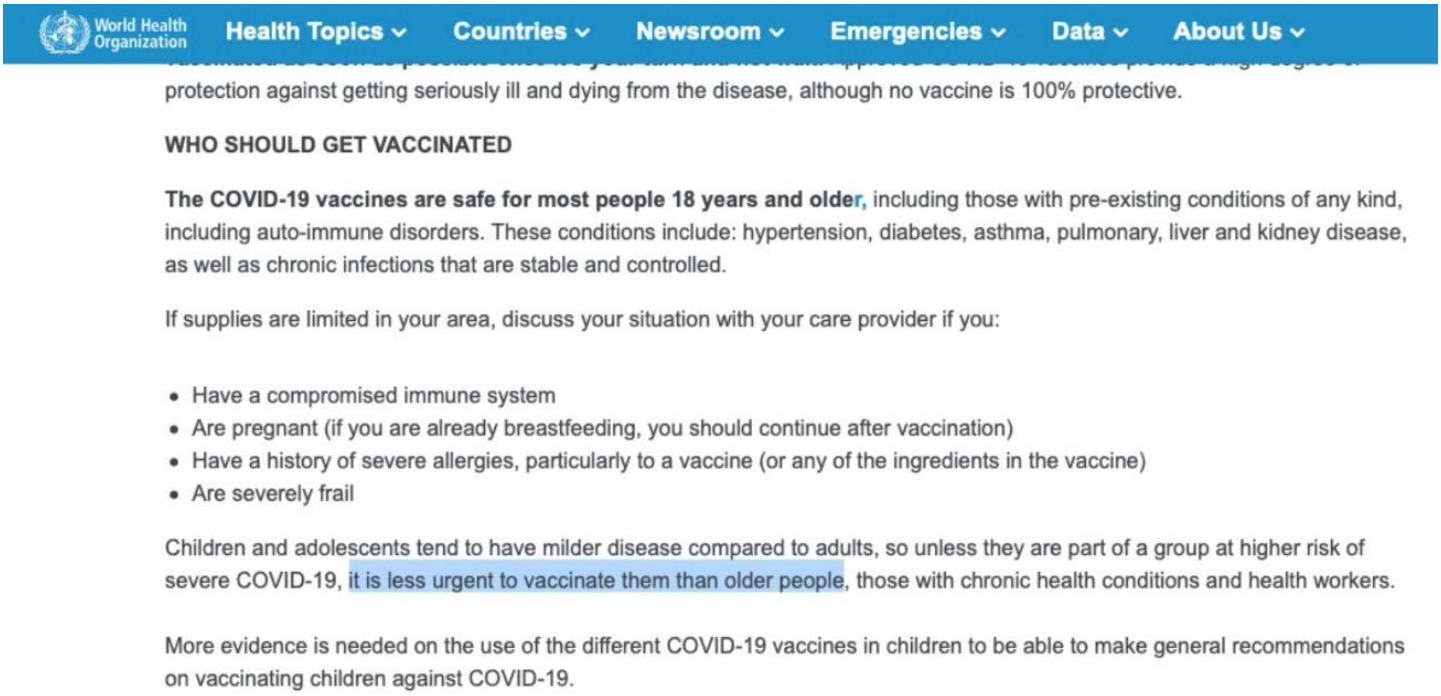
And as the lies from the WHO pile up, the next story exposes just another level of dishonesty.

WHO changes their position against vaccinating children in another embarrassing about face after external pressure

This is a post from the ***World Health Organization*** website a week ago.



Then overnight after I'm sure they were reamed out by big pharma and WHO knows who in our government this…



Not only does this once again spotlight the inconsistencies from and unreliability of WHO, but the way that they act as pawns for the people that pull their purse-strings.

One reason why children do better against SARS-CoV-2

A May 2021 study from the journal ***Science*** titled, **Shared B cell memory to coronaviruses and other pathogens varies in human age groups and tissues**, finds discovers one of the reasons children do better than adults against SARS-CoV-2.

From the abstract

Vaccination and infection promote the formation, tissue distribution, and clonal evolution of B cells, which encode humoral immune memory. We evaluated pediatric and adult blood and deceased adult organ donor tissues to determine convergent antigen-specific antibody genes of similar sequences shared between individuals. B cell memory varied for different pathogens.

Consistent with reported serology, pre-pandemic children had class-switched convergent clones to severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2-CoV-2) with weak cross-reactivity to other coronaviruses, while adult blood or tissues showed few such clones. These results highlight the prominence of early childhood B cell clonal expansions and cross-reactivity for future responses to novel pathogens.

From the study

Recent reports describe SARS-CoV-2–binding antibodies in pre-pandemic children's blood ([12,24]). Such antibodies and other physio-logical distinctions are under investigation in adults and children ([25]) and could contribute to the generally milder COVID-19 disease in children.

Adult frequencies of SARS-CoV-2 convergent clones were lower in blood and lymphoid tissues compared with

children's blood, with few CS examples…

Childhood immune responses are particularly important in an individual's life, as they form the initial memory B cell pool that shapes future responses ([29]). We find that in comparison to adults, children have higher frequencies of convergent B cell clones in their blood for pathogens they have encountered.

End of excerpts

The take-away from this study is that children's immune systems are highly trained for future infections by being exposed to numerous pathogens early in life. I believe that this will be one of the tragedies from this never before tried experiment of quarantining healthy people, isolation, sanitation and the fear mongering germophobic hysteria on our children. Their immune systems will have been inhibited from experiencing the full range of exposure that helps better protect them in the future from viral diseases. And the psychological damage will be difficult to measure but will most likely affect them for years to come.

Evidence continues to show that transmission of the SARS-CoV-2 virus is low in children and teachers after returning to in-person learning

The study released June 9th, 2021 in ***E-Clinical Medicine*** published the medical journal ***Lancet*** titled, **SARS-CoV-2 infection, antibody positivity and seroconversion rates in staff and students following full reopening of secondary schools in England: A prospective cohort study, September–December 2020** found that the rates of transmission and infection were lowest in younger children and increased in teens and young adults. This fits nicely with the last story showing that young children have a robust and versatile immune system response to many viral pathogens.

From the study

There is, however, increasing evidence that the risk of SARS-CoV-2 transmission within school premises is very low, [22–24] especially among students [19]. In North Carolina, for example, surveillance of 11 school districts with more than 90,000 students and staff attending school in-person for 9 weeks, found 773 community-acquired SARS-CoV-2 infections, while contact tracing found only 32 additional infections that were acquired within school [24]. Among 17 rural Wisconsin schools, too, COVID-19 incidence among 4,876 students and 654 staff members during August 31–November 29, 2020, was lower (3,453 cases per 100,000) than in the county overall (5,466 per 100,000) [23]. Of the 191 cases identified in students and staff members, only seven (3.7%), all among students, were linked to in-school spread [23]. In New York City, COVID-19 prevalence in public schools was similar to or less than estimates of prevalence in the community for all weeks during October 9–December 18, 2020 [25]. Additionally, of 36,423 school-based close contacts, only 191 (0.5%) subsequently tested positive for COVID-19 and the likely index case was an adult for 78.0% of secondary cases [25]. Outside the US, public health investigations found that just over half the cases in secondary school clusters in the Netherlands were acquired outside school, mainly during intensive contact with friends or classmates in their free time, and most infections were restricted to small groups of students without affecting teachers [26]. These schools received extensive public health support including contact tracing but, without regular screening of staff and students, asymptomatic infection and silent transmission with school premises could not be ruled out.

https://www.sciencedirect.com/science/article/pii/S2589537021002285

Two new studies provide more evidence of lasting immunity after infection with SARS-CoV-2

A May 26th article in the ***New York Times*** titled **Immunity to the Coronavirus May Persist for Years, Scientists Find** reinforces numerous studies from the last year that have demonstrated that immunity after infection with SARS-CoV-2 in durable and robust.

It references two studies, one titled **SARS-CoV-2 infection induces long-lived bone marrow plasma cells in humans**, published May 24th, 2021, in the journal ***Nature***.

The abstract

Long-lived bone marrow plasma cells (BMPCs) are a persistent and essential source of protective antibodies. Individuals who have recovered from COVID-19 have a substantially lower risk of reinfection with SARS-CoV-2. Nonetheless, it has been reported that levels of anti-SARS-CoV-2 serum antibodies decrease rapidly in the first few months after infection, raising concerns that long-lived BMPCs may not be generated and humoral immunity against SARS-CoV-2 may be short-lived. Here we show that in convalescent individuals who had experienced mild SARS-CoV-2 infections (*n* = 77), levels of serum anti-SARS-CoV-2 spike protein (S) antibodies declined rapidly in the first 4 months after infection and then more gradually over the following 7 months, remaining detectable at least 11 months after infection. Anti-S antibody titres correlated with the frequency of S-specific plasma cells in bone marrow aspirates from 18 individuals who had recovered from COVID-19 at 7 to 8 months after infection. S-specific BMPCs were not detected in aspirates from 11 healthy individuals with no history of SARS-CoV-2 infection. We show that S-binding BMPCs are quiescent, which suggests that they are part of a stable compartment. Consistently, circulating resting memory B cells directed against SARS-CoV-2 S were detected in the convalescent individuals. **Overall, our results indicate that mild infection with SARS-CoV-2 induces robust antigen-specific, long-lived humoral immune memory in humans.**

From the Discussion

Long-lived BMPCs provide the host with a persistent source of preformed protective antibodies and are therefore needed to maintain durable immune protection. However, the longevity of serum anti-S IgG antibodies is not the only determinant of how durable immune-mediated protection will be. Isotype-switched memory B cells can rapidly differentiate into antibody-secreting cells after re-exposure to a pathogen, offering a second line of defence34. Encouragingly, the frequency of S-binding circulating memory B cells at 7 months after infection was similar to that of B cells directed against contemporary influenza HA antigens. **Overall, our data provide strong evidence that SARS-CoV-2 infection in humans robustly establishes the two arms of humoral immune memory: long-lived BMPCs and memory B cells.** These findings provide an immunogenicity benchmark for SARS-CoV-2 vaccines and a foundation for assessing the durability of primary humoral immune responses that are induced in humans after viral infections.

The second study is titled, **Vaccination boosts naturally enhanced neutralizing breadth to SARS-CoV-2 one year after infection.** While as the title indicates, part of what the researchers were looking for is what vaccination would do to further boost antibody levels. While it did boost them (and that is no revelation because it is predictable and been shown previously), the exciting part to me is the following information they discovered about people that have had the SARS-CoV-2 infection and no vaccination.

From the study

Here we report on a cohort of 63 COVID-19-convalescent individuals assessed at 1.3, 6.2 and 12 months after infection, 41% of whom also received mRNA vaccines3,4. In the absence of vaccination antibody reactivity to the receptor binding domain (RBD) of SARS-CoV-2, neutralizing activity and the number of RBD-specific memory B cells remain relatively stable from 6 to 12 months.

Consistent with the longevity of bone marrow plasma cells, infection with SARS-CoV-2 leads to persistent serum anti-RBD antibodies, and corresponding neutralizing responses. Nearly 93% of the plasma neutralizing activity is retained between 6- and 12-months[30,31].

However, neutralizing breadth increased between 1.3 and 12-months for all 15 pairs, even when neutralizing activity against the wild-type was unchanged or decreased (Fig. 5c and Supplementary Table 8). Only 1 of the 15 antibodies obtained after 1.3 months neutralized all the mutants tested (Fig. 5c). In contrast, 10 of the 15 antibodies obtained from the same clones after 12 months neutralized all variants tested with IC50s as low as 1 ng/ml against the triple mutant K417N/E484K/N501Y found in B.1.351 (Fig. 5c and Supplementary Table 8).

In conclusion, continued clonal evolution of anti-SARS-CoV-2 antibodies over 12 months favors increasing potency and breadth resulting in monoclonal antibodies with exceptional activity against a broad group of variants.

From the New York Times article

Important immune cells survive in the bone marrow of people who were infected with the virus or were inoculated against it, new research suggests. Immunity to the coronavirus lasts at least a year, possibly a lifetime, improving over time especially after vaccination, according to two new studies. The findings may help put to rest lingering fears that protection against the virus will be short-lived.

The studies may soothe fears that immunity to the virus is transient, as is the case with coronaviruses that cause common colds. But those viruses change significantly every few years, Dr. Hensley said. “The reason we get infected with common coronaviruses repetitively throughout life might have much more to do with variation of these viruses rather than immunity,” he said.

Upon first encountering a virus, B cells rapidly proliferate and produce antibodies in large amounts. Once the acute infection is resolved, a small number of the cells take up residence in the bone marrow, steadily pumping out modest levels of antibodies.

To look at memory B cells specific to the new coronavirus, researchers led by Ali Ellebedy of Washington University in St. Louis analyzed blood from 77 people at three-month intervals, starting about a month after their infection with the coronavirus. Only six of the 77 had been hospitalized for Covid-19; the rest had mild symptoms.

Antibody levels in these individuals dropped rapidly four months after infection and continued to decline slowly for months afterward — results that are in line with those from other studies.
Some scientists have interpreted this decrease as a sign of waning immunity, but it is exactly what’s expected, other experts said. If blood contained high quantities of antibodies to every pathogen the body had ever encountered, it would quickly transform into a thick sludge.

Instead, blood levels of antibodies fall sharply following acute infection, while memory B cells remain quiescent in the bone marrow, ready to take action when needed.

Five of the participants in Dr. Ellebedy's study donated bone marrow samples seven or eight months after they were initially infected and again four months later. He and his colleagues found that the number of memory B cells remained stable over that time.

The results are particularly noteworthy because it is difficult to get bone marrow samples, said Jennifer Gommerman, an immunologist at the University of Toronto who was not involved in the work.
A landmark study in 2007 showed that antibodies in theory could survive decades, perhaps even well beyond the average life span, hinting at the long-term presence of memory B cells. But the new study offered a rare proof of their existence, Dr. Gommerman said.

Dr. Nussenzweig's team looked at how memory B cells mature over time. The researchers analyzed blood from 63 people who had recovered from Covid-19 about a year earlier. The vast majority of the participants had mild symptoms, and 26 had also received at least one dose of either the Moderna or the Pfizer-BioNTech vaccine.

So-called neutralizing antibodies, needed to prevent reinfection with the virus, remained unchanged between six and 12 months, while related but less important antibodies slowly disappeared, the team found.
As memory B cells continued to evolve, the antibodies they produced developed the ability to neutralize an even broader group of variants. This ongoing maturation may result from a small piece of the virus that is sequestered by the immune system — for target practice, so to speak.

"It kind of looks exactly like what we would hope a good memory B cell response would look like," said Marion Pepper, an immunologist at the University of Washington in Seattle who was not involved in the new research.

End of excerpts

https://www.nytimes.com/2021/05/26/health/coronavirus-immunity-vaccines.html

A study looking at two dozen other studies examining cross-reactivity to other coronavirus infections that provide protection against SARS-CoV-2

This study is a little more technical in nature and terminology.

Pre-existing reactivity and cross-reactivity with common cold corona and other viruses
Several studies have detected responses to SARS-CoV-2 sequences in unexposed controls (Sette and Crotty, 2020b, Sette and Crotty, 2021). In some cases, these responses might correspond to infections associated with a lack of antibodies or to a transient antibody response (Sekine et al., 2020, Nelde et al., 2021). However, in other cases, these responses appear to be linked to preexisting memory responses, which, in some instances, have been mapped to the cross-reactive recognition of the SARS-CoV-2 sequences by T cells induced by endemic "common cold" coronaviruses (17) and potentially other viral species (Bacher et al., 2020, Le Bert et al., 2020b). This phenomenon has received considerable attention because of its potential to influence disease severity, vaccination outcomes, and because of its potential implications for herd

immunity (Bacher et al., 2020, Sette and Crotty, 2020b, Sette and Crotty, 2021, Lipsitch et al., 2020, Sagar et al., 2021a).

Epitopes recognized in non-exposed individuals have been defined in 12 studies. In some cases, these SARS-CoV-2 epitopes had significant homology to common cold coronavirus sequences, with cross-reactivity demonstrated at the molecular level in several instances (Mateus et al., 2020). Other studies, as discussed in more detail below, have examined whether SARSCoV- 2 specific T cells might cross-react with other more closely related viruses, such as SARSCoV- 1 and the Middle East Respiratory Syndrome virus (MERS) (see also below). This issue is of relevance in the context of developing vaccines that can elicit T cell responses that broadly recognize coronaviruses of pandemic potential.

The topic of pre-existing immune responses and cross-reactivity with common cold coronaviruses was addressed by several studies that reported a range of findings. Schulien et al. detected cross-reactive T cells in longitudinal samples pre-and-post SARS-CoV-2 infection, and reported that these cells were expanded post in vitro restimulation (Schulien et al., 2021). Sekine et al. also detected widespread reactivity in non-exposed individuals using peptide pools (Sekine et al., 2020). Shomuradova et al. detected pre-existing T cell reactivity in unexposed donors using HLA-A2 tetramers, but at much lower levels compared to those seen in exposed individuals (Shomuradova et al., 2020). Nelde et al. tested the reactivity of non-exposed donors to epitopes identified in exposed individuals, and detected reactivity, albeit at lower levels, for several epitopes (Nelde et al., 2021). Keller et al. detected T cells with minimal cross reactivity with two homologous nucleocapsid peptides from NL63 and OC43 (Keller et al., 2020). Ferretti detected reactivity to OC43 and HKU1 sequences for 2 of 29 dominant epitopes, and no reactivity for NL63 and 229E (Ferretti et al., 2020). Rha et al. reported that the SARS-CoV-2 S 269-277 and S 1220-1228 epitopes had low homology to OC43, HKU1, 229E, and NL63, and that MHC class I multimer+ cells were not detected in unexposed subjects (Rha et al., 2021). Prakash identified 24 epitopes, and of those, 11 recalled memory CD8+ T cells from unexposed healthy individuals (Prakash et al., 2020).

A potential explanation for the differences observed in the degree of cross-reactivity of epitope repertoires detected in infected and unexposed subjects is provided by the studies of Mateus et al. (Mateus et al., 2020) and Tarke et al (Tarke et al., 2021a). These studies demonstrated that, overall, 50% of the epitopes defined in unexposed donors were also recognized in SARS-CoV-2-infected subjects (Mateus et al., 2020, Tarke et al., 2021a), but also that the viral infection created a new repertoire of epitopes recognized only in infected subjects. Conversely, over 80% of the epitopes defined in SARS-CoV-2-infected subjects were not recognized in unexposed donors. This suggests that a pre-existing repertoire of cross-reactive T cells is present in unexposed donors, but that the SARS-CoV-2 infection generates a largely novel repertoire of T cells, in addition to the pre-existing one. Consistent with this view, the antigens dominantly recognized in exposed donors tend to only partially overlap with those dominant in non-exposed donors (Le Bert et al., 2020b).

The issue of how preexisting memory reactivity might influence immunity has been debated, and a firm conclusion has not been reached as yet (Lipsitch et al., 2020, Sette and Crotty, 2020a, Sette and Crotty, 2020b). While it is not expected that preexisting T cell reactivity might protect against infection, it is possible that preexisting SARS-CoV-2 cross-reactive T cells might modulate disease severity, as reported by a recent study (Sagar et al., 2021b), or might even modulate vaccine responsiveness, allowing for a faster or more vigorous response.

The study of protective versus detrimental T cell responses is important for determining the optimal T cell engagement strategies for vaccines. In addition to understanding the relationship between pre-existing immunity to human coronaviruses and host defense against SARS-CoV-2, it is relevant to also consider the contribution of COVID-19 vaccine-boosted cross-reactive immune responses to vaccine-induced protective

immunity.

Infection with other viruses may have a neutralizing effect against SARS-CoV-2. Did public lockdown measures aid in the spread of SARS-CoV-2 and thus COVID-19 disease?

A June 15th, 2021 study from the ***Journal of Experimental Medicine*** titled, **Dynamic innate immune response determines susceptibility to SARS-CoV-2 infection and early replication kinetics**, finds that other infections such as Rhinovirus (one of the viruses that cause the common cold), prior to being infected by SARS-CoV-2 has a protective effect against SARS-CoV-2 replication in its early stages. This would have profound effect on the ability of the virus to outpace the immune system during its early replication process. It would also make it more difficult for the person to transmit the virus on to others because the viral load would be significantly reduced.

From the study- (Bold emphasis mine)

However, our experiments showed that prior RV infection protected against replication of SARS-CoV-2, that this protection was dependent upon ISG induction ***(ISG stands for Interferon Stimulated Genes, which activate the release of Interferon a powerful tool for activating immune response and reducing infection),*** and that a significant bystander IFN response was detected in cells throughout the epithelium for at least 5 d after RV infection, even after the RV itself was largely cleared (Figs. 5, 6, and S4). These results indicate that the protective effect of heterologous ISG induction throughout the epithelium by RV predominated over other effects, potently suppressing SARS-CoV-2 replication.

While host–pathogen interactions are often studied one at a time in experimental models, in the human upper respiratory tract, **exposure to multiple microbes simultaneously or in series is a frequent occurrence and likely an important influence on innate immunity.** The idea that viral interference could be shaping broad patterns of respiratory virus transmission has only recently begun to gain traction, in part due to epidemiological data suggesting interference among RNA respiratory viruses (Isaacs and Lindenmann, 1957; Greer et al., 2009; Linde et al., 2009; Casalegno et al., 2010; °Anestad and Nordbø, 2011; Schultz-Cherry, 2015; Karppinen et al., 2016; Nickbakhsh et al., 2019; Wu et al., 2020).

Heterologous ISG induction could be particularly important for host defense against a virus like SARS-CoV-2, since it would preempt mechanisms SARS-CoV-2 has in place to antagonize and delay IFN and ISG induction in response to its own replication.

The SARS-CoV-2 pandemic and the public health response have disrupted the status quo in many ways, including dramatically reducing the circulation of common respiratory viruses (Olsen et al., 2020; Jones, 2020; Cowling et al., 2020; Yeoh et al., 2020; Sullivan et al., 2020; Centers for Disease Control and Prevention, 2021b). **This change has led to speculation that diminished population adaptive immunity will lead to a surge of infections when these viruses again recirculate**, and thus far, early data from school reopenings indicate a likely robust resurgence of RV (Baker et al., 2020; Fong et al., 2021; Poole et al., 2020). Our findings suggest that heterologous innate immune responses could be a mitigating factor, since the model predicts an upper limit in the extent to which IFN-sensitive viruses can simultaneously or sequentially infect the same host (see model, Fig. 7 A). **This would also potentially slow viral transmission in the population by reducing the number of susceptible hosts at any given time** (Fig. 7 B). Importantly, we are proposing this model based on our data to highlight the importance of considering viral interference in epidemiological patterns that may emerge in the coming year, but we are not arguing that potential effects of heterologous innate immunity outweigh the proven benefits of public health measures for directly preventing SARS-CoV-2 transmission.

My comment: While it may have not been in the purview of this paper to argue that, I certainly would and could make a very good case for it.

Due to the nature of exponential growth, even a small change in the replication rate, as we observed with inhibition of ISG induction during low-MOI infection (Fig. 6, E–H), could have a profound impact on peak viral load. For example, if conditions allowed the viral doubling time to decrease by 2 h from 6 h to 4 h, **this would lead to a 64-fold greater NP viral load after 72 h. NP viral load has been shown to correlate with viral transmission, an issue that has come into focus recently due to the emergence of SARS-CoV-2 variants with enhanced transmission** (Cevik et al., 2021; He et al., 2020; Singanayagam et al., 2020; Centers for Disease Control and Prevention, 2021a). Our results suggest that viral mutations that enhance IFN/ISG antagonism would enable a faster doubling time and compel studying at this aspect of the biology as a possible mechanism for increased transmissibility in emerging viral variants.

In sum, our results demonstrate an important role for IFN mediated defenses in curtailing SARS-CoV-2 replication at the start of infection, including heterologous innate immune responses induced by prior RV infection. These results, and our findings in longitudinal patient samples, support the concept that airway innate immunity is dynamic, with innate immune defense rapidly changing in response to current and recent viral infections. Our findings also demonstrate that ISG-mediated defenses can profoundly curtail SARS-CoV-2 replication under certain conditions and compel further studies of the role of heterologous innate immunity in protecting against SARS-CoV-2 and other respiratory viruses.

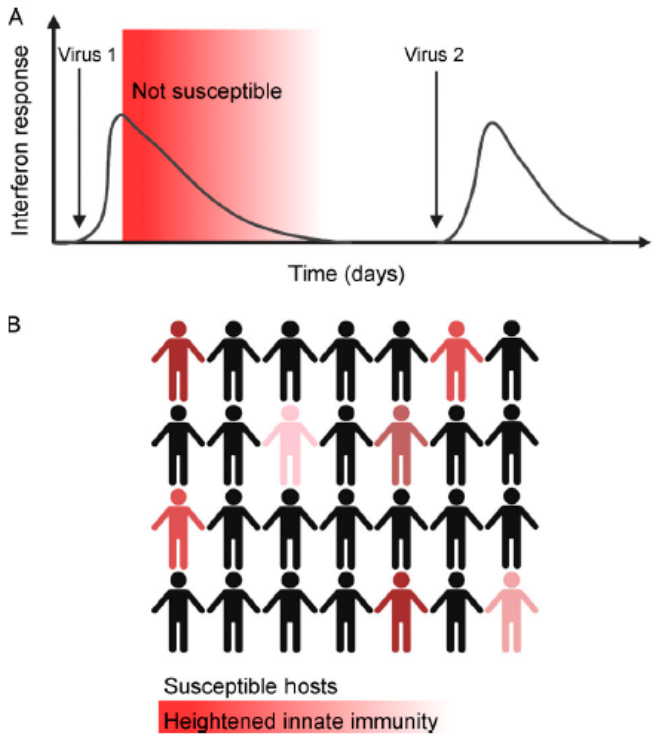


Figure 7. **Model.** Heterologous innate immunity creates a subset of individuals refractory to infection during periods of high respiratory virus circulation. **(A)** Virus 1 induces a mucosal IFN response, which creates a refractory period following infection during which ISGs are elevated and the host is protected from a second viral infection (red shading). After ISGs return to baseline, the host is again susceptible and can be infected with virus 2. **(B)** During periods of high respiratory virus circulation, a fraction of the population is refractory to infection at any given time due to ISG activation from a recent infection (red shaded figures). Thus, heterologous innate immune protection could mitigate against viral transmission at times of high respiratory virus circulation. Figure created with BioRender.com.

End of excerpts

By reducing the number of susceptible hosts (as can be seen in the diagram above), it will slow the spread of infection in the community. This is just another powerful example of how the unprecedented draconian measures implemented to quarantine healthy people by locking down businesses, closing schools and encouraging stay at home orders once again had another negative effect on the outcome of the spread of the virus. This most certainly has contributed to the stresses we saw on our health care system, including severe cases and deaths.

Not a shred of doubt: Sweden was right

Thank God for Sweden- The one country that did not conform

The world's control group for the COVID-19 pandemic. For those new to my newsletter and haven't been following it, Sweden is the one country in the world that did things differently. They never locked down. They never required or even suggested their citizens wear face masks. They never closed restaurants, bars, gyms, schools or other businesses. Their economy has flourished. Their people are not suffering from higher than usual percentages of mental health issues, alcohol and drug use, suicide, domestic violence and other collateral damage. They have avoided deaths of despair that countries using lockdowns and business closures are experiencing. They have essentially asked their citizens to social distance whenever possible and follow good hygiene practices. They have provided us with the much-needed contrast to compare to what virtually every other country did. If what they did continues to work as it has so far, it provides a template for the next "novel" outbreak, if God forbid there ever is a next time.

They made the same mistakes as virtually every other country by not doing enough to protect their elderly in nursing homes and long-term care facilities. That is where a large percentage of their deaths came from early on and you can see that represented by the peak in April deaths on the graph on the previous page. But other than that, it has pretty much been the textbook playbook that the authors of ***The Great Barrington Declaration*** (https://gbdeclaration.org) are pushing for (more about that later). Obviously, they have and are continuing to do something right. This is exactly why I wish we would get the myopic focus off of cases and look at hospitalizations, ICU capacity and deaths. Why should we really care how many cases there are if they aren't causing severe disease, hospitalizations or deaths? This is especially true when according to many top experts, the majority of "cases" (positive PCR) do not even have the clinical disease we call COVID-19. Not to mention that the majority of PCR positive "cases" are not infectious and are unable to transmit an infection to other people.

This excellent short article is presented in its entirety. It reinforces what I have been saying since May 2020. Sweden's approach was scientifically based, followed previous pandemic protocols, was common sense, preserved their economic and social fabric of their society and was going to prove to be the right approach. Even Anders Tegnell, Sweden's Chief Epidemiologist and architect of their approach to COVID-19 was cautious about acknowledging their successes throughout the last 17 months. In an interview in June 2020, he suggested that it may be about another year before the results should be evaluated. Well, here we are. And this article does a nice job of showing the data that shows their tremendous success.

The article is titled, **Not a shred of doubt: Sweden was right**

May 27th, 2021

Counting the deal used to be the work of epidemiologists, statisticians and demographers. So was analyzing the numbers and drawing conclusions. In the past year many are counting deaths, but the numbers have no meaning without the context of a relevant time period, population and history. That is, epidemiology.
The most counted country is probably Sweden, a stubborn dissenter that refused lockdowns, mask mandates and contact tracing. By the time of this writing, 14,349 Swedes have reportedly died from the coronavirus. Has the Swedish model failed? Were the lockdowns justified? Were the economic and social upheavals in most of the world an unavoidable necessity?

The answer to all is a resounding no. The first (and not the only) witness: Sweden. To understand the testimony, we need to learn only two concepts: "flu year" and "excess mortality".

"Flu year" versus calendar year

Many calculate mortality statistics according to the Gregorian calendar, but December 31st is not a meaningful end date for winter mortality in the northern hemisphere. The flu wave and the associated wave of mortality reach the peak at various dates, and sometimes secondary waves appear. Furthermore, the use of the Gregorian calendar combines the mortality in the first part of one winter (sometimes mild) with mortality in the second part of the previous winter (sometimes severe). There is no scientific justification for this grouping when analyzing historical trends.

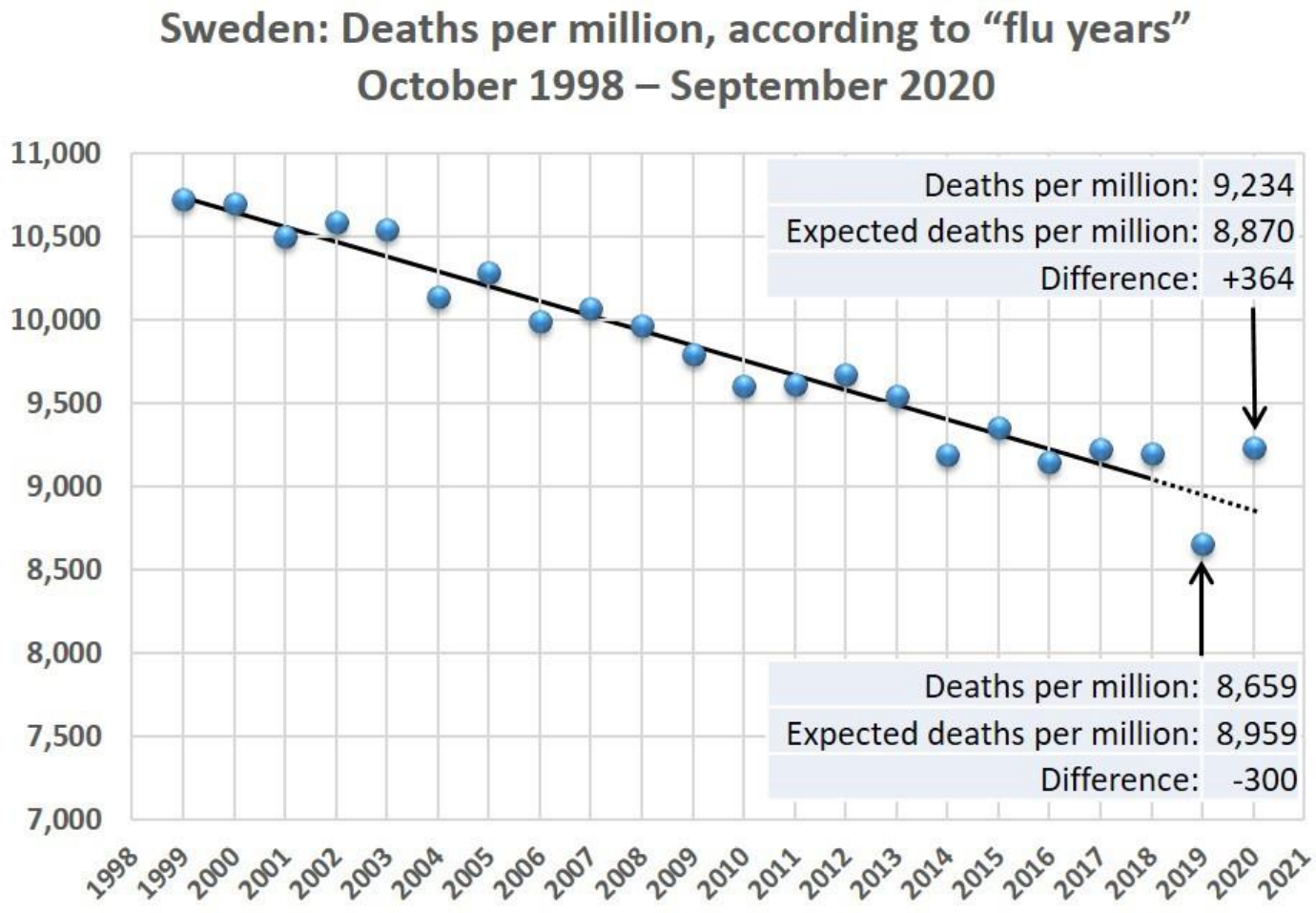
The statistical alternative, which may be called "flu year", contains a full winter season. Annual mortality is calculated from the beginning of the flu season, which is usually counted from week 40 (early October), till week 39 in the following year (end of September). Thus, the coronavirus waves in the spring and summer of 2020 belong to the 2019–2020 flu year, whereas the last winter wave belongs to the current flu year which will end in September.

Excess mortality

The concept of "excess mortality" is a little abstract. We need to compare actual mortality with "expected mortality", but the latter is a theoretical idea that cannot be verified: what would the mortality in the 2019–2020 flu year have been, had there not been a pandemic? How do we calculate "expected mortality"?
One method uses a statistical model called linear regression. We fit a line to the mortality data from previous years, check its past performance, and use the continuation of the line to compute expected mortality. The distance between a data point of actual mortality and expected mortality on the line is excess mortality (or "mortality deficit").

Mortality in Sweden by flu year

The graph shows the annual mortality in Sweden per million people in the last 22 flu years, where each flu year is labeled according to the calendar year in which it ends. For example, the last data point on the graph is mortality between October 2019 and September 2020: 9,234 per million people (95,365 deaths). To magnify, the vertical axis starts at 7,000.



Source: SCB.SE

It is easy to see that the points are located close to a straight line, until the flu year that ended in September 2018. The general downward trend reflects a consistent increase in life expectancy in Sweden for many years. Experienced data analysts will attest that the fluctuations around the line are generally small and expected until 2018 (explained variation: 0.96). In contrast, both the flu year that preceded the pandemic (2018–2019) and the pandemic year (2019–2020) substantially deviate from the line: the former — in lower than expected mortality, and the latter — in higher than expected mortality.

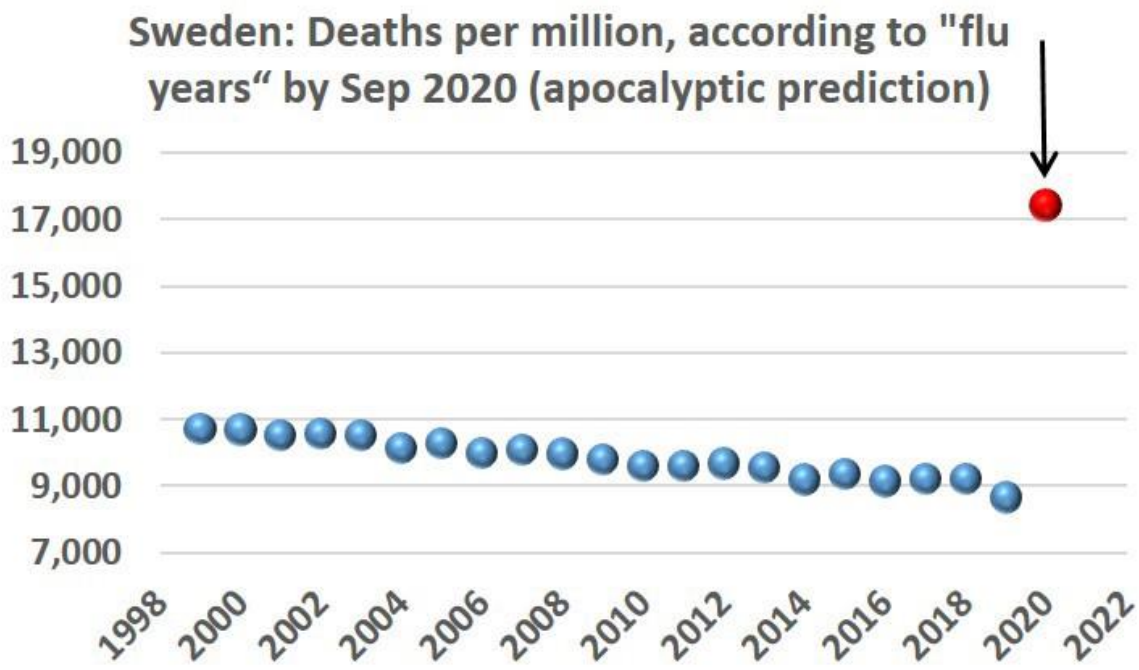
Excess mortality in Sweden in flu year 2019–2020

Continuation of the line, which was fit by the statistical model, yields the following estimates: In 2018–2019 there was "mortality deficit" in Sweden of 300 per million people (-3.3%) whereas in 2019–2020, the pandemic year, there was excess mortality of 364 per million people (+4.1%). Excess mortality following mortality deficit, and vice versa, are well known and expected, as the main source of mortality is an elderly population with limited life expectancy. (The sequence "excess after deficit" is, of course, better than the reverse order.)

Assuming the excess mortality in 2019–2020 "fully balanced" the mortality deficit in the previous flu year, the true excess mortality in Sweden was less than 1% (about 700 deaths). And if we assume, absurdly, that the mortality in 2019–2020 was not affected at all by the mortality deficit in the previous flu year, then the excess mortality in Sweden did not exceed 4.1% (about 3,800 deaths). Excess mortality of a few percentage points, or more, has been calculated in many countries where life has been severely disrupted. Part of that excess has

been attributed to lockdown and panic.

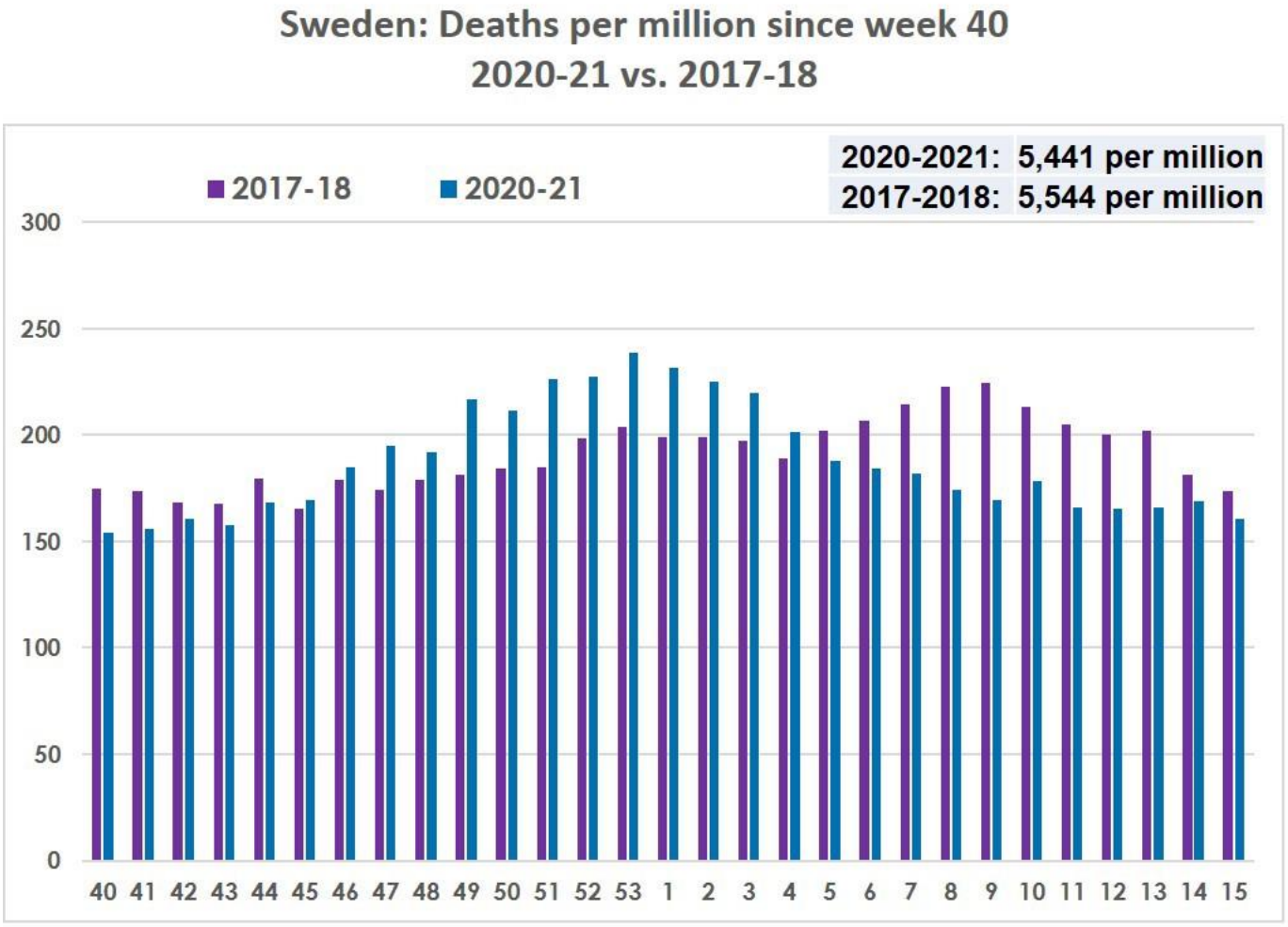
To remind us, the hysterical response to the pandemic was not due to fear of an excess annual mortality of 4% or even 10%. The apocalyptic forecasts, which caused the world to shut down, predicted about 90,000 deaths from the coronavirus in Sweden by the summer of 2020: 100% excess mortality! No wonder policy makers around the world prefer to forget those predictions.



Mortality in Sweden in the current flu year

The final summary of the current flu year (October 2020 — September 2021) will be known in the fall, but the data accumulated more than halfway through allow for interim conclusions. As many know, the coronavirus replaced the flu viruses this year, and there was no flu in Sweden, either. Nor were there apocalyptic predictions; only warnings about the number of accumulated deaths.

I chose to compare the mortality in Sweden in the current flu year (week 40, 2020 till week 15, 2021) to the corresponding mortality in 2017–2018. Two reasons for this choice: First, Europe experienced a severe flu season in that winter, which makes it an appropriate comparison. Second, although the flu season was severe in Sweden compared to previous years, it was still substantially milder than in Europe as a whole.
The graph shows a low mortality wave at the end of 2017 and a noticeable wave in February-March 2018 (another example of why a December 31st cutoff might distort historical trends). This winter, the mortality wave coincided with the coronavirus wave and its peak in late December. (In 2020 there were 53 weeks, so the dates do not exactly match.) A secondary coronavirus wave, which appeared in mid-February, half way through the decline of the former, did not result in a secondary mortality wave.



Source: socialstyrelsen.se (National Board of Health and Welfare)
Updated, May 19

The all-cause death toll in Sweden in the first 29 weeks of the current flu year is 56,452 (5,441 per million people) compared to 55,967 (5,544 per million people) in the same period in 2017–2018. In that winter, the excess mortality rate in Europe attributed to the flu was at least twice as high as in Sweden.
Sweden proved right in the retest.

A colossal mistake

The pandemic has taken its death toll, ranging from large to small in different countries and within countries, and mostly affected the frail elderly. But the lockdowns and panic were unsubstantiated, prevented nothing, and caused indescribable damage to society. Sweden's statistics tell us, unequivocally, that in much of the world lives have been lost and livelihoods have been destroyed — in vain.
Will anyone, in any country, be held accountable?

https://shahar-26393.medium.com/not-a-shred-of-doubt-sweden-was-right-32e6dab1f47a

Professor John Ioannidis from Stanford's great presentation summarizing what we now know about the lethality of the virus and the effects of the failed and damaging public health measures that were employed

Dr. John Ioannidis is arguably the top epidemiologist in the world. He is also a Professor of Medicine and Public Health at Stanford. And he delivers what I would consider one of the best presentations showing the data and the evidence surrounding the COVID-19 fiasco.

This is the edited version (approx. 30 minutes). Thanks to Ivor Cummins, AKA The Fat Emperor for doing that time consuming work. Watch it while it's still up. https://www.youtube.com/watch?v=e4grP1718Ps

This is the full 1 hour 45-minute version. https://www.youtube.com/watch?v=B_ehqHQOBO0&t=0s

Legal updates-

The Informed Consent Action Network

ICAN RECEIVES NEARLY 3,000 FAUCI EMAILS - READ WHAT FAUCI WAS SAYING AS THE COVID-19 PANDEMIC BEGAN!

Last year, ICAN made FOIA requests to NIH for documents regarding COVID-19, including two requests for Anthony Fauci's emails. ICAN has received nearly 3,000 emails sent by Fauci from early February 2020 through May 2020. Read what Fauci was saying privately about masks, therapeutics, vaccines, ventilators, and many other COVID-19 topics.

On April 10, 2020 and May 5, 2020, respectively, ICAN submitted the following two FOIA requests:

· All emails sent by Anthony Fauci between November 1, 2019 and the present that include the term Moderna or mRNA-1273 in any portion of the email.

· All emails sent by Anthony Fauci between November 1, 2019 and the present that include the terms SARS-CoV, COVID, COVID-19, or coronavirus in any portion of the email.

When NIH failed to respond to those requests, ICAN brought a lawsuit against the agency on June 29, 2020. In response, NIH agreed to produce Fauci's emails on a rolling basis. To date, we have received 2,957 pages of Fauci's sent emails dated between early February 2020 through May 2020 and will continue to receive email productions on a rolling basis.

Read Fauci's emails here and a few highlights from these emails are outlined below:

- February 5-6, 2020 (000239) – Fauci asked to recommend names for WHO group with the broad mission to "look at the origins and evolution of 2019n-CoV." Fauci responds by seeking to reframe the mission in a manner that would only look for natural and not lab made origin.

- February 7, 2020 (000189) - Fauci sent an internal NIAID communication reflecting that it was unlikely that the SARS-CoV-2 virus originated in a wet market.

- February 16, 2020 (000447) – Fauci tells CBS reporter that if the mortality turns out to be 0.2% to 0.4%, then SARS-CoV-2 should be treated like a severe seasonal flu. But when the case fatality rate was later revised to between 0.2% and 0.4% by the CDC, Fauci continued to act as if the virus was something far more dangerous.

- February 17, 2020 (000422) – Fauci receives communication from a Chinese citizen that is part of an international student program in the United States stating that, based on his contacts back in Wuhan, including correspondence from a nurse working in a Wuhan hospital, there is far more spread of the virus and far more deaths than China is admitting.

- February 21, 2020 (000300) – Fauci asks a Deputy Director at NIAID to "Please handle" an email received by a group of doctors and scientists, including a virologist, that opined that "we think there is a possibility that the virus was released from a lab in wuhan (sic)."

- February 23, 2020 (000257) – Fauci states "Transmission is definitely by respiratory droplet" and that "Children have very low rate of infection."

- February 22, 2020 (000274-277) – Fauci confirms that "The vast majority of people outside of China do not need to wear a mask. A mask is more appropriate for someone who is infected than for people trying to protect against infection."

- February 27, 2020 (000649) – Fauci tells Morgan Fairchild to tell her followers to be ready for "social distancing, teleworking, temporary closure of schools, etc."

- February 28, 2020 (001054) – Fauci, while uncertain what animal may have served as the intermediary jump from bats to humans for SARS-CoV-2, keeps repeating the narrative that it was a jump from bats through some natural non-lab means that was the origin of the virus.

- February 28, 2020 (001059) – Fauci giving personal update to Mark Zuckerberg regarding developing a COVID-19 vaccine including telling Zuckerberg that "We may need help with resources" and that if there is a delay in the development timeline he just told Zuckerberg about, "I will contact you."

- March 1, 2020 (000922) – CBS's Chief Medical Correspondent, seeking to please Fauci, emails Fauci a link to his segment which he appears to repeat what Fauci has told him, including that face masks "may give some partial protection by catching droplets containing virus but the virus is so tiny the virus can go right through it or around it" and describing the origin of the virus as "jumping from animals to people." Fauci responds with "Outstanding!!" apparently pleased that CBS pushed Fauci's narrative that the virus was a natural jump from bats to humans.

- March 1, 2020 (000937) – Despite media reports, Fauci makes it crystal clear he was not being muzzled by the White House.

- March 16, 2020 (001554) – Fauci is asked "Given the relative safety of all but the elderly and those whose immune systems are compromised, and that they are far fewer than the rest of the population,

why not quarantine only them?" and responds by stating "Stay tuned."

- March 17, 2020 (001537) – The next day, it does not appear Fauci intends to change his tune of pushing everyone, even healthy people with low risk of the virus, to give up all civil liberties and remain prisoners in their home, as reflecting in an email exchange between Fauci and Mark Zuckerberg, in which they share mobile numbers and plan to coordinate efforts to get people to comply with Fauci's messaging, including social distancing for everyone, but the details of their plan are not included in the email exchange.
- March 31, 2020 (001816) – Fauci receives a summary from his agency of the studies regarding how effective masks are to preventing the virus and the conclusion is as follows: "Bottom line: generally there were not differences in ILI/URI/or flu rates when masks were used."

- April 2, 2020 (001778) – Fauci and Bill Gates have phone call where they agreed to a "collaborative" and "synergistic approach to COVID-19 on the part of NIAID/NIH, BARDS and the BMGF (Bill and Melinda Gates Foundation)." It is concerning that one private person, Bill Gates, and his organization, BMGF, can exert that much behind-the-scenes influence on decisions that will impact the civil rights of all Americans during the pandemic.

- April 8, 2020 (002351-2352) – Fauci, rejects most requests for calls, but accepts without any questions a request to arrange a call with the CEO of a Lilly, a major pharmaceutical company.

- April 11, 2020 (002263-2264) – While Fauci claimed to have little time for anything else, Fauci confirmed the continued filming of "a film that will celebrate the importance of your [Fauci's] life, science and public health" including filming during his "drive to NIH … once or twice a week," "capture your working/appropriate conversations," and "work on the Task Force."

- April 12, 2020 (002229) – Fauci writes "Many tests that have been used thus far are not accurate and ARE MISLEADING."

- April 16, 2020 (002142) – Fauci advises that even in the health care setting the mask policy should remain "voluntary."

- April 20, 2020 (002548-2549) – A Washington Post reporter contacts Katie Miller at NIAID for copies of article that Fauci stated are proof that the virus originated by natural means rather than being developed in a lab. Instead of letting Katie Miller or someone on his staff respond, Fauci, who stated he gets 1,000 or 2,000 emails per day and only has time to respond to a tiny number of these emails, personally responds to the Washington Post reporter (who did not even write to Fauci) with the copies of the studies.

- April 22, 2020 (002471-2472) – The National Academy of Science representative confirming to Dr. Francis Collins, head of NIH, that "WHO, Gates Foundation and European Commission have been leading and planning" the "global coordinating effort to accelerate vaccines, diagnostics and therapeutics" and that "there will be an announcement on the global structure with will [sic] involve Gates, WHO etc." and Fauci explains in an email that "we have Gates reps on our ACTIV (Accelerating COVID-19 Therapeutic Interventions and Vaccines) working groups." Why is an unelected individual with his own private interests getting this incredible level of influence over decisions that will affect the freedoms and liberties of everyday Americans?

- April 27, 2020 (002910) – Fauci appears to dismiss potential live saving treatment. Fauci receives a report from the Chief, Section of Viral Pathogenesis at NIAID, Dr. Paolo Lussa, that "they treated a first group of five patients with potent anti-aggregant therapy (Tirofiban/Aggrastat) and apparently in all of them the p02 started to rise within less than 2 hours, they got off the ventilator and went on to full recovery." In response to this incredible news, Fauci merely writes "Thanks, Paolo." Apart from pushing Remdesivir, made by Gilead, a company with which Fauci has deep and long-standing connections, Fauci's response to Dr. Lussa accords with his otherwise singular focus on developing and pushing a vaccine.

- May 1, 2020 (002838) – While pushing one narrative regarding ventilators publicly, Fauci writes in a private email that "You are correct in that there is a more recent tendency to use ventilators only as a very last resort since oxygenation rather than ventilation appears to be key to recovery."

ICAN DEMANDS THE FDA REQUIRE ADDITIONAL DATA BEFORE GRANTING APPROVAL OF A COVID-19 VACCINE

ICAN's most recently filed Citizen Petition to the FDA is, perhaps, the most important one filed to-date. Approaching what appears to be the imminent licensure of Pfizer's COVID-19 vaccine, ICAN's legal team submitted a Citizen Petition demanding essential and specific data be required by the FDA before it licenses a vaccine for COVID-19. These requested data are vital to ensuring both safety and efficacy of the vaccine before any approval by the FDA.

Despite valid safety and efficacy concerns, COVID-19 vaccines have been and likely will continue to be mandated indiscriminately for groups that, for different reasons, have essentially zero or close to zero risk of serious complications from COVID-19.

Because of the compelling need to ensure the safety and efficacy of any COVID-19 vaccine approved by the FDA, including whether or not the risks do not outweigh the benefits, particularly in certain age categories, and in the face of such indiscriminate mandates, ICAN has requested that the FDA require that the following data be submitted to the FDA for review before approving any vaccine for COVID-19:

Documentation of adverse events and reactions for at least twenty-four months forvadults, thirty-six months for children and sixty months for infants and toddlers, or such longer duration as appropriate, and in no event ending prior to the subject reaching eight years of age;

1. Data demonstrating that safety risks do not outweigh potential benefits for any age for which the vaccine is approved;

2. Data reflecting that the vaccine does not cause DNA integration and germline transmission;

3. Data on the safety and efficacy of the vaccine in individuals who currently have or have had a SARS-CoV-2 infection;

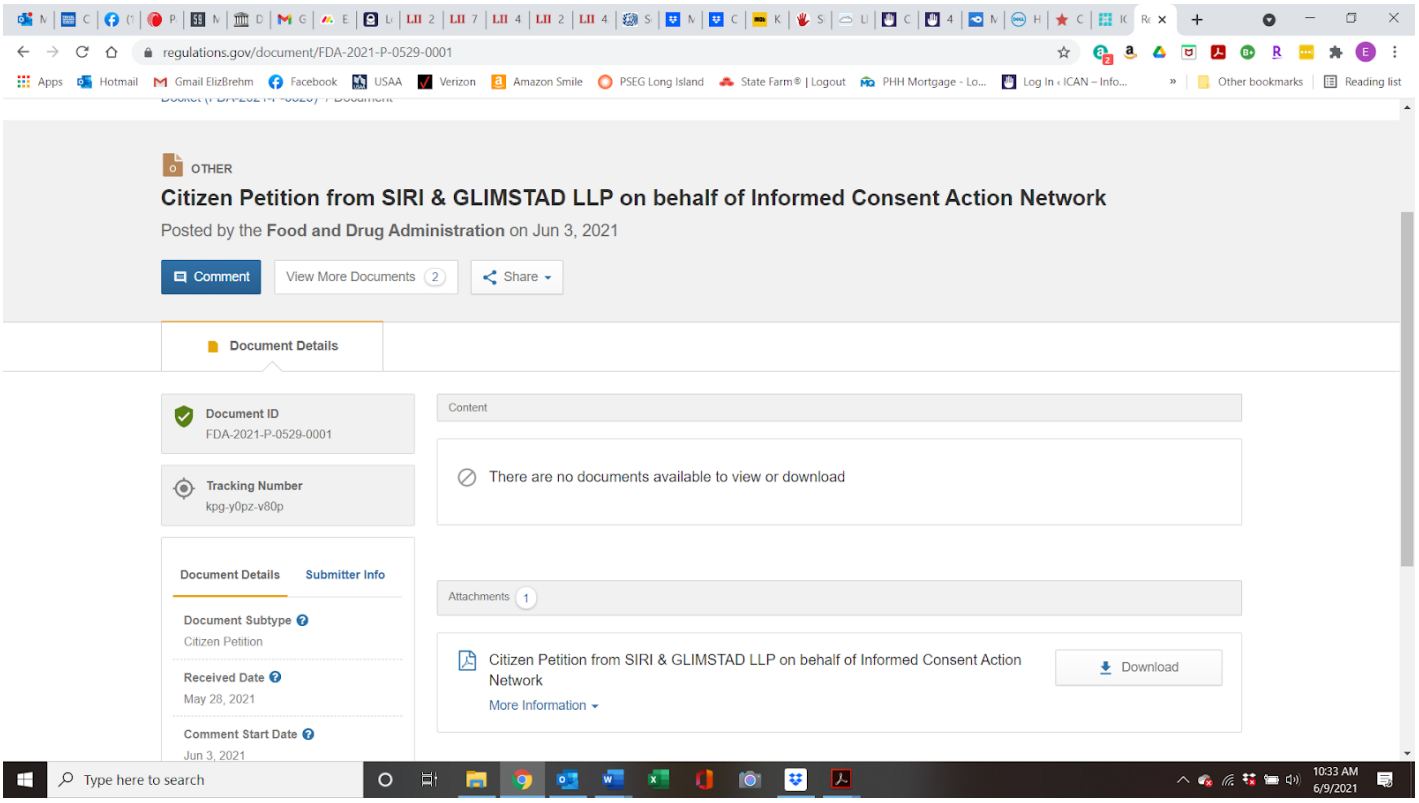
4. Results of reproductive testing including proper immunological studies looking at potential reactivity

of the vaccinated against the Syncytin 1 and 2 proteins;

5. PCR tests used to qualify an event of COVID-19 for a trials' endpoint use a maximum of 28 amplification cycles; and

6. Accurate data reflecting actual risk reduction and number needed to vaccinate to prevent one case of COVID-19.

ICAN requests you write in support of this petition here. Please visit the FDA docket and click on the blue "Comment" button to submit supportive data or statements.



Please add your voice to the growing chorus demanding that the FDA do its job and put the safety of the people ahead of any other interests.

To share this legal update, please use this link: https://www.icandecide.org/ican_press/ican-filed-petition-to-the-fda-demanding-more-data-before-any-licensure-of-covid-vaccine/

As always, its critically important that you watch and share Del Bigtree's ***Highwire*** show on https://highwire.com or on BitChute or other platforms. New shows air each Thursday….

…AND to financially support the amazing and vital work that the ***Informed Consent Action Network (ICAN)*** is doing! Go to https://icandecide.org and donate today.

In addition, ***America's Front Line Doctors*** has filed a stay for the introduction of the COVID-19 vaccines to children under age 17. It is the First Suit Filed Against HHS Over COVID-19 EUA for Children

May 21, 2021

Full text of the motion can be found HERE or on www.AFLDS.org.

ABOUT AMERICA'S FRONTLINE DOCTORS

America's Frontline Doctors (AFLDS) is a non-partisan, not-for-profit organization. AFLDS stands up for every American looking for the best quality healthcare by empowering doctors working on the front lines of our nation's most pressing healthcare challenges. Our growing community of member physicians come from across the country representing a range of medical disciplines and practical experience. To learn more about America's Frontline Doctors, visit www.AFLDS.org. To book an AFLDS member physician on your media outlet or program, please send requests to AFLDSMedia@empirestrategy.com .

New PubMed article of the month-

A study showing superior health in unvaccinated and breastfed children vs. unvaccinated children. The children were also stratified by breastfeeding and type of birth delivery status.

A study published June 12th, 2021, in the ***Journal of Translational Science*** titled, **Health effects in vaccinated versus unvaccinated children, with covariates for breastfeeding status and type of birth** found some dramatic differences in the health of vaccinated and unvaccinated children. It is another excellent study from Brian Hooker and Neil Z. Miller.

Abstract

Using survey data from respondents associated with three medical practices in the US, vaccinated children were compared to unvaccinated children for the incidence of severe allergies, autism, gastrointestinal disorders, asthma, ADHD, and chronic ear infections. All diagnoses were based on parental reporting with chart review for confirmation of diagnoses. Cases were stratified with non-cases based on year of birth and sex, and compared using a logistic regression model which also accounted for breastfeeding status and type of birth (vaginal versus cesarean section). Vaccinated children were significantly more likely than unvaccinated children to be diagnosed with severe allergies (OR = 4.31, 95% CI 1.67 - 11.1), autism (OR = 5.03, 95% CI 1.64 - 15.5), gastrointestinal disorders (OR = 13.8, 95% CI 5.85 - 32.5), asthma (OR = 17.6, 95% CI 6.94 - 44.4), ADHD (OR = 20.8, 95% CI 4.74 - 91.2), and chronic ear infections (OR = 27.8, 95% CI 9.56 - 80.8).

Vaccinated children were less likely to be diagnosed with chickenpox (OR = 0.10, 95% CI 0.029 - 0.36). Children who were "vaccinated and not breastfed" or "vaccinated and delivered via cesarean section" had the highest rates of adverse health outcomes. In this study, higher ORs were observed within the vaccinated versus unvaccinated groups for several adverse health conditions. Further research is essential to understand the full scope of health effects associated with childhood vaccination.

The Conclusion

In the study presented here, children from three pediatric medical practices in the United States were used as a convenience sample to compare health outcomes in fully vaccinated, partially vaccinated, and completely unvaccinated populations. Within the logistic regression models, higher ORs were observed within the fully and partially vaccinated groups versus the unvaccinated group for severe allergies, autism, gastrointestinal disorders, asthma, attention deficit disorder (ADD/ADHD), and chronic ear infections. The OR for chickenpox, our positive control, was significantly low, affirming the protective effect of vaccination.

Similar results have been observed in earlier studies. Results from the analysis of relationships between vaccination and breastfeeding status showed that the lowest percentages of adverse diagnoses were observed for "unvaccinated and breastfed" children; the highest were observed for "vaccinated and not breastfed" children.

Results from the analysis of relationships between vaccination and birth delivery status showed that the lowest percentages of adverse diagnoses were observed for unvaccinated children delivered vaginally and the highest were observed for vaccinated children delivered via cesarean section. These particular analyses, and results, appear to be unique in the medical literature.

Remember to download my FREE COVID-19 Vaccines Critical Review and 2-page summary at https://www.wellnessdoc.com/covid-19-vaccine-review-2/

Thank you for subscribing to the 1200 Studies Update Newsletter, where the truth often flows against the mainstream narrative.

I appreciate all your support! It's the only way I can continue to bring this important information to you monthly.

Please tell your friends and family about my newsletter 😊. There are a lot of hearts and minds that need to know this type of information, especially right now with the threat of mandatory or coerced vaccination happening all around us.

Just updated!!

Oh, one last thing…. If you love science-based information and would like to explore the counterargument to the public narrative about vaccines including now the COVID-19 vaccines, check out my eBook **1200 Studies – Truth Will Prevail**. It has easy search and navigation features including links to article abstracts and studies on PubMed or the source journal. These features make it an invaluable research and reference tool. At 950 pages long, the eBook is a living document and now includes excerpts from over 1500 published studies – authored by thousands of scientists and researchers – that contradict what officials are telling the public about vaccine safety and efficacy.

Download the latest version at www.1200studies.com