A Chronology of the COVID-19 vaccines- From the clinical trials to their epic failure

By Dr. Alan Palmer- Updated November 1st, 2021 (**Jump to most recent updates**)

Other resources from Dr. Palmer

Risk from COVID vs Risk from COVID vaccines for children

Dr. Palmer's monumental work; his 955-page eBook with excerpts and summaries from over 1,500 studies challenging the safety and efficacy of vaccines

Disclaimer:

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

Introduction

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

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

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

Other than the massive amount of evidence in my eBook, there is a general distrust of the pharmaceutical industry. An August 2019 ***Gallup*** poll found that the pharmaceutical industry ranked 25th out of 25 industries in terms of public opinion. With 58% of people polled having a negative view and 15% being neutral, that

means that only 27% of people view the industry in a positive light. This is an all-time low for pharma. And, close behind in 24th position is the federal government at only 4 points better. https://news.gallup.com/poll/266060/big-pharma-sinks-bottom-industry-rankings.aspx.

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

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

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

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

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

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

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

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

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

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

In 2017, The ***Informed Consent Action Network (ICAN) and Robert F. Kennedy Jr.*** sued the United States government and won in an issue regarding vaccine safety. According to a legal document entitled, "Mandate for Safer Childhood Vaccines," Health and Human Services (HHS) has openly admitted to not having filed any vaccine safety reports in over 30 years."
The court filing, ICAN's summary of events and the HHS response revealing that they have no records can be found here: http://icandecide.org/government/ICAN-HHS-Stipulated-Order-July-2018.pdf

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

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

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

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

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

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

> An exhaustive study looking at 160 countries and effects of mitigation measures published in the journal ***Frontiers in Public Health*** titled, **Covid-19 Mortality: A Matter of Vulnerability Among Nations Facing Limited Margins of Adaptation**. https://www.frontiersin.org/articles/10.3389/fpubh.2020.604339/full
>
> - A key quote from the study's authors- "**Stringency of the measures settled to fight pandemia, including lockdown, did not appear to be linked with death rate".**

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

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

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

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

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

Dr. Sunetra Gupta, professor at Oxford University, an epidemiologist with expertise in immunology, vaccine development, and mathematical modeling of infectious diseases.
This is the author's reason for creating it and the number of people that have endorsed these measures to date by signing on to the declaration.

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

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

Signatures

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

total signatures

856,404

concerned citizens	medical & public health scientists	medical practitioners
797,721	14,879	43,804

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- People with religious convictions need to know that certain COVID-19 vaccines may be contaminated with DNA from aborted fetuses
- Victims of vaccine injury will not be compensated as makers will be free of liability in most if not all countries including the U.S. You're on your own.
- Who really "needs" the vaccine? As of the time of this writing, the vaccine manufacturers are losing market share FAST and this is why.
- Conflicts of interest and personal financial gain drive decision making for vaccine development
- Now that the vaccines have been rolled out to elderly and long-term care facilities, unusually high rates of deaths are being reported in elderly nursing home residents after they receive the shots
- Status of Vaccine Adverse Event Reporting System (VAERS) reported injuries and deaths from COVID-19 vaccines
- The technology for tracking vaccine recipients and monitoring their biological processes is ready for implementation
- Then there's the permanent body I.D. systems and tracking that Gate's wants to mandate along with vaccines
- Another kind of biometric monitoring advanced by Bill Gates and Microsoft- As this technology evolves, will vaccines be the delivery system?
- Alternatives to a vaccine- Prophylaxis and early effective treatment options
- Repurposed inexpensive drugs as a first line of defense
- Natural Alternative Options

April 11th, 2021 update

- Associate Editor Peter Doshi of the British Medical Journal questions the "effectiveness" claims of the Pfizer and Moderna vaccines
- Dr. Doshi had previously questioned the "end points" of the trials as not addressing the most important aspects for a successful vaccine, including protecting the elderly
- Now that the vaccines have been rolled out to elderly and long-term care facilities, unusually high rates of deaths are being reported in elderly nursing home residents after they receive the shots
- Concerns over the Johnson & Johnson's vaccine
- New concerns over the Moderna and Pfizer mRNA vaccines

- Polyethylene Glycol (PEG) is suspected in severe anaphylactic reactions and deaths from the COVID-19 vaccines
- Another reason why natural immunity and acquired immunity from getting COVID-19 is better than the vaccine
- Shockingly, Anthony Fauci knows that injected vaccines do not interrupt infection or transmission. This is a striking admission!
- What are the latest Infection Fatality Rates for different age groups in the U.S.?
- World renowned vaccine scientist warns of a global catastrophe from the vaccine program
- A brilliant evolutionary biologist and scientist lays out the most likely scenario for the COVID-19 vaccines to result in an epidemic of future illness in vaccinees and risk of autoimmune disease
- A new study showcases the advantage of natural infection over vaccine immunity with regard to SARS-CoV-2 variant strains
- Urgent letter from doctors and scientists to the European Medicines Agency over COVID-19 Vaccine concerns
- New research points to link between AstraZeneca Vaccine and blood clots
- A data breach reveals confidential emails showing that the spike protein RNA in the mRNA vaccines may not be as advertised
- Pfizer revises ultra-cold storage guidance for Covid-19 jab to refrigerator temperatures- This raises suspicions
- Is the death rate from the vaccines higher than from COVID-19?
- First lawsuit challenging mandatory vaccines
- AstraZeneca Vaccine linked to blood clots leading to deaths and severe injury
- Bill Gates says a third shot may now be needed
- Personal anecdotes of serious and fatal reactions

May 1st 2021 Update

- Latest VAERS COVID vaccine injury reports and the incredibly high real-world numbers
- The U.S. government funded a Harvard study that found that less than 1% of adverse reactions to vaccines are reported

- The Spike Protein as the progenitor of the epidemic of thrombotic events occurring post-vaccination around the globe
- Have the vaccines contributed to the fall in cases?
- Are they really vaccines? See what the government filed documents say
- What about herd immunity? Where are we at?
- How much are the vaccines responsible for the drop in COVID-19 deaths in the U.S.?
- More concerns over the blood clotting issues from the COVID-19 vaccines
- Deep vein thrombosis after Pfizer vaccine
- Study shows the spike protein cause damage to the Blood-Brain-Barrier (BBB) and resultant brain inflammation
- Tiny country of Gibraltar sees unexpected increase in deaths in elderly population after vaccination with COVID-19 vaccines

July 1st, 2021 Update

- What percentage of the children under 18 in the U.S. have died from COVID-19?
- 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
- Explosive new report blows the lid off of the claims of efficacy and safety of the COVID-19 vaccines
- Notice of liability for harm served on all members of the European Parliament
- COVID vaccines for children- We had better think again! A letter from a consortium of U.K. medical specialists calling for a halt
- Cases of myocarditis making the news are just the tip of the iceberg. FDA adding warning labels
- Myocarditis is much more serious than the CDC and the media have been portraying
- Not only are the vaccines risky, but the vaccinated don't appear to be as protected as the unvaccinated against variants
- Speaking of variants, is the Delta Variant the scary boogieman that people are being told it is?
- Since Delta IS the Indian Variant and India was hit hard this spring, shouldn't we be concerned?

- How about the mainstream media's sensationalized reporting? Is there any basis for it? Let's look at how they've handled previous variants.
- Inventor of Messenger RNA (mRNA) technology used by Pfizer and Moderna drops a bombshell about the COVID-19 vaccines in a must watch interview
- Another outstanding interview with Dr. Malone was done on the Highwire by Del Bigtree.
- 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-represent the conclusion
- 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
- 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

August 1st 2021 Update

- Latest VAERS update as of August 13th, 2021- A catastrophic number of casualties
- Study shows that spike protein from the SARS-CoV-2 virus or from the spike protein generating vaccines damage heart tissue in unexpected ways
- Known harms of the spike protein
- The lies are so blatant, can we ever believe our CDC and media again?
- Yet, pharma is ready to capitalize on the lack of durability of their products
- Fact checked false information. The unvaccinated are 99% of hospitalizations and deaths
- Another twist in the skewing of the numbers

- The CDC isn't counting vaccinated people that get tests outside the hospital as positive cases. No wonder the numbers are lop-sided
- Public health experts blaming low vaccination rates for delta variant's spread, but much of the published data are blaming the vaccines for pushing the virus to mutate or "escape" the vaccines
- Yet our "health" officials continue to use misinformation to accuse those sharing accurate data and science of spreading misinformation
- Notice the fear mongering is once again about case numbers and not deaths? How many people are dying from COVID-19 now as compared to other times of the pandemic?
- This study details another mechanism for clotting caused by the COVID-19 vaccines other than the spike protein toxin that they force your cells to make

September 1st, 2021 Update

- Current VAERS reported COVID-19 vaccine injuries and deaths in the U.S.
- Percentage of people reporting injuries and deaths after COVID-19 vaccines
- What about the European Union? What is the reported casualty count there?
- There has been a simultaneous name change (rebranding) of all the top COVID-19 vaccines
- The approval of the Pfizer vaccine may be the most scandalous thing the FDA has ever done (and that's saying a lot)
- The official narrative we had been hearing of COVID-19 is now a disease of the unvaccinated, is falling apart as data coming in from around the world contradicts the CDC's claims
- In many countries, the mass vaccination programs have been associated with spikes in deaths immediately following the start and now deaths in fully vaccinated appear to be rising higher than in the unvaccinated
- How are some of the countries with the lowest vaccination rates doing?
- Percentages of cases in the vaxxed versus the unvaxxed segments of the population. Here are the reasons why the reported narrative is wrong
- Breaking News on immunity conferred by infection with SARS-CoV-2! New data out of Israel shows conclusively that COVID recovered people have a remarkably smaller chance of reinfection than fully vaccinated people
- Medical Freedom should be non-negotiable
- Breakthrough cases are significantly under-reported by the CDC

- Ireland also seeing an uptick of seriously ill, fully vaccinated individuals
- Why is the virus evading the vaccines? These next two stories will shed some light on that. But you will never hear this from the mainstream media
- Vaccine developer and expert Geert Vander Bossche posts a dire new warning about continuing the mass vaccination program
- An article from the pre-COVID era describes how viruses and bacteria are driven to mutate under pressure from vaccines and antibiotics
- The virus is evading the vaccines. This is called vaccine escape and the variants are called escape mutants (sounds like something out of a sci-fi movie, doesn't it?) Why is that happening?
- A new study reveals information that may be a clue that Antibody Dependent Enhancement may be in play with the rising hospitalizations and deaths in vaccinated individuals
- A reminder from this article I ran in last month's newsletter about the concerns many scientists and bioethicists have about informing people about the real risk of ADE
- A study in the Journal of Infection rings the alarm bells about Antibody Dependent Enhancement from the COVID-19 vaccines
- A perspective on why the spike protein was a bad choice for the shots (other than the fact that the spike protein acts as a toxin in the body)
- Vaccine researcher admits 'big mistake,' says spike protein is dangerous 'toxin'
- Other valuable resources from Dr. Palmer:
    - eBook *1200 Studies- Truth will Prevail*
    - *Monthly 1200 Studies COVID-19 newsletter*
    - Other COVID-19 topic eBooks

October 1st, 2021 Update

- U.K. regulators admit that there has been four times the number of deaths reported from the COVID-19 vaccines in 8 months than all vaccines combined in the last 20 years
- The mRNA vaccines use technology the suppresses the immune system so the lipid nanoparticles can get through the body's defenses to deliver the payload to our cells. What are the frightening prospects of that?
- Reports of rapidly growing cancers are on the rise in COVID-19 vaccinated individuals and this doctor has a plausible theory as to why that is happening

- Another dire warning about continuing the mass vaccination program from vaccine developer Dr. Geert Vanden Bossche
- Perhaps this series of September 13th Tweets by Dr. Vanden Bossche sums up the vaccinated vs unvaccinated debate most succinctly
- Vermont, the highest vaccinated state in the U.S. has skyrocketing cases, hospitalizations and deaths
- Three states with the highest vaccination rates also have some of the highest hospitalizations for COVID-19
- The first report of mass breakthrough cases in the U.S. came in July 2021
- Fauci's predictions on the success of the vaccines was, well let's just say it, 180 degrees wrong
- How can we tell what will happen in the near future with the effectiveness of the vaccines, cases, hospitalizations and deaths in the U.S. if we keep going?
- So, how is Israel doing with breakthrough cases?
- Let's look at how the "vaccine effectiveness" number can be deceptive
- A comparison of deaths in Sweden with triple vaxxed Israel
- An urgent appeal to the European Medicines Agency to stop the vaccination program and launch a large-scale independent investigation into the injuries and deaths caused by the vaccines
- I recommend sharing this excellent rapid drawing video discussing the risks of the COVID-19 vaccines
- Naturally acquired immunity from SARS-CoV-2 infection continues to be ignored in the push to vaccinate everyone, despite the overwhelming scientific evidence
- Our federal health agencies have been corrupted by the financial influence of the drug industry
- The risk of Antibody Dependent Enhancement (ADE) is increased by the COVID-19 vaccines according to a study in the Journal of Infection
- If you are a physician or scientist, consider signing on to the Rome Physician's Declaration. It asserts that radical changes must be made in the way public health agencies have interfered with doctors ability to practice medicine
- Calculate your risk of hospitalization and death from COVID-19
- Speaking of risk from COVID-19, a new CDC funded study looks at over a half million people to determine the highest risk factors for hospitalization and death
- How do the different states compare in COVID-19 death rates?

- A look at the estimated percentage of the population that have been infected by SARS-CoV-2 in the various U.S. states

- We are starting to see the bravado of forcing healthcare and emergency medical responders to be vaccinated begin to crumble

November 1st, 2021 Update

- The nonsensical policies of pretending that vaccines that can't prevent infection or transmission to participate in society just became all the more ridiculous

- Massive study across 68 countries and nearly 3,000 counties in the U.S. finds that high vaccination levels of the population seem to correlate with higher infection transmission and case rates

- A report from a hospital in Israel showing 39 of 42 cases in an outbreak were in people that were fully vaccinated

- New study from Sweden shows how rapidly the three leading vaccines against COVID-19 decrease in effectiveness

- Is it even possible to reach herd immunity with the vaccines? Many experts from the most vaccinated countries don't seem to think so

- The mRNA vaccines may inhibit the innate immune system which could reduce effectiveness against viral infection and lead to increased risk of cancer

- Introducing the two scientists being touted as heroes for helping mRNA evade the body's immune system. But will history remember them as villains?

- A contemporary study describes how this same mechanism used in the Pfizer vaccine negatively impacts the body's innate immune response

- A 2021 study explains how the mRNA vaccines are designed to escape the innate immune system

- A disturbing trend for vaccinated individuals noted from Public Health England's updates- Cases, hospitalizations and deaths rising in the fully vaccinated

- Public Health England numbers continuing to deteriorate month by month for the vaccinated

- Israeli hospital outbreak, with 39 of 41 people being fully vaccinated and highly masked

- Why is the virus evading the vaccines so rapidly and efficiently?

- The U.K. continues its downhill slide for the vaccinated

- More statistics on the failure of the vaccines

- **The state of Illinois is 68% fully vaccinated, but transmission rates are high across the state**
- **Waterford Ireland has the highest vaccination rate in the country and also an out-of-control COVID-19 surge**
- **Singapore, a country then has fully vaccinated 80% of their population is experiencing soaring case rates**
- **Despite the tidal wave of evidence against the safety and effectiveness of the COVID-19 shots, the FDA plan to move forward with full approval of 5-11 year-olds. Here are 10 reasons why that is a terrible idea.**
- **Guidance for obtaining religious exemptions**
- **Do the adenovirus vaccines like J & J and AstraZeneca integrate into DNA of the person getting the shots?**
- **There is a lack of correlation between percentage of population vaccinated and rates of COVID-19 across a broad swath of countries**
- **Is the approval of Pfizer's vaccines a bait and switch, when the version that will not be available until sometime next year was the one FDA approved and the original one being used until then is still under EUA?**
- **It appears that the spike protein toxin may circulate up to four months after injection with the mRNA shots**
- **Speaking of vaccine effectiveness, if greater than 60% of people who are vaccinated have already had COVID and have natural immunity isn't that going to make the vaccine look more effective than it really is?**

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

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

Immune Enhancement has plagued past attempts to make a coronavirus vaccine

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

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

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

From the article:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

End of excerpts:

Four big concerns I have are:

1. One very important thing to consider is that, while Phase 3 trials did include older individuals, they chose relatively healthy people. That is in no way representative of the general population of the elderly in the U.S.

2. We may not know what the extent of pathogenic priming reactions will be in the people getting the vaccine, until they are challenged by coming in contact with the wild virus in the future.

3. This "priming' of the immune system by the vaccine may lead to development of autoimmune disease in the future. Because these vaccine trials have been so short lived in humans, around 90 days rather than 4 to 6 years or longer as is typically the case, we may not know for many months or even a few years what the fallout may be regarding autoimmune disease.

4. Currently 1 in 6 Americans has one or more autoimmune diseases. We know from many previous studies, that people with autoimmune disease and their offspring, are more likely to suffer adverse reactions from vaccines. How will individuals with current autoimmune disease do after exposure to the COVID-19 vaccines?

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

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

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

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

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

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

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

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

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

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

Keep this story in mind until you read this STATUS UPDATE story about deaths in elderly later in this document

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

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

Dear Mr. Hancock,

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Michael Yeadon

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

Dr. Yeadon has a very impressive bio.

Dr. Yeadon is an Allergy & Respiratory Therapeutic Area expert, developed out of deep knowledge of biology & therapeutics and is an innovative drug discoverer with 23y in the pharmaceutical industry. He trained as a biochemist and pharmacologist, obtaining his PhD from the University of Surrey (UK) in 1988 on the CNS and peripheral pharmacology of opioids on respiration. Dr Yeadon then worked at the Wellcome Research Labs with Salvador Moncada with a research focus on airway hyper-responsiveness and effects of pollutants including ozone and working in drug discovery of 5-LO, COX, PAF, NO and lung inflammation. With colleagues, he was the first to detect exhaled NO in animals and later to induce NOS in lung via allergic triggers. **Joining Pfizer in 1995, he was responsible for the growth and portfolio delivery of the Allergy & Respiratory pipeline within the company. During his tenure at Pfizer, Dr Yeadon was responsible for target**

selection and the progress into humans of new molecules, leading teams of up to 200 staff across all disciplines and won an Achievement Award for productivity in 2008. Under his leadership the research unit invented oral and inhaled NCEs which delivered multiple positive clinical proofs of concept in asthma, allergic rhinitis and COPD. He led productive collaborations such as with Rigel Pharmaceuticals (SYK inhibitors) and was involved in the licensing of Spiriva® and acquisition of the Meridica (inhaler device) company. **Dr Yeadon has published over 40 original research articles and now consults and partners with a number of biotechnology companies. Before working with Apellis, Dr Yeadon was VP and Chief Scientific Officer (Allergy & Respiratory Research) with Pfizer.**

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

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

From the article:

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

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

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

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

We now know that PCR Testing is a disaster

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

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

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

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

To bypass this section on PCR testing and go to the next section click **HERE**

The many problems with PCR testing

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

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

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

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

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

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

Dr. Mina stated that 70% of the COVID-19 PCR positive tests are in people that are no longer infectious! Read that again and let that sink in.

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

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

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

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

You can see from the graph below, the Ct (Cycle Threshold) scale reflects the highest viral load associated with the lowest Ct numbers. Let me explain. When the lab runs the test, it runs these "cycles" to see if genetic material from the SARS-CoV-2 virus is present. **With each cycle run there is a huge amount of amplification applied to see if the next cycle can catch any of the specific genetic code. If large amounts of virus are present, it requires fewer cycles to identify it. The more cycles run before finding evidence of the virus, the lower the viral load in the sample and less likely the person can infect others. The problem arises when cycles above 30 are run. It may pick up fragments of genetic material from SARS-CoV-2, but none of those pieces would be able to infect another person. Yet, the test comes up positive! And labs are instructed to run up to 40 cycles with these sample which gives an erroneous FALSE positive. Hence Dr. Mina's assertion is that up to 70% of "positives" are people unable to transmit to others and are not infectious to others!** And they are told to quarantine unnecessarily. Fortunately, Dr. Mina has a great solution that I'll discuss below.

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

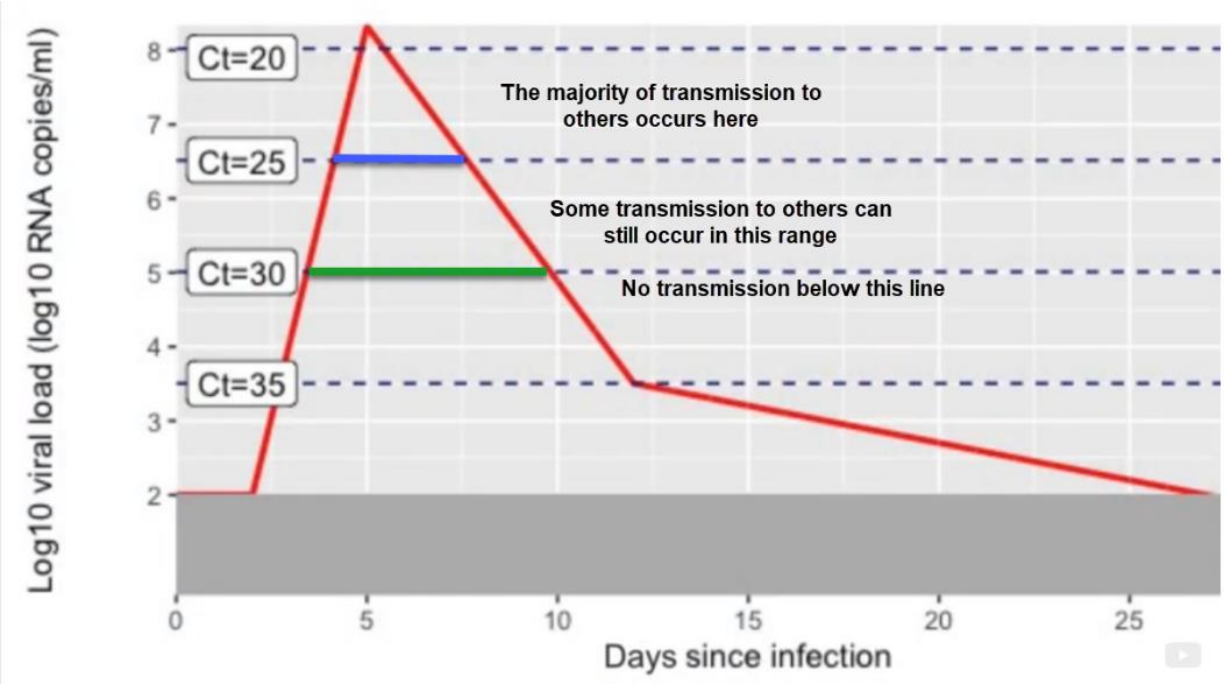
Story continued next page…

A visual representation of the viral explosion and decline

The red line represents the amount of viable virus in the body, sometimes called “viral load”. You can see that ability to transmit the virus to others occurs primarily between days 3 and 10. According to Dr. Mina, the vast majority of people capable of transmitting the virus to others are above the purple line.

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

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



As you can see, the viral levels increase rapidly from about day 3 until day 5. The immune system (if working properly) gains the upper hand and the viral levels then drop precipitously. Imagine running Ct up to 40 or more, amplifying the sample exponentially in order to trigger a “positive” as most labs have done during the pandemic and you can understand why the rates of false positives are so high.

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

Many people are being quarantined for no reason-

If someone gets a PCR test on day 6, has to wait 3-4 days to get the results and is at day 10 post infection, they are no longer able to infect others. But what is the protocol being used? They are told to quarantine for 14 days when there is NO reason for them to do that at that point, since the only reason to quarantine an

infected person is to prevent the spread to others. The same thing is true for the majority of people that test positive (and not a false positive, but that's a whole other issue that happens quite often as you will see). **Again, according to Dr Mina 70% of people that test positive are not able to transmit the infection to others.**

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

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

This test has several benefits:

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

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

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

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

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

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

PCR testing has had flaws from the start

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

Highlights from the article:
The FDA had required a particular protocol be followed when designing the test, and the lab didn't seem to be using the correct one, it said. "The first round of [quality control] for final kit release used an 'incorrect' testing

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

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

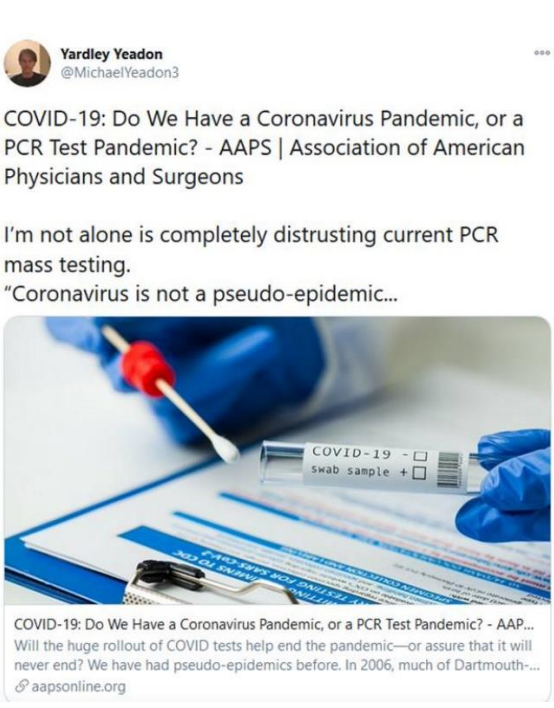
Because the respiratory disease lab had fewer entrenched systems than Lindstrom's previous lab, the review also found that basic mistakes were made. "The absence or failure of document control to ensure the use of a single verified correct test quality control procedure matching [Emergency Use Authorization] procedure," the review said, "resulted in deficiencies."

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

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

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

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



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

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

From the article:

Will the huge rollout of COVID tests help end the pandemic—or assure that it will never end?
We have had pseudo-epidemics before. In 2006, much of Dartmouth-Hitchcock Medical Center was shut down, and 1,000 employees were furloughed or quarantined, because whooping cough was thought to be spreading like wildfire based on 142 positive PCR tests.

The employees also had cultures taken, and a couple weeks later not a single one had a positive culture for the slow-growing bacteria, *Bordetella pertussis*. There had simply been an outbreak of some other ordinary respiratory disease, not the dreaded whooping cough. Gina Kolata wrote in *The New York Times*: "Faith in Quick Test Leads to Epidemic That Wasn't."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Some excerpts

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

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

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

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

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

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

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

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

A better way to ensure PCR accuracy

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

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

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

Some takeaways from the abstract:

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

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

Routine sequencing of a 398-bp PCR amplicon can categorize any isolate into one of 6 clades of SARS-CoV-2 strains known to circulate in the United States. The author proposes that extremely accurate routine laboratory tests for SARS-CoV-2 be implemented as businesses attempt to return to normal operation in order

to avoid raising false alarms of a re-emerging outbreak. False-positive laboratory test reports can easily create unnecessary panic resulting in negative impacts on local economies.

End of excerpts

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

Based on a lie?

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

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

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

At the end of the day, I believe that the paper home tests promoted by Dr. Michael Mina are the real answer. They are fast, inexpensive, can be administered at home and give real time results about whether a person is contagious or not. That approach would prevent unnecessary quarantine, allow life, business and society to resume and allow us to focus on safeguarding the elderly and those with serious comorbidities, the only people really threatened by COVID-19.

Here are other examples of the problems with PCR testing.

From the FDA: **Risk of Inaccurate Results with Thermo Fisher Scientific TaqPath COVID-19 Combo Kit - Letter to Clinical Laboratory Staff and Health Care Providers.**
https://www.fda.gov/medical-devices/letters-health-care-providers/risk-inaccurate-results-thermo-fisher-scientific-taqpath-covid-19-combo-kit-letter-clinical?

And this: **False Positive Results with BD SARS-CoV-2 Reagents for the BD Max System - Letter to Clinical Laboratory Staff and Health Care Providers**
https://www.fda.gov/medical-devices/letters-health-care-providers/false-positive-results-bd-sars-cov-2-reagents-bd-max-system-letter-clinical-laboratory-staff-and

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

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

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

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

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

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

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

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

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

According to the article:

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

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

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

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

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

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

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

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

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

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

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

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

The Moderna Trial is due to complete October 27, 2022. WHAT? Nearly 2 years from now? Yes. See the screen captures below from the clinicaltrials.gov website. That just confirms that the public is part of the clinical trials! With tens of millions of doses rolling off production lines now, are they going to inform each recipient of their participation in this experiment by informed consent, or just proceed without notification and consent?

See screen capture next page…

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

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

Study Design Go to

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

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

For the Pfizer/ BionTech vaccine, the trial is not scheduled to be completed until January 29th 2023.

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

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

Study Design Go to

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

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

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

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

Follow-up periods for Phase 3 clinical trials are not nearly long enough

How long would it be reasonable to follow subjects of a vaccine trial after they are injected to see if they suffered any adverse effects? Is 2 weeks long enough? Is 1 month long enough? Is 6 months? 12 months? Well with emergency use authorization being given after only 3 months of Phase 3 trial data, do you feel comfortable becoming part of the experiment?

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

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

Another caveat is, that the FDA doesn't consider certain side effects serious, so they will only be tracked for 1 month. These include, but are not limited to alopecia, autoimmune disease, lupus erythematosus, vasculitis, Bell's Palsy, hypotonia, migraine, myelitis, neuropathy, seizures, mental disorders, rhinitis, and vertigo. The ironic thing is that many of these take months or years to even show up.

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

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

According to Clinicaltrials.gov, if someone withdraws from the studies due to "Adverse Events (AEs) or Medically Attended AEs (MAAEs) Leading to Withdrawal [Time Frame: Up to Day 759 (2 years after second dose)]".
https://www.clinicaltrials.gov/ct2/show/NCT04470427

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

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

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

From the article:

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

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

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

From the letter:

Many may assume that successful phase 3 studies will mean we have a proven way of keeping people from getting very sick and dying from COVID-19. And a robust way to interrupt viral transmission. Yet the current phase 3 trials are not actually set up to prove either, Doshi said. "None of the trials currently underway are designed to detect a reduction in any serious outcome such as hospitalisations, intensive care use, or deaths. Nor are the vaccines being studied to determine whether they can interrupt transmission of the virus," he wrote.

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

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

Follow-up:

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

From his letter:

"Suspected covid-19"

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

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

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

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

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

The 371 individuals excluded from Pfizer vaccine efficacy analysis

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

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

We need the raw data

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

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

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

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

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

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

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

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

For those that want to see more evidence of the "fuzzy math" used to determine the "effectiveness" and the risks of the mRNA vaccines you can read this excellent article…
https://everlyreport.com/what-you-need-to-know-about-the-covid-vaccine/

"Significantly noticeable" side effects in the trials

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

Some key points:

- President Trump's coronavirus vaccine czar said Pfizer's and Moderna's Covid-19 vaccines are safe, with only 10% to 15% of volunteers reporting "significantly noticeable" side effects.

- The side effects can last up to a day and a half, said Dr. Moncef Slaoui, who is leading the Trump administration's Covid-19 vaccine program Operation Warp Speed.

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

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

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

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

End of excerpts

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

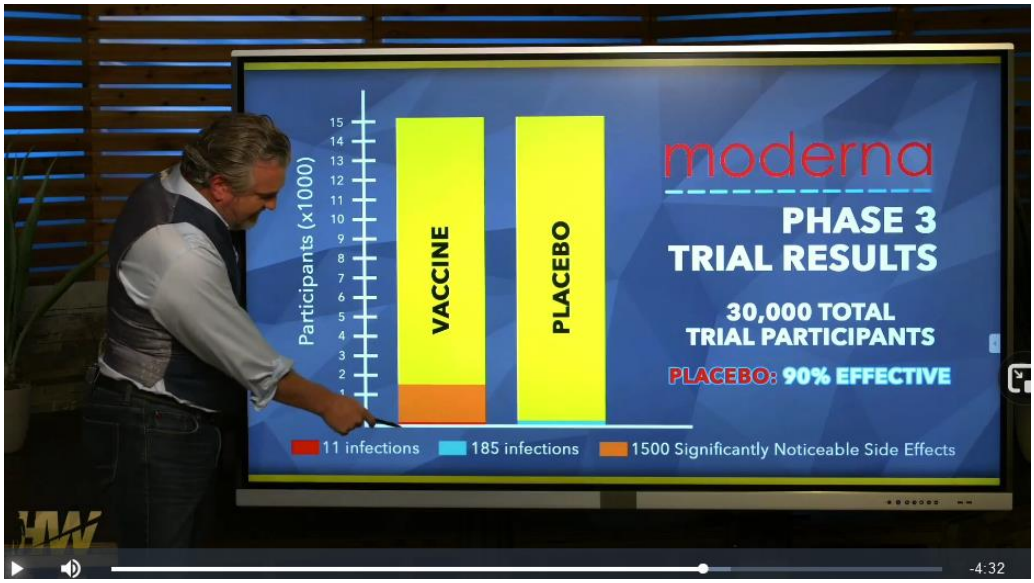
Well, that quote from Dr. Slaoui is a real smoke screen. Autoimmune disease, cancer or other chronic metabolic diseases take much longer to rear their ugly head, typically months or even years, not just the short 2 to 3 months since participants were injected. And, I would have to assume that someone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

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

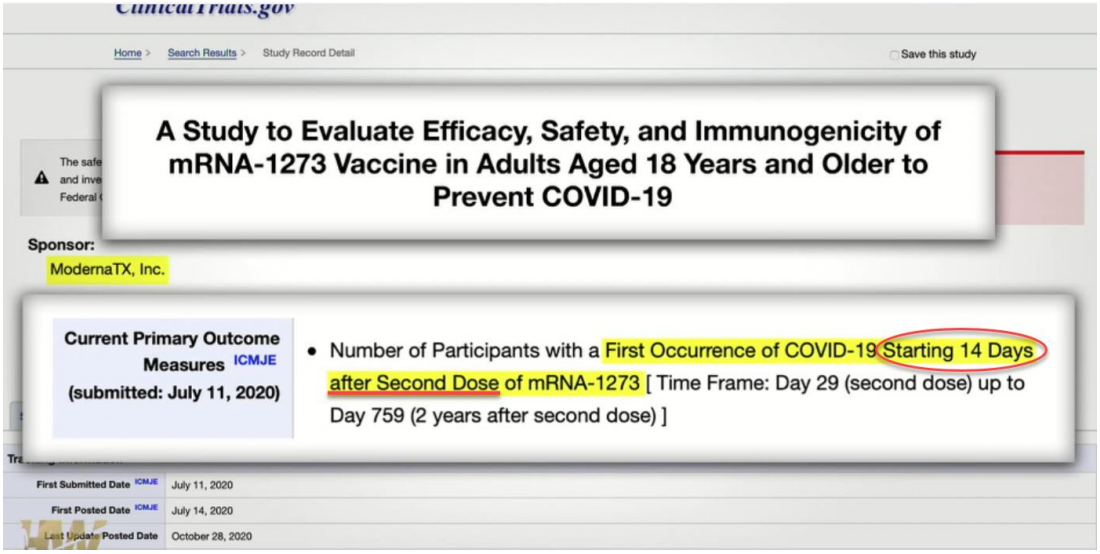
In the graphic below looking at the Moderna vaccine and using the 10-15% range of people experiencing significant side effects, Del shows that if just 10% (1,500 of 15,000 getting the shots) experienced those types of symptoms, the number of people experiencing those significant side effects from the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

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

This is a screen capture from the episode "How Effective is the COVID-19 vaccine".
https://thehighwire.com/videos/how-effective-is-the-covid-19-vaccine/



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



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

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

Lowering the bar for expectations for the vaccines

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

From the article:

Dr. Anthony Fauci says that early COVID-19 vaccines will likely only prevent symptoms — not stop transmission. He also pointed out that such vaccines may only be 50% or 60% effective.

What are the details?

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

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

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

My questions are:

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

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

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

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

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

Moderna's mRNA 1273 Vaccine

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

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

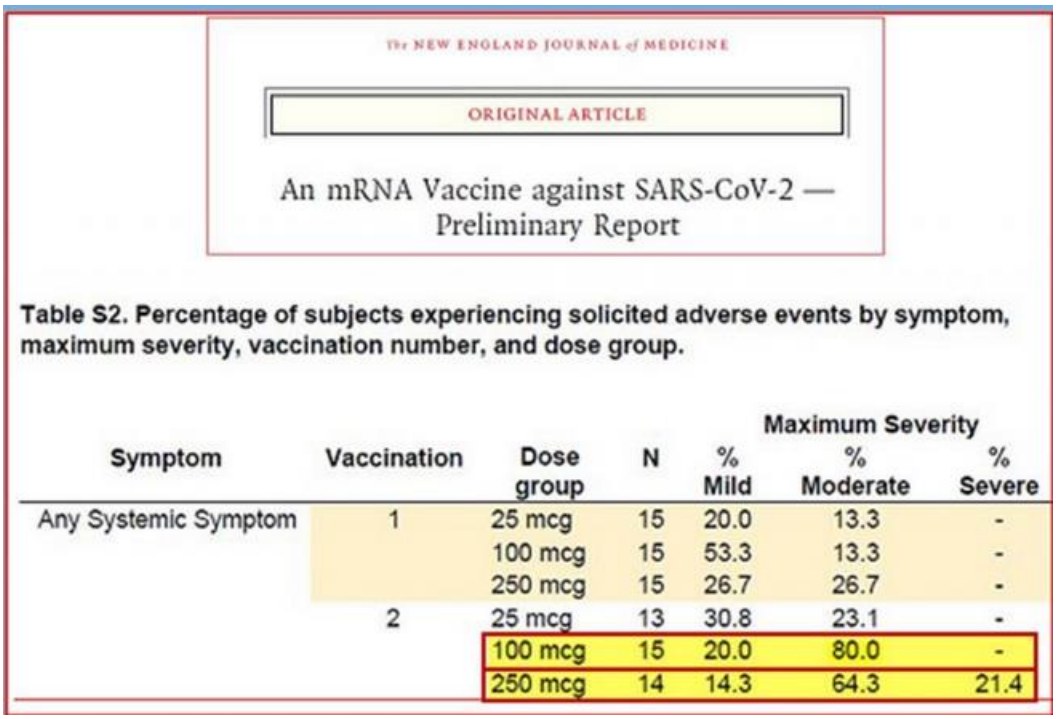
"**Their trick is to only capture adverse reactions that occur more than 28 days after injection *if* the participant withdraws from the clinical trial.** This is nonsensical, since there is little for a participant to withdraw from after getting two doses during the first 28 days of the clinical trial. Once a participant has received both doses, if anything, a participant would have an incentive to remain part of the follow-up check-

ups to address any adverse effects." Link to the Clinical Trials.gov where the trial details are outlined https://www.clinicaltrials.gov/ct2/show/NCT04470427?term=mrna-1273&draw=2&rank=1

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

Phase 1 trial

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



The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

An mRNA Vaccine against SARS-CoV-2 — Preliminary Report

Table S2. Percentage of subjects experiencing solicited adverse events by symptom, maximum severity, vaccination number, and dose group.

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

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

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

Pfizer/BionTech

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

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

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

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

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

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

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

A major flaw in the study design

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

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

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

- They don't say whether the "cases" had symptoms or not

- They don't mention anything about hospitalizations or deaths, meaning there is no indication it prevents either

- There is no indication about how long the vaccine lasts if it truly is effective and protective. Some indications suggest you might need to take this vaccine every three to six months in order for it to be effective

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

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

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

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

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

Another leading vaccine candidate the AstraZeneca/Oxford vaccine draws scrutiny

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

AstraZeneca and the University of Oxford have also rigged the clinical trial of their COVID-19 vaccine, **ChAdox1 nCoV-19**, to avoid capturing many potential life-altering adverse reactions that may occur from this experimental vaccine. ICAN's legal team once again filed an emergency petition to stop this unethical conduct. Unlike the clinical trials for Moderna and Pfizer's vaccines for COVID-19, which are occurring in the United States, the current clinical trial for AstraZeneca's COVID-19 vaccine is not under the direct authority of the FDA, since this clinical trial is not occurring in the United States.

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

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

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

AstraZeneca's vaccine has multiple issues with their clinical trials

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

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

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

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

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

Concerns over the genetically modified virus technology

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

Concerns over the Johnson & Johnson vaccine

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

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

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

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

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

   The following excerpt is from an April 24th, 2019 article published in ***ScienceMag*** titled **Dengue vaccine fiasco leads to criminal charges for researcher in the Philippines.**
   https://www.sciencemag.org/news/2019/04/dengue-vaccine-fiasco-leads-criminal-charges-researcher-philippines

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

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

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

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

End of excerpts

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

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

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

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

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

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

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

Major issues with all of them

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

The article is titled, **Covid-19 Vaccine Protocols Reveal That Trials Are Designed To Succeed.**

Here are some highlights from that article:

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

What would a normal vaccine trial look like?

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

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

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

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

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

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

The second surprise from these protocols is how mild the requirements for contracted Covid-19 symptoms are. A careful reading reveals that the minimum qualification for a case of Covid-19 is a positive PCR test and one or two mild symptoms. These include headache, fever, cough, or mild nausea. This is far from adequate. These vaccine trials are testing to prevent common cold symptoms.

These trials certainly do not give assurance that the vaccine will protect from the serious consequences of Covid-19. Johnson & Johnson is the only trial that requires the inclusion of severe Covid-19 cases, at least 5 for the 75 participant interim analysis.

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

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

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

End of excerpts

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

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

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

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

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

Clinical trials fraught with even more problems and adverse reactions

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

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

From the article:

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

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

She said she didn't experience a fever but had a bad migraine that left her exhausted and struggling to focus, the outlet reported. But the next day, she woke up feeling better after taking Excedrin.
While she was uncomfortable, the side effects outweigh the risks of becoming infected with the virus, she said. "My hope is that this works but also that the communication [on side effects] is good," she said, adding that Moderna may need to tell people to take a day off after a second dose.

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

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

Hutchinson compared the ordeal — which lasted for 12 hours — to "full-on Covid-like symptoms" on Twitter. "I'm obviously an isolated case, but since all indications point to this vaccine being approved, I feel like people should know that the side effects may be severe, especially after the second shot," he wrote.
Pfizer trial participants have reported similar symptoms.

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

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

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

Other vaccine adverse reactions and long-term concerns

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

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

In an article published online in Germany reveals what Bill Gates is anticipating with regards to collateral damage from the COVID-19 vaccines. The truth is, based on other attempts at developing coronavirus vaccines and the clinical trials so far, it may be far worse than that.
https://kenfm.de/bill-gates-predicts-700000-victims-from-corona-vaccination/

From the article:

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

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

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

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

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

Autoimmune diseases

A study published March 31, 2020 in ***Autoimmunity Reviews*** titled, **Corona (COVID-19) time musings: Our involvement in COVID-19 pathogenesis, diagnosis, treatment and vaccine planning**, sounds the alarm about serious concerns over the rush to a vaccine for SARS-CoV-2. https://pubmed.ncbi.nlm.nih.gov/32268212/

From the study:

"We all are expecting the vaccine production trials to materialize quickly. We believe that once the vaccine found to be effective (most probably on a theoretical basis) it will be distributed to millions or billions of people. We believe that this vaccine will be approved through an expedited process thus not necessarily enabling surveillance due to the shortness of time thus eventual side effects of the vaccine could not be evaluated. The amino acid sequences of the virus like in other viruses, might have a cross-reaction with the human body sequences [28–31]. Therefore, one of the side effects of giving a MASS vaccine could be

emergence of autoimmune diseases especially in individuals who are genetically prone for autoimmunity [28–31]. Actually, the coronavirus was reported to induce retinal autoimmune disease in an experimental model [32]."

A May 2020 publication in the journal ***Clinical Immunology*** titled, **Potential antigenic cross-reactivity between SARS-CoV-2 and human tissue with a possible link to an increase in autoimmune diseases.** They talk about other instances where vaccines have cause autoimmune disease manifestations. They express concerns that without adequate long-term research on the new COVID-19 vaccine and its propensity to trigger autoimmune disease that we could cause a "monumental cost on humanity in the form of another epidemic, this time a rising tide of increased autoimmune diseases and the years of suffering that come with them." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7246018/

From the study:

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

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

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

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

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

The concerns are directed in particular to the following points:

- The formation of so-called “non-neutralizing antibodies” can lead to an exaggerated immune reaction, especially when the test person is confronted with the real, “wild” virus after vaccination. This so-called **antibody-dependent enhancement ADE** *(AKA Adverse Immune Enhancement or Pathogenic Priming),* has long been known from experiments with corona vaccines in cats, for example. In the course of these studies all cats **that initially tolerated the vaccination well died after catching the wild virus.**

- The vaccinations are expected to produce antibodies against spike proteins of SARS-CoV-2. However, **spike proteins also contain syncytin-homologous proteins**, which are essential for the formation of the placenta in mammals such as humans. **It must be absolutely ruled out that a vaccine against SARS-CoV-2 could trigger an immune reaction against syncytin-1, as otherwise infertility of indefinite duration could result in vaccinated women.**

- The mRNA vaccines from BioNTech/Pfizer contain polyethylene glycol (PEG). **70% of people develop antibodies against this substance – this means that many people can develop allergic, potentially fatal reactions to the vaccination.**

- The much too **short duration of the study** does not allow a realistic estimation of the late effects. As in the narcolepsy cases after the swine flu vaccination, **millions of healthy people would be exposed to an unacceptable risk** if an emergency approval were to be granted and the possibility of observing the late effects of the vaccination were to follow. Nevertheless, BioNTech/Pfizer apparently submitted an application for emergency approval on December 1, 2020.

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

Vaccines in pregnancy

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

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

From the study
The above findings showed that maternal inflammation affects the fetal microglia during the embryonic stage, resulting in alterations in microglial process motility that begin at the embryonic stage and remain in the

developmental stage, or even the adolescent stage. Moreover, these research results demonstrate the possibility of a connection between changes in microglial process motility and deficits in social behavior that are characteristic of developmental disorders and schizophrenia.

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

Potential for causing neurodegenerative diseases

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

From the article:

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

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

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

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

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

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

Much concern regarding these vaccines is how our body's immune system may react to the spike protein from the "vaccine" after being manufactured (copied) by our own cells. An article in the prestigious journal ***Nature***

Neuroscience December 16th, 2020 titled, **The S1 protein of SARS-CoV-2 crosses the blood–brain barrier in mice** raises some very serious and concerning questions.

First my commentary:

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

From the study:

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

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

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

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

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

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

From the article:

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

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

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

To read the full article with links to references go here:
https://childrenshealthdefense.org/defender/moderna-pfizer-vaccines-blood-clots-brain-inflammation-heart-attacks/

Erasing the placebo group

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

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

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

Despite numerous statements by Anthony Fauci and Alex Azar among others that the oversight committee for the vaccine clinical trials consist of scientists independent of pharma influence. Well it appears that is not the case. This bias and conflict of interest puts all Americans at risk. ***The Informed Consent Action Network (ICAN)***,

through its attorneys, headed by Aaron Siri, has therefore sent a demand letter to the Director of ***HHS***, Director of ***NIAID***, Director of the ***FDA's*** CBER, the White House Coronavirus Task Force, and POTUS. You can see that letter here: https://www.icandecide.org/wp-content/uploads/2020/10/Conflicted-Members-on-DSMBs-for-COVID-19-Vaccines-Final.pdf

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

The members of these DSMBs were selected in secret. They meet in secret. Their identities are supposed to remain a secret. This veil of secrecy has held with the exception of two members. The identity of the chairperson of the NIAID DSMB, Dr. Richard Whitley, was mistakenly revealed by his university in an announcement that has been scrubbed from its website. As for the Pfizer DSMB, made up of five individuals, one of its members, Dr. Kathryn Edwards, was apparently mistakenly revealed in a CBS article.

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

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

ICAN, through its attorneys, headed by Aaron Siri, has therefore sent a demand letter to the Director of HHS, Director of NIAID, Director of the FDA's CBER, the White House Coronavirus Task Force, and POTUS. This letter lays out in detail: the conflicts of interest that Dr. Whitley and Dr. Edwards have with pharmaceutical companies; the litany of lies told by Dr. Fauci and other public health officials regarding the supposed independence of the DSMBs; and demands that they "**remove any member of the NIAID DSMB, including Dr. Whitley, who has ever been a consultant, has been on a speakers' bureau, or has had meals or travel paid for by any pharmaceutical company**."

You can read the full demand letter here.

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

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

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

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

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

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

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

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

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

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

A 2014 article published in the **Journal of Public Health and Epidemiology** titled, **Impact of environmental factors on the prevalence of autistic disorder after 1979**, produces convincing evidence of the effects of human fetal cell lines on the "change point" where the incidence of autism rose sharply in the late 1980s. https://academicjournals.org/journal/JPHE/article-full-text-pdf/C98151247042

One explanation as to why boys are affected with autism implicates human DNA found in vaccines comes from an article from the ***Journal Immunotoxicology*** published in 2011 and titled, **Theoretical Aspects of Autism**. The article clearly shows that It's not just the mercury that puts children at risk from vaccines. There is human DNA and retroviruses found in childhood vaccines. This article discusses many plausible explanations for the rise in autism as a result of various vaccine related factors, including this quote: "The human DNA from the vaccine can be randomly inserted into the recipient's genes by homologous recombination, a process that occurs spontaneously only within a species. Hot spots for DNA insertion are found on the X chromosome in eight autism-associated genes involved in nerve cell synapse formation, central nervous system development, and mitochondrial function (Deisher, 2010). This could provide some explanation of why autism is predominantly a disease of boys. Taken together, these data support the hypothesis that residual human DNA in some vaccines might cause autism." http://www.tandfonline.com/doi/full/10.3109/1547691X.2010.545086

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

Currently, there are 35 vaccines other than the COVID-19 vaccines that contain fetal DNA. Those can be identified on the Children of God for Life website at https://cogforlife.org

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

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

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

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

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

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

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

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

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

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

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

"The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the Secretary of the Department of Health and Human Services (Secretary) to issue a declaration (PREP Act declaration) ***that provides immunity from liability (except for willful misconduct) for claims of loss caused, arising out of, relating to, or resulting from administration or use of countermeasures to diseases****, threats and conditions determined by the Secretary to constitute a present, or credible risk of a future public health* ***emergency to entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of such countermeasures. A PREP Act declaration is specifically for the purpose of providing immunity from liability, and is different from, and not dependent on, other emergency declarations."***
https://www.phe.gov/Preparedness/legal/prepact/Pages/default.aspx
In other countries, drug makers are creating similar protection agreements as they move toward a rollout of their vaccines.

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

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

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

That 8X ratio is according to an article posted online November 27th titled "The CDC researchers estimated that about 52.9 million Americans had been infected in the US by the end of September". The number of

confirmed COVID-19 cases was only 6.9 million up to that time. That is about an 8 to 1 ratio of those that have it and either don't know it or have very mild symptoms and never get a test to those that do test positive. (PCR testing inaccuracy as we have seen is a whole other issue!)
https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1780/6000389

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

And here is why. Even if you have had COVID-19, the official narrative is that you should still get your vaccine shots. After all, our government and pharma have collaborated on producing billions of doses of these vaccines. And again, I am not telling you not to. BUT the science shows that immunity develops after infection and the immune response is lasting. While some studies are showing that antibody levels drop a certain percentage in the weeks and months after infection, THIS IS NORMAL! And everyone that has studied immunology knows this. Once the threat is gone, the immune system doesn't maintain a level of "red alert". Antibody levels drop, but memory cells remain inactive. Then once the virus shows up again, they jump into action and crank out antibodies against the virus. And, because of the "maturing" of those cells the response is more robust than even during the first infection. In addition to the antibody response, the T-Cell response also has been shown to last for many years from previous coronavirus infections including SARS-CoV-1. There is no reason to believe that the same won't be true with SARS-CoV-2. And lastly, because natural immunity is always more lasting and effective against the wild virus because it covers the whole virus not just a small section like the spike protein, it will always superior. If the mutations we are seeing in various corners of the world and those to come affect the spike protein, the vaccines will be even less effective than natural immunity.

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

Young people age 0-19 have a 99.997% survival rate. People 20-49 have a 99.98% survival rate. And even people aged 50-69 have a 99.5% survival rate.
https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html

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

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

Co-morbidities are a major consideration in addition to age

Sixty percent of adults suffer from at least one chronic disease. Forty percent have two or more.
This is undoubtably one of the key reasons why COVID-19 has hit countries like the U.S., that have high rates of chronic disease harder. The average person that has died from COVID-19 has 2.6 comorbidities per CDC.

These are the 4 most significant risk factors for severe outcome from COVID-19 and the percentage of American adults in that age group that have them:

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

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

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

   The following groups have increased risk of death from COVID-19 as compared to Caucasian and Asian Americans: African American (2.1X), Hispanic Americans (1.1X), Native Americans (1.4X). These ethnic groups also have higher rates of obesity, diabetes, cardiovascular disease than Caucasian and Asian Americans.

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

See the table next page…

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

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

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

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

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

The third truth is, that several studies have shown that 30-40% of the population have T-Cell immunity from previous coronavirus infections. There are 4 human coronaviruses that make up about 15-20% of the "common colds" people get. Since they are a very similar cousin to SARS-CoV-2, people that have developed T-cell and Memory B-Cell immunity to those, exhibit a cross-reactivity to the SARS-CoV-2 virus. Cytotoxic T-cells and the Innate Arm of the immune system are almost never discussed yet play a powerful role in immune protection. There are several articles that could be cited, but here is a good one that also shows that the immunity should be long-term:
https://www.sciencemag.org/news/2020/05/t-cells-found-covid-19-patients-bode-well-long-term-immunity?#

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

Elderly people are at risk

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

From the article:

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

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

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

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

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

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

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

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

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

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

From the article:

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

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

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

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

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

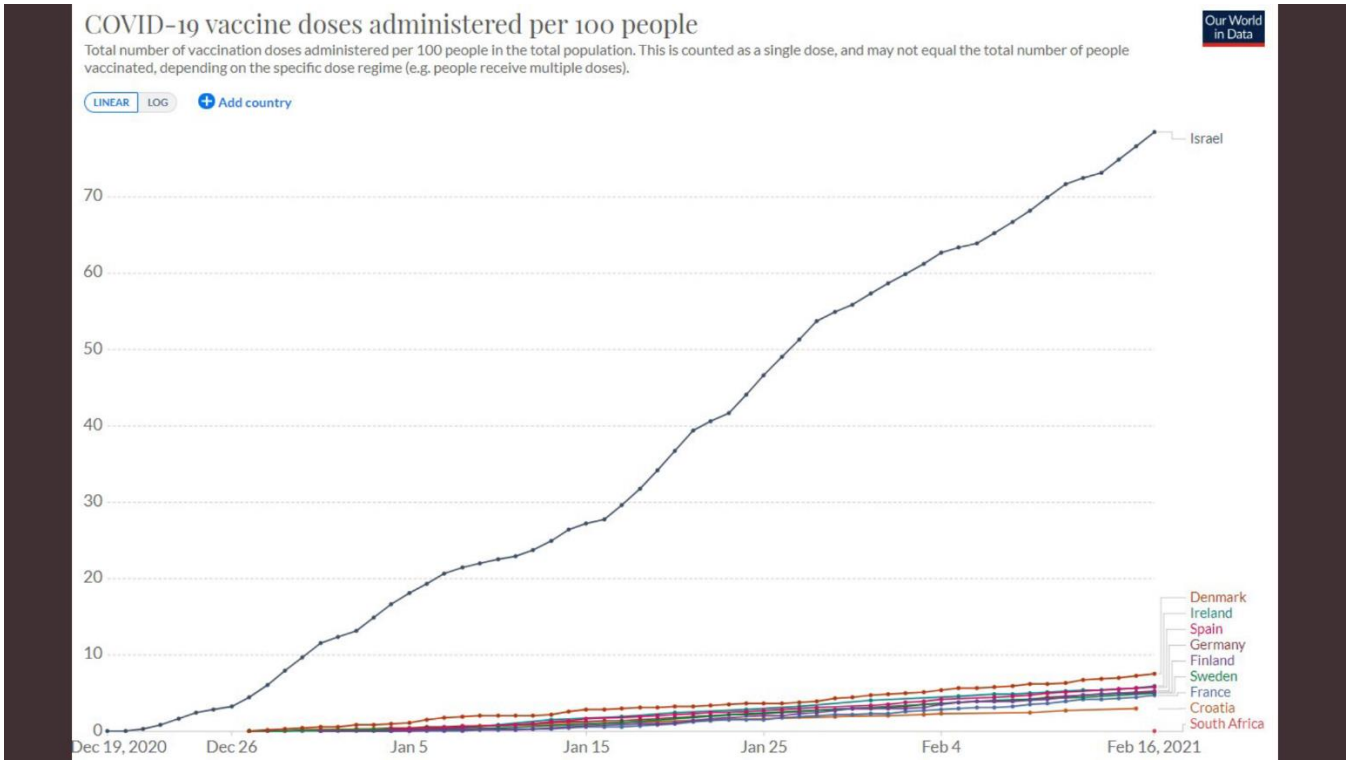
Spain halts vaccine in nursing home after 46 residents die shortly after the first Pfizer shot

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

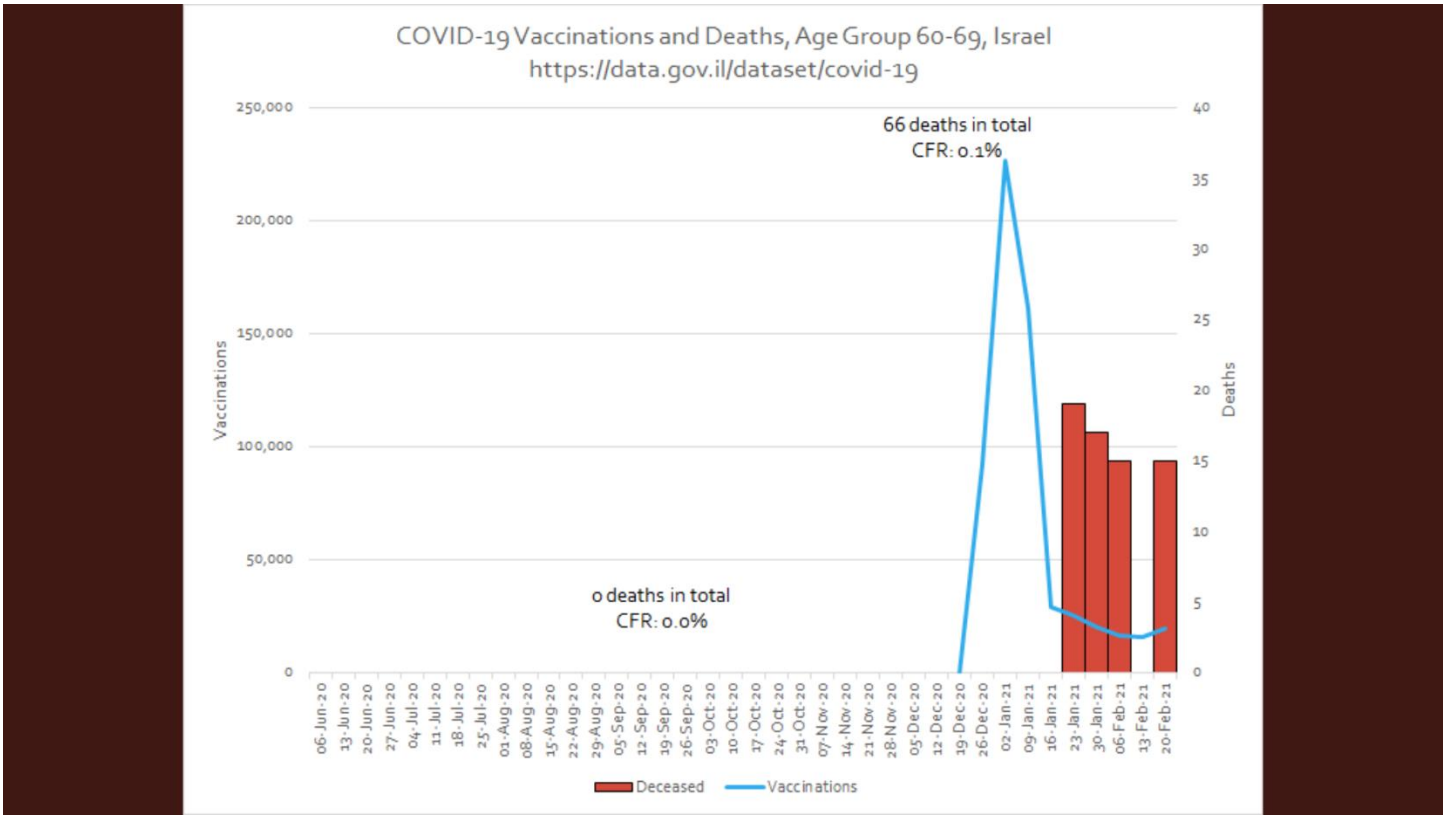
https://europerenaissance.com/2021/02/19/spain-second-pfizer-shots-halted-after-46-nursing-home-residents-die-after-the-first-shot/

Continued next page…

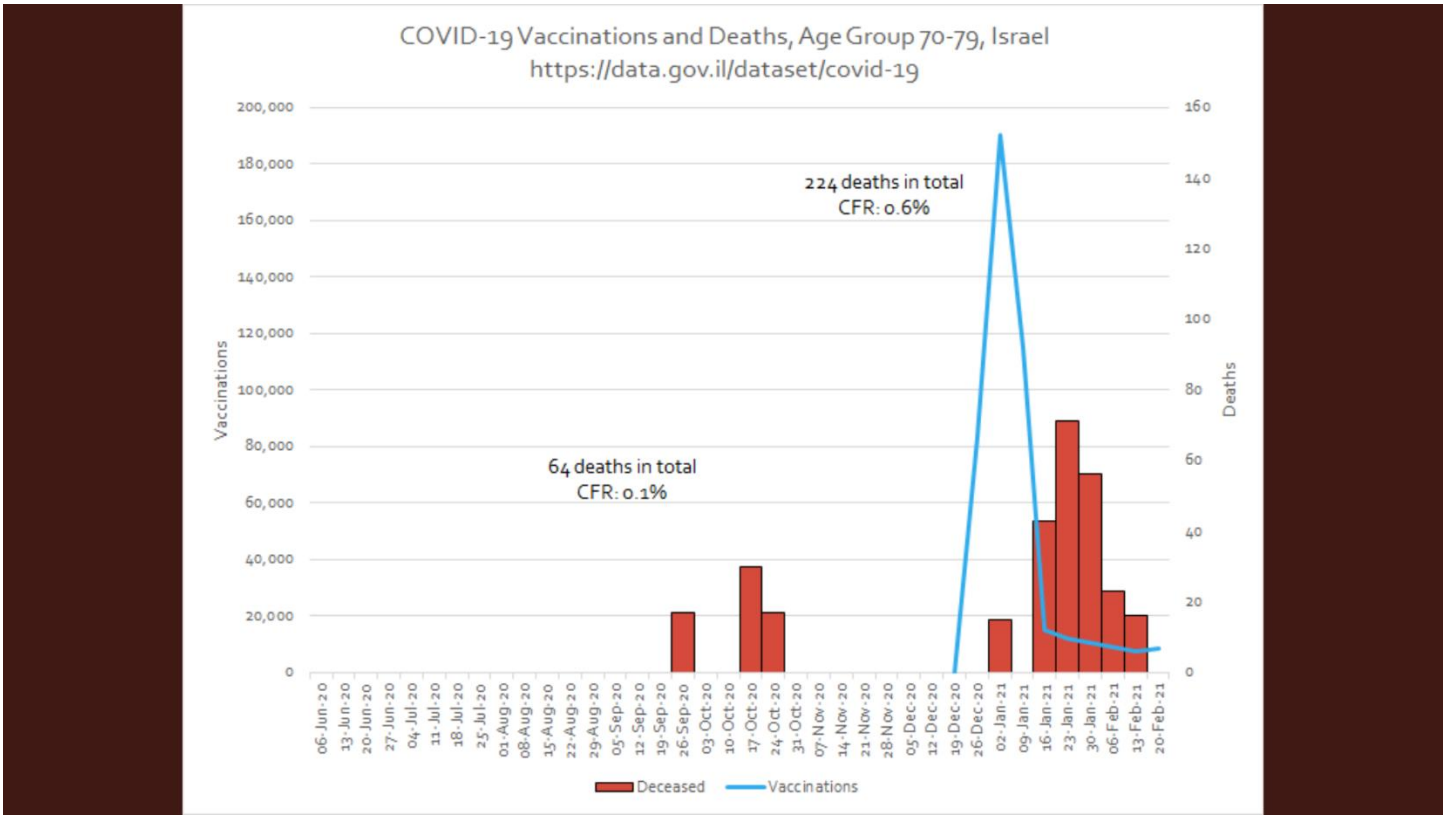
Israel has the highest rate of COVID-19 vaccine distribution in the world, but it seems to correlate with a large increase in deaths in their elderly



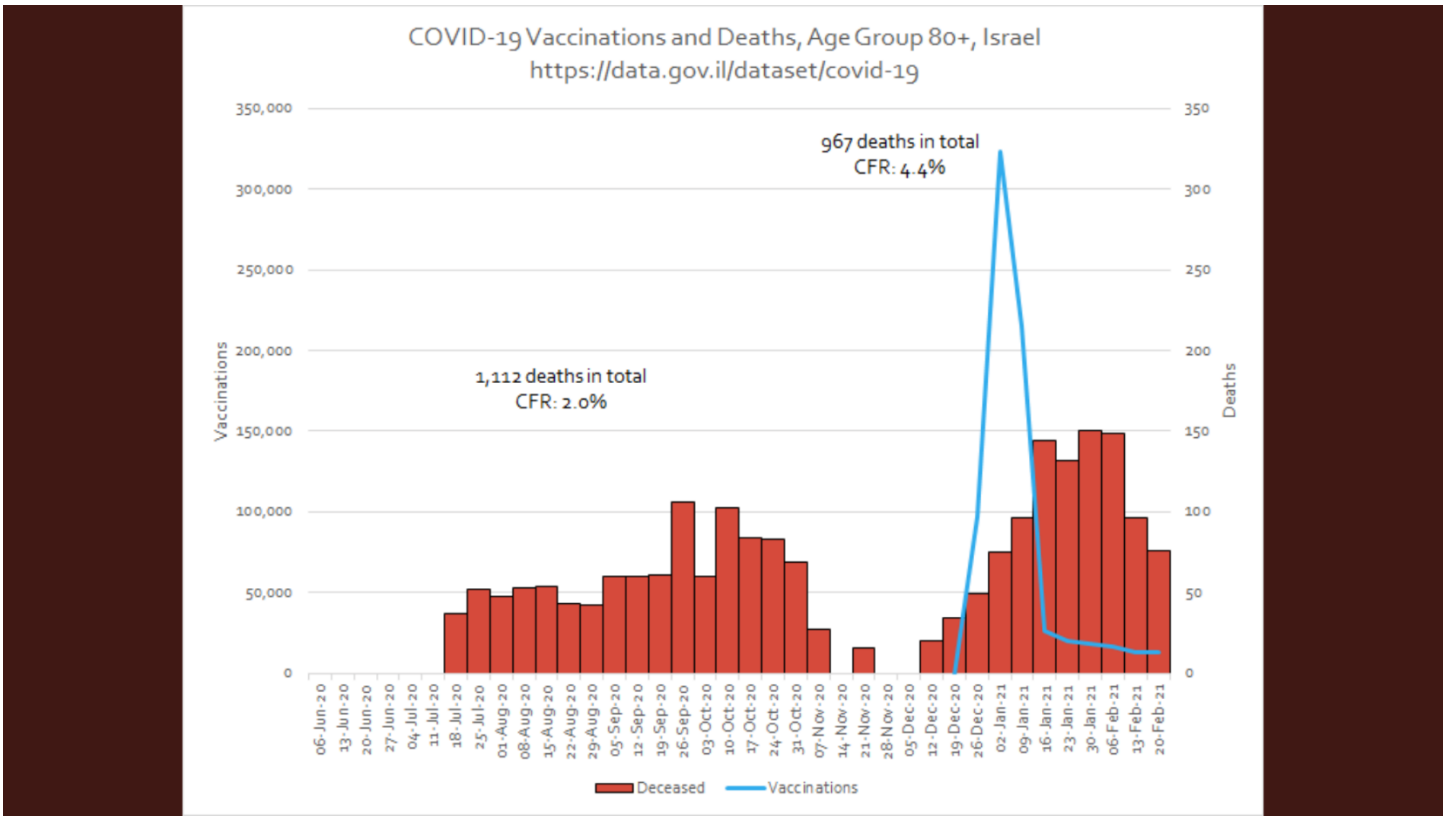
Deaths in the 60 to 69 year-old age group- Vaccination campaign is the blue line



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



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



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

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

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

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

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

In a revealing article on Mercola.com, Whitney Webb an investigative journalist discusses the Sci-Fi reality that the biotech industries and globalists have for the human population. I'm going to devote a bit of content space to this article because it is very alarming. The rest of the article can be found here. https://articles.mercola.com/sites/articles/archive/2020/11/01/operation-warp-speed.aspx

From the article:

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

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

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

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

Operation Warp Speed

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

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

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

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

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

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

Pharmacovigilance Surveillance

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

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

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

"So, you have Google being contracted to monitor this pharmacovigilance surveillance system that aims to monitor the physiology and the human body for two years," Webb says.
"And then you have the ties to the ProfusA project, which oddly enough is supposed to work inside the human body for 24 months — the exact window they've said will be used to monitor people after the first [vaccine] dose."

Guinea Pigs 'R Us

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

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

A lot of the same initiatives proposed under that original program after 9/11 have essentially been resurrected, with updated technology, under the guise of combating COVID-19."
Later in the article Webb discusses ways that HHS is partnering with technology companies to create predictive models that will supposedly predict outbreaks before they occur in certain geographic regions. This will allow the government to shut down cities and communities even before any signs of outbreak. This is potentially ripe for abuse and very difficult for independent sources to verify and could lead to population control under the guise of "health measures".

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

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

From the article:

"The research, conducted by M.I.T. bioengineers Robert Langer and Ana Jaklenec and their colleagues, uses a patch of tiny needles called microneedles to provide an effective vaccination without a teeth-clenching jab.

Microneedles are embedded in a Band-Aid-like device that is placed on the skin; a skilled nurse or technician is not required. Vaccines delivered with microneedles also may not need to be refrigerated, reducing both the cost and difficulty of delivery, Langer and Jaklenec say."

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

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

In a related 2019 article titled, **Bill Gates, MIT Develop New 'Tattoo ID' to Check For Vaccinations**, other nefarious plans for biometric I.D.s as a means of population management is discussed. https://21stcenturywire.com/2019/12/23/bill-gates-develops-new-id-tattoo-to-check-for-vaccinations/

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

And that leads us to the Bill Gates' Microchip patent

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

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

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

From the article:

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

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

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

A detailed description of the "invention" **provides 28 concepts for how the device could be used.** "Microsoft's involvement is interesting. And why has the patent been given the code number 060606? Is it a coincidence or the deliberate choice of what is referred to in the ***Book of Revelation*** as the number of the "mark of the beast"?

Alternatives to a vaccine- Prophylaxis and early effective treatment options

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

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

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

Repurposed inexpensive drugs as a first line of defense

Disclaimer: *As a chiropractic physician, I do not prescribe medications and I do not tell people not to take their medications. I am simply acting as a journalist and reporting what is being reported and what the peer*

reviewed studies have shown. Each person must decide for themselves, with consultation from the medical provider what would be in their best interest. Even though these medications have been proven very safe over decades of use, like with any drug it may not be recommended for a very small subset of people with certain risk factors.

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

- **Hydroxychloroquine (HCQ) WITH ZINC-** HCQ acts as a Zinc ionophore helping Zinc to get into the cells where it can interfere with replication of the SARS-CoV-2 virus. It costs about $30 for a course of treatment. It is sometimes prescribed with Azithromycin as a prevention against secondary bacterial infection.

- **Ivermectin-** Costs about $80 for a course of treatment. Ivermectin acts both as an anti-viral and an anti-inflammatory drug. This makes it effective early in care and later as well. The anti-inflammatory aspect may lend itself well to patients after the viral replication phase in helping to control an over-reactive immune response.

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

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

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

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

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

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

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

Here is a site that shows many studies and the efficacy of HCQ.
https://www.sciencedirect.com/journal/international-journal-of-antimicrobial-agents/special-issue/10V3JMBH9GZ

More on Ivermectin

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

Watch Dr. Pierre Kory's passionate testimony about the effectiveness of Ivermectin on December 8, 2020, at the U.S. Senate Committee on Homeland Security and Governmental Affairs.
https://www.youtube.com/watch?v=YgOAaLmoa68&feature=emb_logo

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

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

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

Natural Alternative Options

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

There are many other nutritional compounds that also support healthy immune function and protect against viral illness. Check out my Viral Prevention and Treatment strategies page at https://www.wellnessdoc.com/nutritional-viral-prevention-and-treatment-products/

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

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

HERE

For prevention (prophylaxis) of viral illness, you may want to try an **immune/detox drink** that I have been making for myself and my family over the last few months. It combines several nutrients that I have covered in my ***Nutrient of the Month*** columns of my monthly newsletter over the past few months.

I like to use orange flavored Emergen-C. With the vanilla whey, it makes it taste like an orange dreamsicle. 😉

In a glass of water, add:

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

Mix with a wire whip or blender

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

- The Quercetin (a Zinc ionophore like HCQ) and Zinc act together to deliver Zinc into your cells and inhibit viral replication (not just COVID-19, but all viruses).
- The NAC, Selenium, Glutamine and undenatured Whey Protein help your body make Glutathione, the "Master Antioxidant" and detoxifier.
- The Vitamin C increases activity and effectiveness of the Innate Arm of the immune system, including Natural Killer Cells, Neutrophils, Lymphocytes and Macrophages.

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

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

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

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

Update April 11th, 2021

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

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

From his letter:

"Suspected covid-19"

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

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

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

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

The 371 individuals excluded from Pfizer vaccine efficacy analysis

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

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

We need the raw data

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

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

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

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

Footnote

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

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

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

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

For those that want to see more evidence of the "fuzzy math" used to determine the "effectiveness" and the risks of the mRNA vaccines you can read this excellent article…
https://everlyreport.com/what-you-need-to-know-about-the-covid-vaccine/

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

Dr. Peter Doshi , Associate Editor for the BMJ released a letter on October 22nd article titled, **Coronavirus Vaccine Trials Underway May Not Tell if the Shots Save Lives of COVID-19 Patients: British Medical Journal Expert**. In that letter, he questioned the end points of the Moderna and Pfizer vaccine trails stating "None of the trials currently underway are designed to detect a reduction in any serious outcome such as hospitalisations, intensive care use, or deaths. Nor are the vaccines being studied to determine whether they can interrupt transmission of the virus."

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

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

End of excerpts:

You can read the full letter here:

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

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

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

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

From the article:

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

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

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

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

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

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

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

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

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

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

From the article:

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

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

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

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

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

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

Considering that the total population of the nursing home was only 145, this is an extremely high number. The residents were vaccinated in early January. In mid-February it was reported that another 28 residents and 12 staff members have tested positive for COVID-19.
https://europerenaissance.com/2021/02/19/spain-second-pfizer-shots-halted-after-46-nursing-home-residents-die-after-the-first-shot/

Concerns over the Johnson & Johnson's vaccine

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

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

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

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

The following excerpt is from an April 24th, 2019 article published in ***ScienceMag*** titled **Dengue vaccine fiasco leads to criminal charges for researcher in the Philippines.**
https://www.sciencemag.org/news/2019/04/dengue-vaccine-fiasco-leads-criminal-charges-researcher-philippines

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

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

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

End of excerpts

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

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

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

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

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

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

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

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

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

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

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

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

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

End of excerpts

New concerns over the Moderna and Pfizer mRNA vaccines

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

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

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

From the article:

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

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

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

To read the full article with links to references go here:
https://childrenshealthdefense.org/defender/moderna-pfizer-vaccines-blood-clots-brain-inflammation-heart-attacks/

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

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

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

There are 4 articles of interest I came across in the last month…

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

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

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

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

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

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

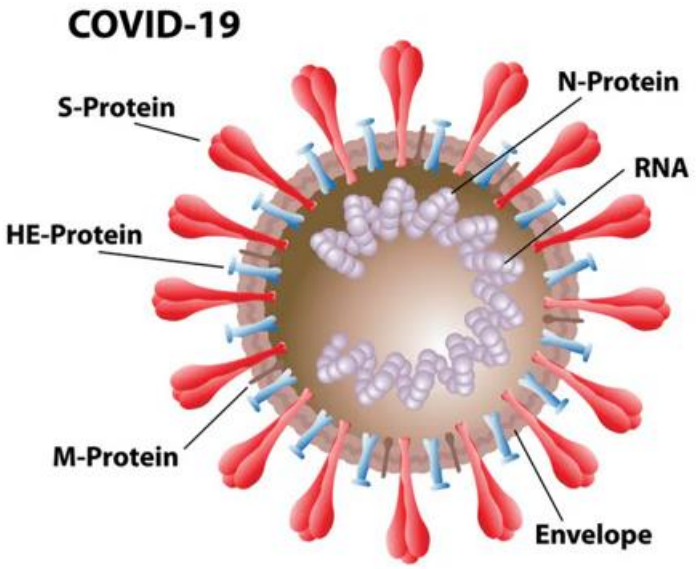
   This article reinforces that doctors have a poor level of awareness of the scope of the risk of allergic reactions to PEG. This is especially concerning since we are seeing a large uptick in allergic reactions from the COVID-19 vaccines, some fatal. Doctors need to know that this risk exists, how to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

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

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

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

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



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

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

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

The COVID-19 vaccine model of "immunity"

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

The body's model of immunity

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

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

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

The following is a quote from the article…
Given that recent polling suggests that only 40% to 60% of people in the United States are currently planning to get vaccinated, it is conceivable that without some impact on transmission, the virus will continue to circulate, infect, and cause serious disease in certain segments of the unvaccinated population.

Administration of parenterally administered vaccines alone typically does not result in potent mucosal immunity that might interrupt infection or transmission (9). https://pubmed.ncbi.nlm.nih.gov/33460347/

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

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

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

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

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

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

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

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

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

See table next page…

Updated on CDC site 03-19-21

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

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

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

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

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

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

Geert Vanden Bossche, PhD, DVM

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

Novartis vaccines and diagnostics:
- Director, Research Program Leader and Head of Adjuvants

Solvay Biologicals:
- Global Project Director Influenza Vaccines

Bill and Melinda Gates Foundation:
- Senior Program Officer, Global Health, Vaccine Discovery

Global Alliance for Vaccines and Immunization (GAVI)
- Program Manager

Univac
- Chief Innovation and Scientific Officer

German Center for Infection Research (DZIF)
- Head of the Vaccine Development Office

VARECO
- Managing Director

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

Here are the opening sections of his letter:

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

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

I am all but an antivaxxer. As a scientist I do not usually appeal to any platform of this kind to make a stand on vaccine-related topics. As a dedicated virologist and vaccine expert I only make an exception when health authorities allow vaccines to be administered in ways that threaten public health, most certainly when scientific evidence is being ignored. The present extremely critical situation forces me to spread this emergency call. As the unprecedented extent of human intervention in the Covid-19-pandemic is now at risk of resulting in a global catastrophe without equal, this call cannot sound loudly and strongly enough.

As stated, I am not against vaccination. On the contrary, I can assure you that each of the current vaccines have been designed, developed and manufactured by brilliant and competent scientists.

However, this type of prophylactic vaccines are completely inappropriate, and even highly dangerous, when used in mass vaccination campaigns during a viral pandemic. Vaccinologists, scientists and clinicians are blinded by the positive short-term effects in individual patents, but don't seem to bother about the disastrous consequences for global health. Unless I am scientifically proven wrong, it is difficult to understand how current human interventions will prevent circulating variants from turning into a wild monster.

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

You can read the entire letter here:
https://mcusercontent.com/92561d6dedb66a43fe9a6548f/files/bead7203-0798-4ac8-abe2-076208015556/Public_health_emergency_of_international_concert_Geert_Vanden_Bossche.01.pdf

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

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

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

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

Here goes:

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

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

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

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

(1) **viremia** being allowed to increase in infected people (denial of early treatment) because new mutations occur in people

(2) **test escape** (increased survival and transmission of viruses due to non-isolation of people infected w/variants that escape the test)

(3) **immunological escape** (survival and transmission of viruses that can escape our immune responses

(4) **migration** (heterogeneity in public health response (maintenance of all variants at different frequencies somewhere in the globe))

(5) genetic drift

All of the above interact and are not competing.

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

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

This completely ignores the pathogenic priming of people toward autoimmunity.

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

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

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

Real-world contemporary example

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

Due to original antigenic sin, a partial immune response to viral epitopes in the spike protein only will cause people to mount an ineffective immune response to the virus when it evolves new spike protein epitope

variants. These people will not have long-term adaptive immunity to the other pathoimmunogenic epitopes from the virus, and thus they will experience a new immune response - **as if they have not been vaccinated.**

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

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

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

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

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

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

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

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

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

What about "Recurrent Infection"?

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

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

Their fabled, magical belief in "protection" from vaccines is going to be shattered by COVID-19, and it's going to be a wake-up call to those who wanted the vaccine so badly. They won't be able to keep up via updates to the vaccine, it's just not possible. Recall what's going on w/HPV vaccination - type replacement - it's the same thing.

https://www.sciencedirect.com/science/article/pii/S0163445321000438
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7749790/
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3187504/
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7115648/

https://www.sciencedirect.com/science/article/pii/S0163445321000104
https://www.sciencedirect.com/science/article/pii/S0163445321000438

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

Risks vs "benefits" of the COVID-19 vaccines- JLW

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

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

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

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

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

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

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

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

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

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

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

But check this out, for example

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

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

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

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

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

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

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

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

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

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

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

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

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

From the abstract:

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

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

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

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

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

Discussion:

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

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

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

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

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

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

The letter in its entirety:

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

28 February 2021

Dear Sirs/Mesdames,

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

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

We note that a wide range of side effects is being reported following vaccination of previously healthy younger individuals with the gene-based COVID-19 vaccines. Moreover, there have been numerous media reports from around the world of care homes being struck by COVID-19 within days of vaccination of residents. While we recognise that these occurrences might, every one of them, have been unfortunate coincidences, we are concerned that there has been and there continues to be inadequate scrutiny of the possible causes of illness or death under these circumstances, and especially so in the absence of post-mortems examinations.
In particular, we question whether cardinal issues regarding the safety of the vaccines were adequately addressed prior to their approval by the European Medicines Agency (EMA).

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

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

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

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

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

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

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

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

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

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

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

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

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

New research points to link between AstraZeneca Vaccine and blood clots

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

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

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

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

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

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

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

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

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

My comment: Of course they didn't!

See the rest of the article with all the links here:
https://childrenshealthdefense.org/defender/link-astrazeneca-vaccine-blood-clots/?itm_term=home

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

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

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

From the article:

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

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

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

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

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

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

AN IMPORTANT SECTION AT THE END OF THE ARTICLE:

Lipid nanoparticles—where do they go and what do they do?
Conceived three decades ago, RNA based therapeutics11 have long inspired imaginations for their theoretical potential to transform cells of the body into "an on-demand drug factory."12 But despite heavy investment by the biotech industry, bench-to-bedside translation was constantly hindered by the fragility of mRNA.

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

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

End of excerpts

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

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

Final thoughts

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

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

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

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

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

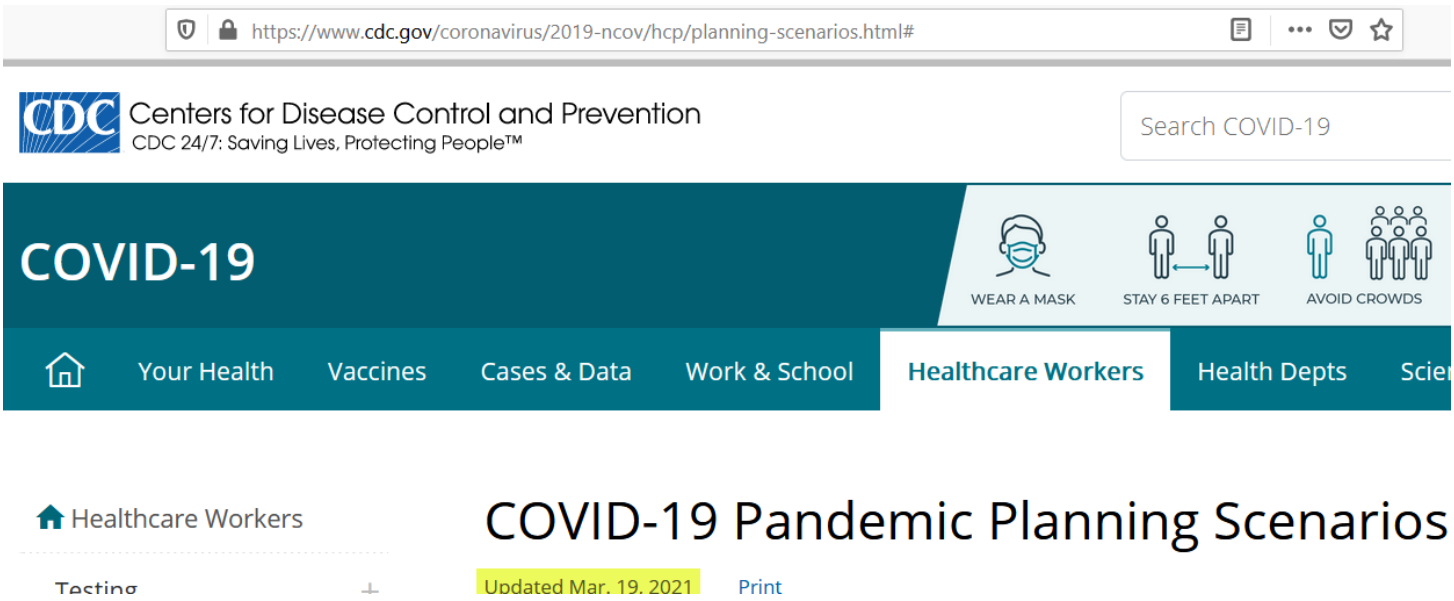
https://www.rt.com/news/516069-pfizer-covid19-vaccine-refrigerator-cold/

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

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

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

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



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

The SUMMARY of most likely scenario according to the CDC:

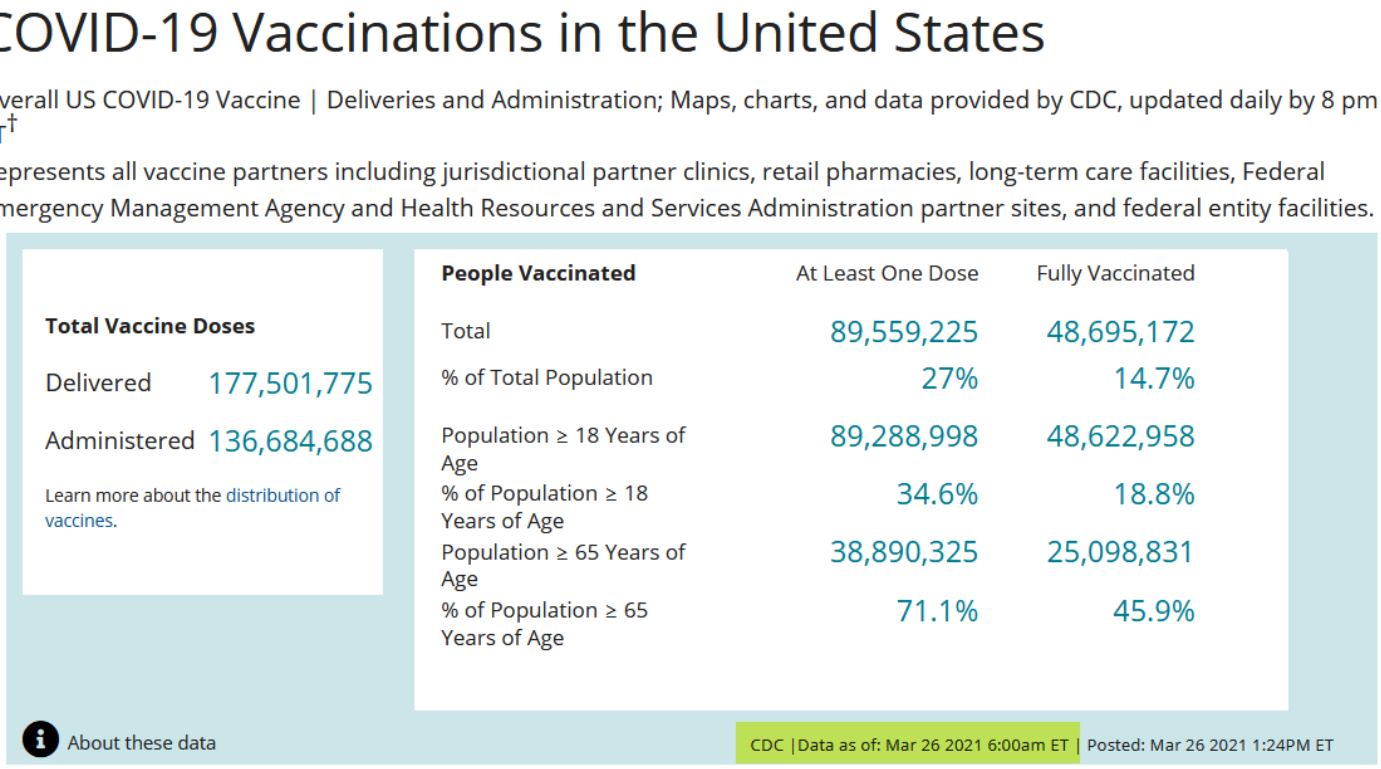
- In the 0-17 year-old age group, the Infection Fatality Rate is 0.002% (20 deaths per million infections, or 1 death in every 50,000 infections)

- In the 18-49 year-old age group it is 0.05% (500 deaths per million infections, or 1 death in every 2,000 infections)
- In the 50-64 year-old age group it is 0.6% (6,000 deaths per million infections, or 1 death in every 167 infections)
- In the 65+ age group it is 9% (90,000 deaths per million infections, or 1 death in every 11 infections). The CDC previously reported in June 2020, that people 65 and over account for 80.73% of all COVID-19 deaths. https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html

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

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

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



COVID-19 Vaccinations in the United States

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

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

Total Vaccine Doses

Delivered 177,501,775

Administered 136,684,688

Learn more about the distribution of vaccines.

People Vaccinated	At Least One Dose	Fully Vaccinated
Total	89,559,225	48,695,172
% of Total Population	27%	14.7%
Population ≥ 18 Years of Age	89,288,998	48,622,958
% of Population ≥ 18 Years of Age	34.6%	18.8%
Population ≥ 65 Years of Age	38,890,325	25,098,831
% of Population ≥ 65 Years of Age	71.1%	45.9%

About these data

CDC | Data as of: Mar 26 2021 6:00am ET | Posted: Mar 26 2021 1:24PM ET

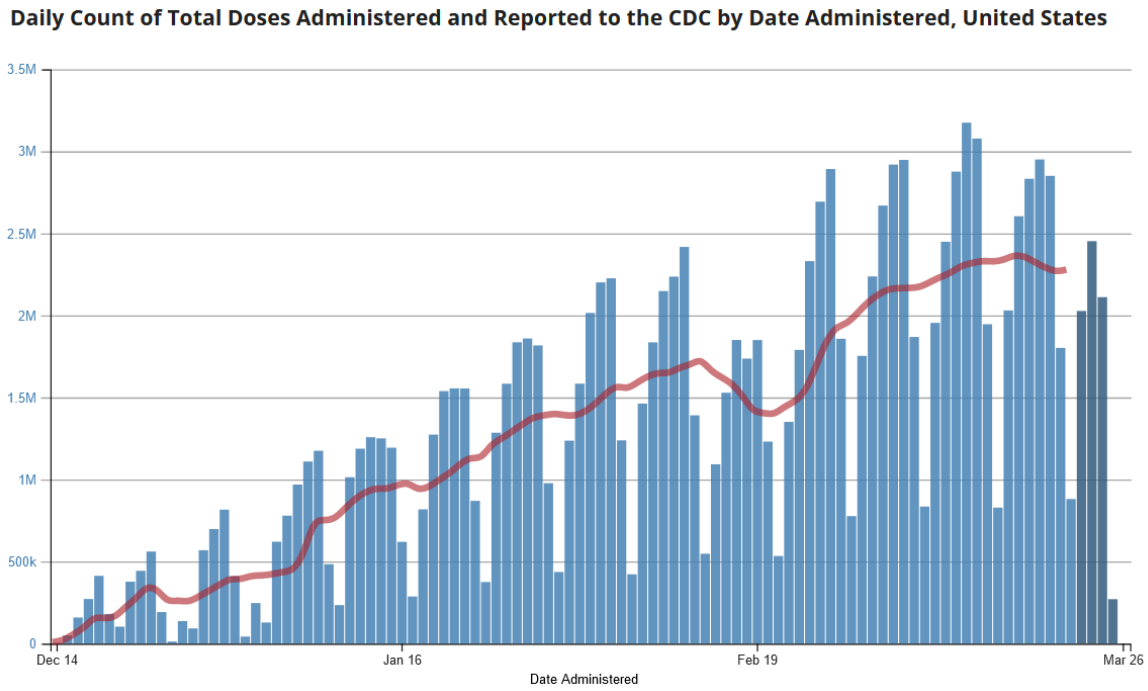
https://covid.cdc.gov/covid-data-tracker/#vaccinations

Since the latest reported VAERS death totals were as of March 19th, and this chart was through March 25th, I had to back out the doses given from March 19th through March 25th. This is how I did that. I used the data from the CDC's web site shown in the chart below. It is an interactive chart, so I could see how many doses

were given each day. Since both the Pfizer and Moderna vaccines require 2-doses to be fully vaccinated I cut the number of doses to back out from the total in half.

Continued next page…

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



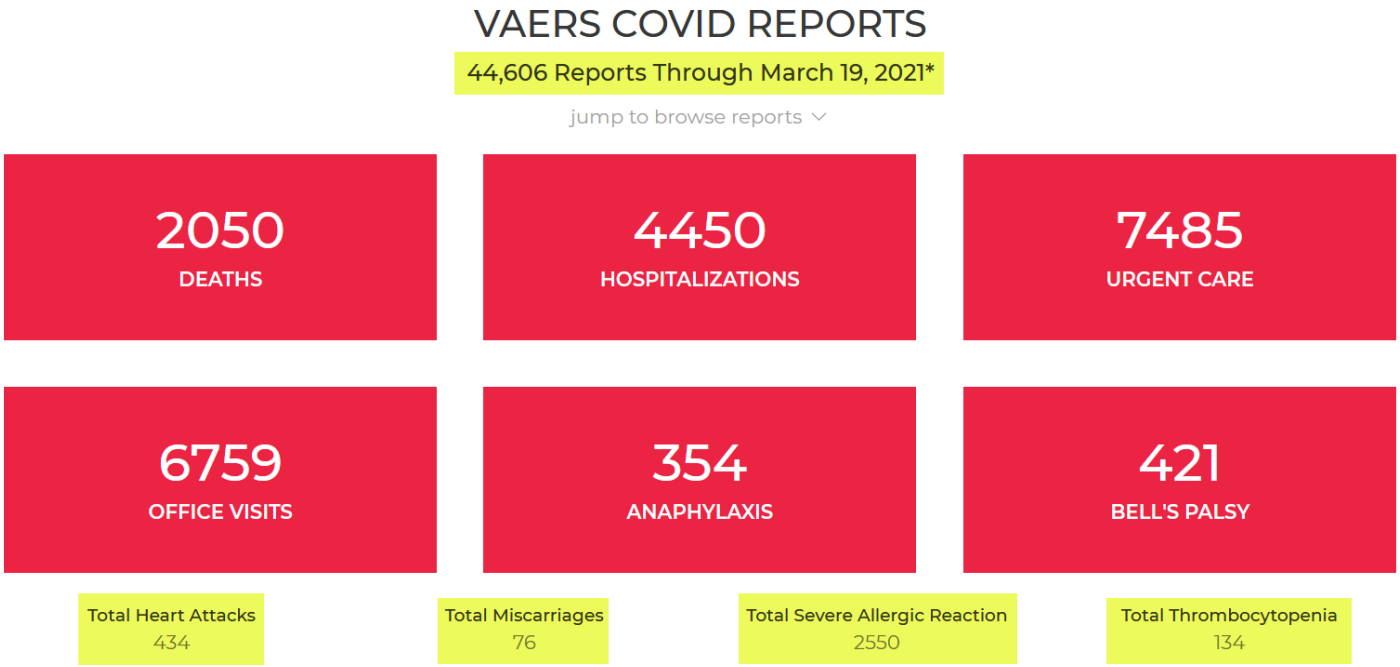
My calculation resulted in 14,123,487 doses March 19th (last VAERS death total available) through the 25th, the last full day reported for vaccines doses administered. Since I am calculating the number of people fully vaccinated and Pfizer and Moderna require 2 doses, I will divide the 14,123,487 does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

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

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

See chart next page…

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



Now the calculations

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

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

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

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

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

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

- **The 18-49 year-old age group-** The risk of death from the vaccines is approximately 10 times higher from the vaccines than from the infection! (0.49% to 0.5%)

- **The 50-64 year-old age group-** The risk of death is nearly the same from the vaccines as compared to the infection. (.49% to .6%)

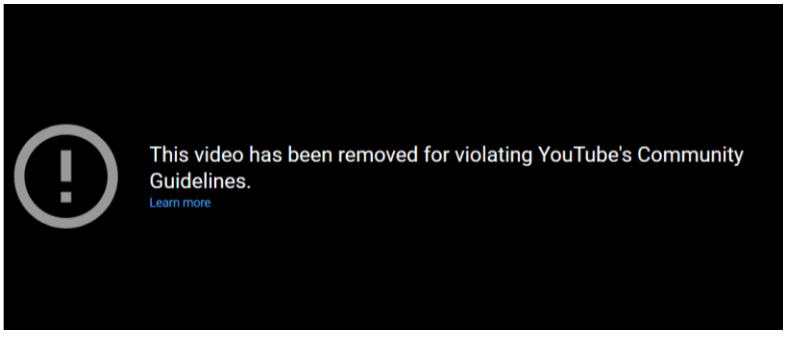
And remember, according to the ***Annals of Internal Medicine*** article above, the Infection Fatality Rate for the under 40 age group is only 0.01%. So according to their statistics the risk of death from the vaccines are nearly 5 times higher!

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

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

First lawsuit challenging mandatory vaccines

You could have seen the video here: https://www.youtube.com/watch?v=t3P9CYGq9M4 , but the arbiters of truth have taken it down.



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

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

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

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

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

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

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

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

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

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

From the story:

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

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

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

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

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

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

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

From the story:

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

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

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

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

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

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

Bill Gates says a third shot may now be needed

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

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

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

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

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

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

End of excerpts:
https://www.cbsnews.com/news/covid-vaccine-variants-third-shot-bill-gates/

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

When will it end?

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

Personal anecdotes of serious and fatal reactions:

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

1. The person that died from the vaccine was an elderly man with dementia living in a care home. He was otherwise doing well prior to the vaccine. After the shot he lapsed into confusion to the point of "being incoherent" and had extreme difficulty breathing as my friend (his daughter) related to me. Shortly thereafter he developed fluid in his lungs and had to have them drained three times. Sadly, he passed away shortly thereafter.

2. The other person was an ex-firefighter, 61 years old who was a health and fitness fanatic in great shape. He was not intending to get the vaccine, but the only reason he got the vaccine was to travel to Nepal to climb up to "Base Camp" on Everest with a group of firefighters. They were doing that trip to bring about awareness of the high rates of cancer in the firefighter community. Again, this man had been training for this expedition and was incredibly fit. After receiving his first vaccine, he suffered a reaction that has left him fighting for his life in the hospital. Both lungs have "collapsed" according to my friend who is a retired fellow fire fighter. He is waiting on a double lung transplant.

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

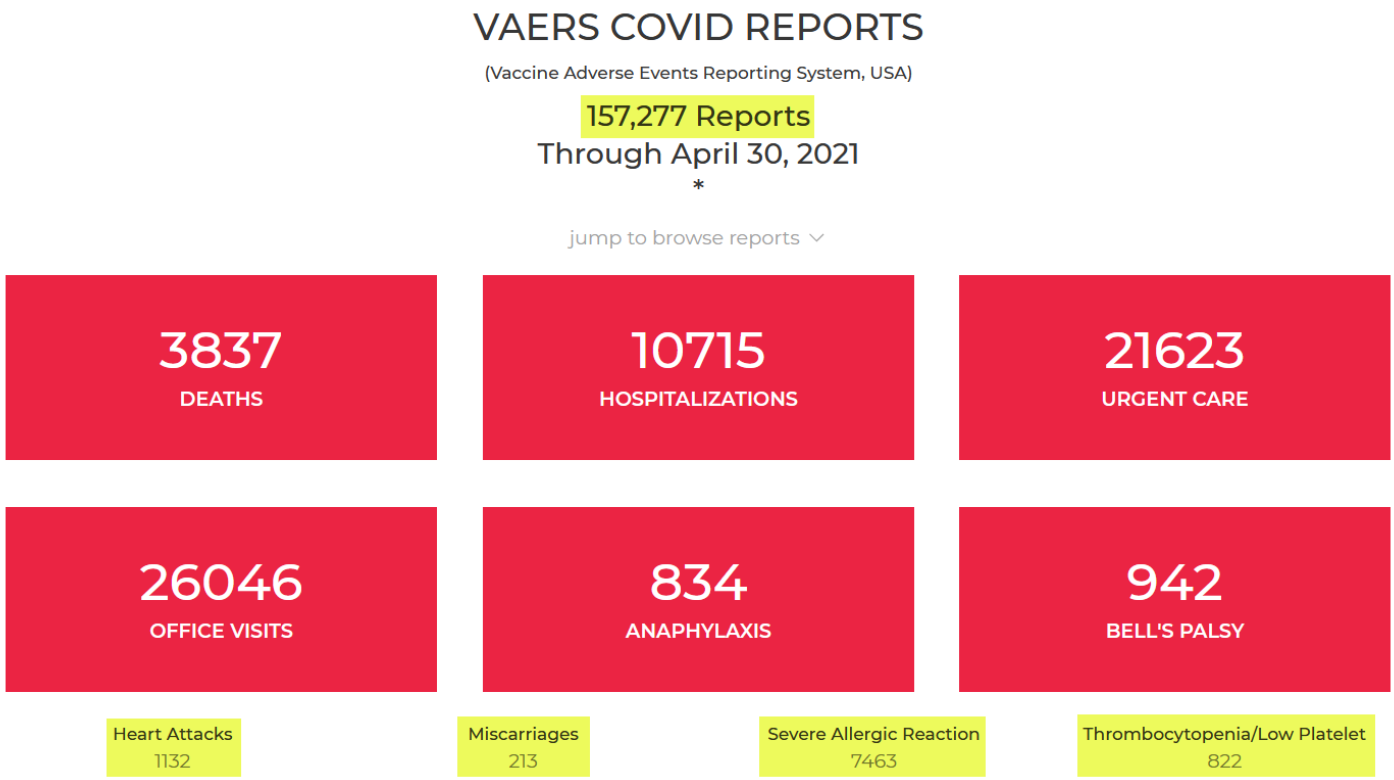
These are three events that were completely preventable. The shocking and maddening thing is that this is happening all over our country and the world, yet the media is silent. Doctors are either afraid or unwilling to report them because of being criticized for doing the right thing, or in some warped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

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

May 1st Update

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

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



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

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

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

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

The Purpose of the Study:

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

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

Results from the study:

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

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

"Adverse events from drugs and vaccines are common, but underreported. Although 25% of ambulatory patients experience an adverse drug event, less than 0.3% of all adverse drug events and 1-13% of serious events are reported to the Food and Drug Administration (FDA). Likewise, fewer than 1% of vaccine adverse events are reported. Low reporting rates preclude or slow the identification of "problem" drugs and vaccines that endanger public health."

In addition, ESP: VAERS investigators participated on a panel to explore the perspective of clinicians, electronic health record (EHR) vendors, the pharmaceutical industry, and the FDA towards systems that use proactive, automated adverse event reporting." (Since in the end, this improved automated reporting system was stymied and went nowhere, one has to wonder what influence the pharma reps on the panel had on that).

Here's the kicker. After spending nearly 3 years and a million dollars, the CDC went dark on the program. Was it because the surveillance system would significantly increase the reporting of vaccine adverse reactions?

The last statement from the Results section of the article says it all…

"Unfortunately, there was never an opportunity to perform system performance assessments because the necessary CDC contacts were no longer available and the CDC consultants responsible for receiving data were no longer responsive to our multiple requests to proceed with testing and evaluation."

One has to wonder what is stopping the automation of the vaccine adverse reporting system from being implemented. This report suggested that its implementation would be easy to accomplish. That was in 2010. It is now 2018 and nothing has been done to accomplish this vital information system. And lives hang in the balance.

It is feared that the greatest number of deaths will not occur for some time to come

Many scientists and researchers warn that the potential for ***Antibody Dependent Enhancement*** AKA ***Pathogenic Priming*** as well as other autoimmune and immune dysregulation effects from the vaccines can lead to a large number of delayed deaths from the vaccines.

And here's an example of one of those raising a red flag!

The Spike Protein as the progenitor of the epidemic of thrombotic events occurring post-vaccination around the globe

In the first part of this newsletter, I am going to concentrate on the clotting issue that many top experts now believe is leading to the unprecedented number of cases of severe injury and death happening around the world post COVID-19 "vaccines". I personally know of three people that this has happened to as relayed to me from my closest circle of friends. This is just one of the many potential mechanisms of injury, but I believe is an important one to take a deeper dive into.

I've used scare quotes around the word vaccine, because as many of you reading this know, these are not vaccines in the traditional sense. The top four products are actually gene modifying technologies that introduce the spike protein into our cells either by a lipid nanoparticle encapsulating it (Moderna and Pfizer) or a viral vector with the spike protein spliced into an adenovirus (Johnson and Johnson and AstraZeneca). These two methods are the delivery mechanism to get the spike protein inside our cells. Once inside our cells, the ribosomes within the cell then manufacture or make copies of the spike protein sequences. These then are presented on the surface of the cell as they "bud" through the exterior layers and are eventually released into our circulation. Aside from that method of release into our body, our immune system upon recognizing these budding viral proteins mount an attack on the cell, eventually essentially blowing up the cell. When that happens all of the manufactured spike proteins are released into circulation to travel throughout the body and wreak havoc.

It has often been said as these novel technologies were being produced, that they will turn our cells into vaccine making factories. This ability of the spike proteins produced by our own cells as a result of the programming or "hacking the software of life" as Tal Zacs, Moderna's Chief Scientific Officer is quoted as

saying about their mRNA vaccine technology in a ***Ted Talk*** is a risky proposition, especially when attempts to make vaccines in the past were never able to make it past animal trials due to the lethality of the vaccines. https://www.ted.com/talks/tal_zaks_the_disease_eradicating_potential_of_gene_editing

As I said months ago when I first saw this video…"Hacking the software of life? What could possible go wrong!"

As this release of spike protein happens throughout the body in the hours and days after a person receives the vaccine, some people have an exaggerated reaction to this exposure to the spike protein and develop this clotting phenomenon in the small blood vessels of organs, leading to severe complications and death. As I've studied this, I have heard experts express concern and reservation about how this is then treated in the hospital, as they say that the traditional way of treating these clotting disorders with blood thinners may actually make matters worse.

We are really in unchartered territory here. And that is why you don't shortcut long-term safety studies for vaccines, especially new and experimental technologies. This is especially true for a virus that has a world-wide infection survival rate of 99.95% for people under 70 years of age. https://www.marktaliano.net/publication-bulletin-of-the-world-health-organization-infection-fatality-rate-of-covid-19-john-p-a-ioannidis/

A prime example of the dangers of the spike protein

This March 8th, 2021 pre-print study titled **SARS-CoV-2 spike protein S1 induces fibrin(ogen) resistant to fibrinolysis: Implications for microclot formation in COVID-19**, is a wake-up call for the need for an intensive INDEPENDENT investigation to the injuries and deaths post COVID vaccines all around the world. This is something that I have been suspicious about and have reported on in previous newsletters.

The spike protein is thought to be the triggering mechanism for the thrombotic (clotting) disorders seen in the microvasculature of the body in some patients with COVID-19. After this section I will show one of the mechanisms for how that happens.

But first, I think it is important to read some very relevant sections of this study. I've included a good portion of the study because I believe it is a powerful wake up call for the world and the use of these experimental products.

***PPP stands for Platelet Poor Plasma.**

ABSTRACT

Severe acute respiratory syndrome coronavirus 2 (SARS-Cov-2) -induced infection, the cause of coronavirus disease 2019 (COVID-19), is characterized by unprecedented clinical pathologies. One of the most important pathologies, is hypercoagulation and microclots in the lungs of patients. Here we study the effect of isolated SARS-CoV-2 spike protein S1 subunit as potential inflammagen *sui generis*. Using scanning electron and fluorescence microscopy as well as mass spectrometry, we investigate the potential of this inflammagen to interact with platelets and fibrin(ogen) directly to cause blood hypercoagulation. Using platelet poor plasma (PPP), we show that spike protein may interfere with blood flow. Mass spectrometry also showed that when spike protein S1 is added to healthy PPP, it results in structural changes to β and γ fibrin(ogen), complement 3,

and prothrombin. These proteins were substantially resistant to trypsinization, in the presence of spike protein S1. Here we suggest that, in part, the presence of spike protein in circulation may contribute to the hypercoagulation in COVID-19 positive patients and may cause substantial impairment of fibrinolysis. Such lytic impairment may result in the persistent large microclots we have noted here and previously in plasma samples of COVID-19 patients. This observation may have important clinical relevance in the treatment of hypercoagulability in COVID-19 patients.

From the study:

Spike protein, can however be shed, and it has been detected in various organs, including the urinary tract (George et al., 2021). S1 proteins can also cross the blood-brain-barrier (Rhea et al., 2021). Free S1 particles may also play a role in the pathogenesis of the disease (Letarov et al., 2020, Buzhdygan et al., 2020). Free spike
protein can potentially be released due to spontaneous "firing" of the S protein trimers on the surface of virions, and infected cells liberates free receptor binding domain-containing S1 particles (Letarov et al., 2020). Here we study the effect of isolated SARS-CoV-2 spike protein S1 subunit as potential proinflammatory inflammagen *sui generis*. We investigate the potential of this inflammagen to directly interact with platelets and fibrin(ogen) to cause fibrin(ogen) protein changes and blood hypercoagulation. We also determine if the spike protein may interfere with blood flow, by comparing naïve healthy PPP samples, with and without added spike protein, to PPP samples from COVID-19 positive patients (before treatment). We conclude that the spike protein may have pathological effects directly, without being taken up by cells.

Discussion:

In this laboratory analysis, we provide evidence that spike protein does indeed play a major role in hypercoagulability seen in COVID-19 patients. It causes anomalous clotting in both purified fluorescent fibrinogen and in PPP, where the nature of the clots were shown to be amyloid (ThT as our amyloid dye of choice). An interesting observation was that these dense deposits were noted both in smears exposed to spike protein, and when thrombin was added. The addition of thrombin causes purified (Alexa Fluor™488) fibrinogen to polymerize into fibrin networks. Typically, these networks are netlike (Figure 3A). In the presence of spike protein, the structure changed to form dense clot deposits (Figure 3B). These deposits were seen in our fluorescent fibrin(ogen) model and PPP from healthy individuals exposed to spike protein. In healthy PPP exposed to spike protein, followed by incubation with ThT, there was a significant increase in anomalous clots with an amyloid nature, (Figure 4D), when compared to the health PPP. Spike protein also caused major ultrastructural changes in WB (as viewed with the SEM), where platelet hyperactivation were noted (Figure 6C and D). Increased in spontaneously formed fibrin network, as well as anomalous clot formation were also observed in SEM micrographs (Figure 6E - H). Interestingly, extensive spontaneous fibrin network formation was noted, without the addition of thrombin. This is in line with results that were recently published, where we showed similar ultrastructure in blood smears form COVID-19 positive patients. In these patient's platelet hyperactivation, anomalous clotting with amyloid signal and spontaneous fibrin fibre formation were also observed (Pretorius et al., 2020, Venter et al., 2020).

Figure 4: Representative fluorescence micrographs of platelet poor plasma (PPP) from healthy individuals after addition of ThT (green fluorescent signal). **A)** PPP smear. **B)** PPP with spike protein. **C)** PPP with thrombin to create extensive fibrin clot; **D)** PPP exposed to spike protein followed by addition of thrombin. Final spike protein concentration was 1ng.mL^{-1}.

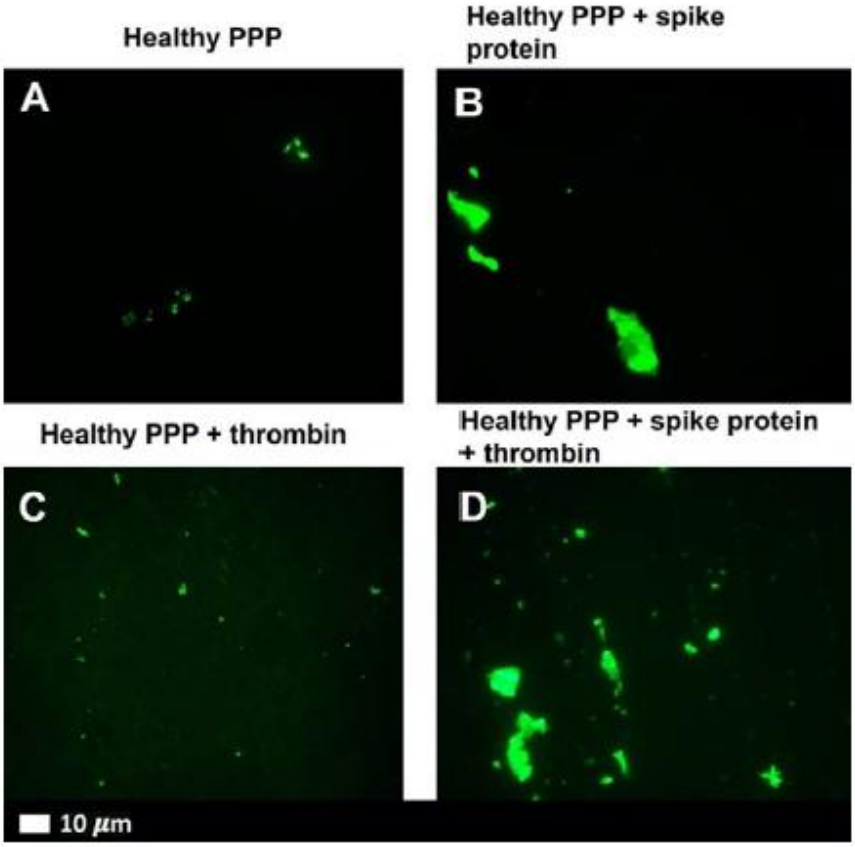


Figure 5A: Fluorescence microscopy micrographs of representative naïve whole blood (WB), where platelets were incubated with fluorescent marker, CD62P-PE. **B)** WB after exposure to spike protein. The white arrows point to hyperactivated activated platelets.

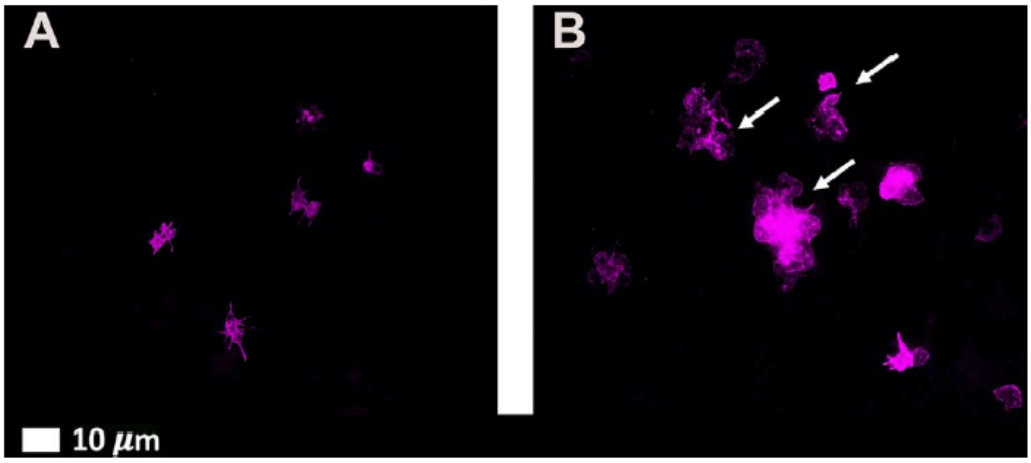


Figure 6A to H: Representative scanning electron micrographs of healthy control whole blood (WB), with and without spike protein. **A and B)** Healthy WB smears, with arrow indicating normal erythrocyte ultrastructure. **C to H)** Healthy WB exposed to spike protein (1 $ng.mL^{-1}$ final concentration), with **C and D**) indicating the activated platelets (arrow), **E and F**) showing the spontaneously formed fibrin network and **G and H**) the anomalous deposits that is amyloid in nature (arrows) (Scale bars: E: 20µm; A: 10µm; F and G: 5µm; H: 2µm; C: 1µm; B and D: 500nm).

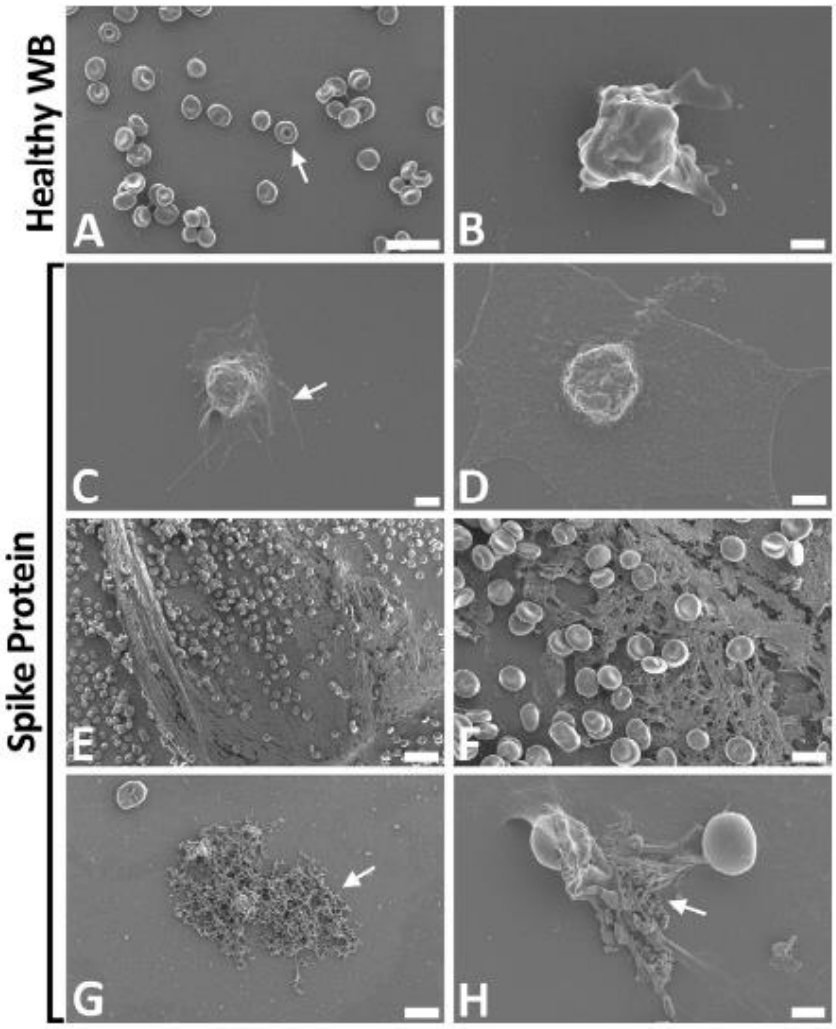
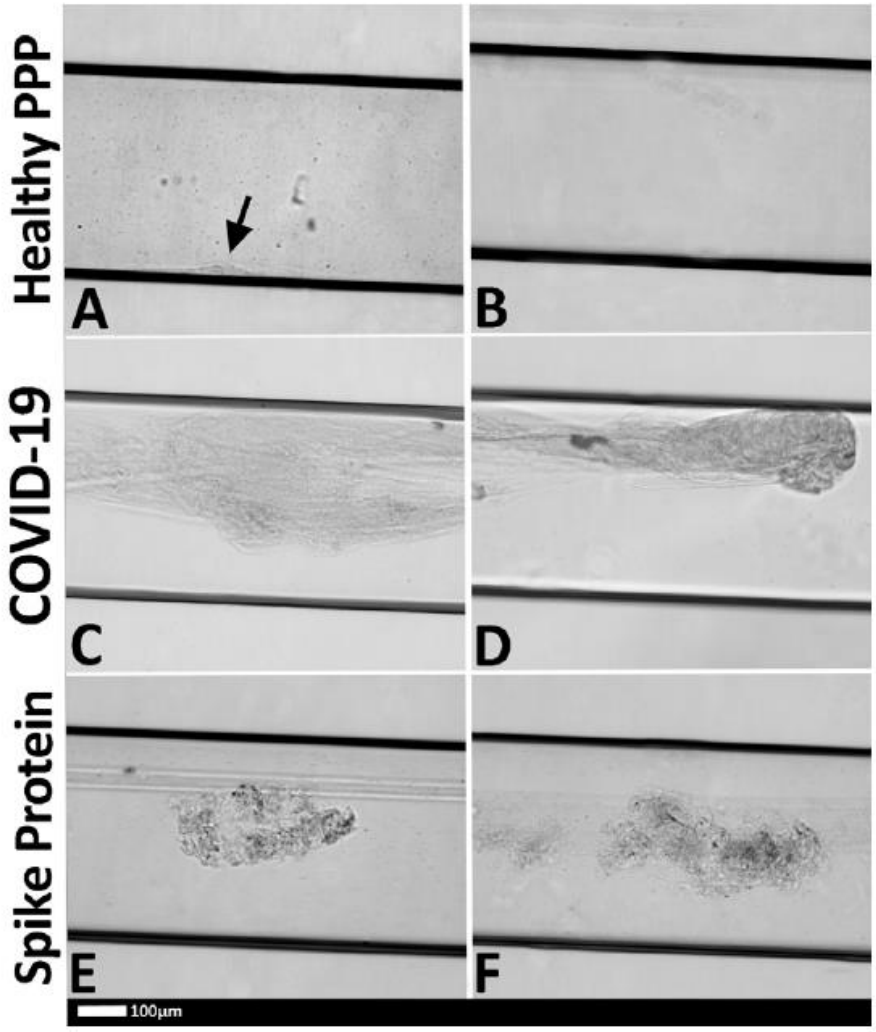


Figure 7: Representative micrographs of PPP clots in the microfluidic chambers (black horizontal lines are the outlines of the chambers) that were coated with thrombin. **A)** Healthy PPP clot, with small clot formation (arrow), with **B)** no clot formed in the healthy PPP sample; **C and D)** examples of clots from COVID-19 PPP samples and **E and F)** healthy PPP clot with spike protein.



The clots that were observed in the healthy PPP with added spike protein, were of particular interest as they demonstrated a bridge between healthy PPP clots and COVID-19 clots. As described in the results, the healthy PPP clots were relatively small and orderly, while COVID-19 PPP clots were large, disorderly masses that formed rapidly and disrupted PPP flow in the channel. The healthy PPP clots with added spike protein, were a combination of the two, demonstrating disorderly clumped clot areas, co-existing with laminar fibrous PPP clots (which were larger than the healthy PPP clots). This intermediate state may arise from a number of factors, including the interaction of other biological actors which were absent from the flow setup and the time of exposure to spike protein. Further investigations would be beneficial for understanding the clotting mechanisms that are altered in the presence of spike protein.

The Conclusion:

Scanning electron- and fluorescence microscopy revealed large dense anomalous and amyloid masses in whole blood and PPP of healthy individuals where spike protein was added to the samples. Mass spectrometry confirmed that when spike protein was added to PPP, it interacts with plasma proteins, resulting in fibrin(ogen), prothrombin and other proteins linked to coagulation, to become substantially resistant to

trypsinization, resulting in less fragments. Flow analysis confirmed that microclots may impair blood flow. Here we suggest that, in part, the presence of spike protein in circulation may contribute to the hypercoagulation in COVID-19 positive patients and may cause severe impairment of fibrinolysis. Such lytic impairment may be the direct cause of the large microclots we have noted here in SEM and fluorescence microscopy, and previously in plasma samples of COVID-19 patients (Pretorius et al., 2020, Venter et al., 2020).

End of excerpts

Have the vaccines contributed to the fall in cases?

This is the multi-billion-dollar question. The timing of the release of the vaccine was almost perfect to take advantage of the appearance that they would be effective. But there are at least three problems with I see with that assumption. Here are the key factors I see at play.

1. The timing of the release and increase of population vaccination coverage correlated closely with the normal decrease in respiratory viral patterns due to seasonality. The question is would the cases, hospitalizations and deaths have decreased at the same rate without any vaccines?

2. The CDC has predicted that 8 times more people than have tested PCR positive have had the infection. As of the writing of this newsletter, approximately 33,000,000 people have tested positive in the U.S. Eight times 33,000,000 is 264,000,000 people. Add the 33,000,000 to that number and you have 297,000,000 people that have had the SARS-CoV-2 virus to date. With a population of 335 million people in the U.S., that means that approximately 91% of the population has immunity. With predictions ranging from 70-90% to reach herd immunity, we have to be there or very close by now.

   That 8X ratio is according to an article posted online November 27th titled **Estimated Incidence of Coronavirus Disease 2019 (COVID-19) Illness and Hospitalization—United States, February–September 2020**
   "The CDC researchers estimated that about 52.9 million Americans had been infected in the U.S. by the end of September". The number of confirmed COVID-19 cases was only 6.9 million up to that time. That is about an 8 to 1 ratio of those that have it and either don't know it or have very mild symptoms and never get a test to those that do test positive. (PCR testing inaccuracy as we have seen is a whole other issue!) https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1780/6000389

3. The WHO, CDC and numerous credible scientific experts have admitted the fact that the "Vaccines" do NOT prevent infection and do NOT prevent transmission. Therefore, there is no way that they could be responsible for falling cases. (see my next story to find out why I've used the scare quotes). They MAY reduce symptoms is all that they have been able to demonstrate. But to what extent?

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

the approximately 95% effectiveness that was reported. Peter Doshi is a highly credible scientifically qualified source to analyze the data and comment on it.

One of the issues Dr. Doshi had with Pfizer's reporting of the clinical data was the following…

"Another reason we need more data is to analyse an unexplained detail found in a table of FDA's review of Pfizer's vaccine: 371 individuals excluded from the efficacy analysis for "important protocol deviations on or prior to 7 days after Dose 2." What is concerning is the imbalance between randomized groups in the number of these excluded individuals: 311 from the vaccine group vs 60 on placebo." This could obviously skew the numbers in favor of the vaccinated group to make the efficacy look better than it was.

Another issue was exclusion of "suspected" COVID-19 cases.

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

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

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

Are they really vaccines? See what the government filed documents say

We are continually told that the COVID-19 shots are vaccines. But are they really?

It appears from the following documents that they are really "Gene Therapy". It makes sense when you hear Dr. Fauci and others say that they may reduce symptoms of clinical disease. In essence, they are a treatment and to not prevent infection as would be the traditional role of a vaccine.

See next page….

Verizon LTE 4:52 PM 50%

covidvaccinereactions.com — Private

BioNtech's SEC Filing Source:
https://www.sec.gov/Archives/edgar/data/1776985/000119312519241112/d635330df1.htm

AA sec.gov

F-1 1 d635330df1.htm F-1

Table of Contents

As filed with the Securities and Exchange Commission on September 9, 2019.
Registration No. 333-

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM F-1
REGISTRATION STATEMENT
UNDER
THE SECURITIES ACT OF 1933

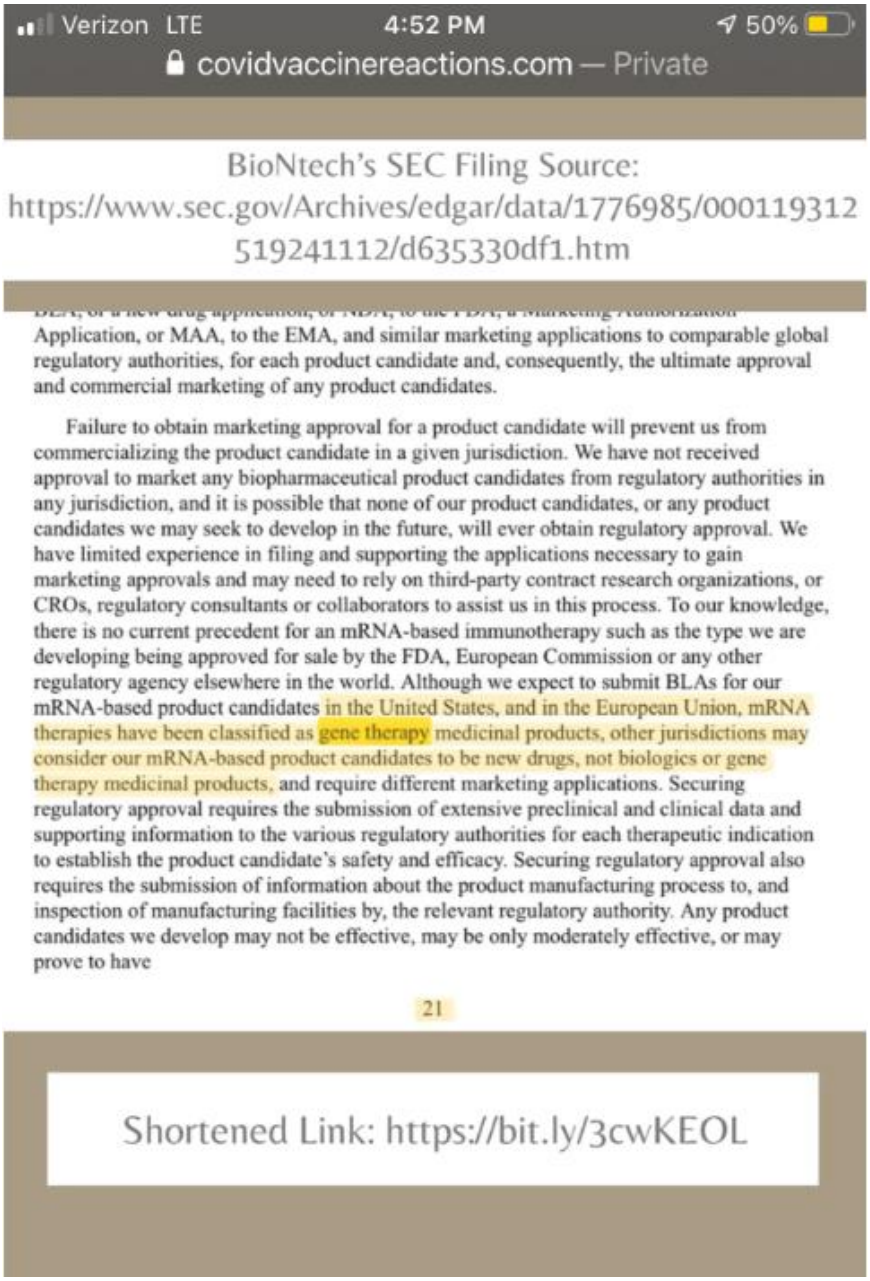
BioNTech SE
(Exact Name of Registrant as Specified in Its Charter)

Not Applicable
(Translation of Registrant's name into English)

Federal Republic of Germany (State or Other Jurisdiction of Incorporation or Organization)	2836 (Primary Standard Industrial Classification Code Number)	NOT APPLICABLE (I.R.S. Employer Identification Number)

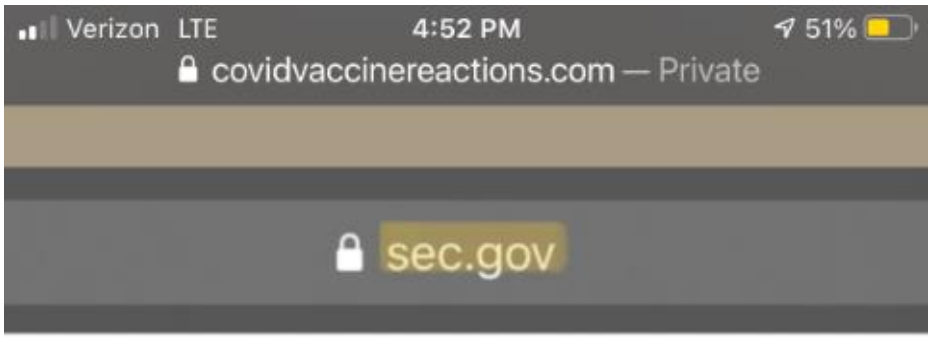
Prof. Ugur Sahin, M.D.
An der Goldgrube 12
D-55131 Mainz
Germany
Tel: +49 6131-9084-0
(Address, Including Zip Code, and Telephone Number, Including Area Code, of Registrant's Principal Executive Offices)

Shortened Link: https://bit.ly/3cwKEOL



ENLARGED

CROs, regulatory consultants or collaborators to assist us in this process. To our knowledge, there is no current precedent for an mRNA-based immunotherapy such as the type we are developing being approved for sale by the FDA, European Commission or any other regulatory agency elsewhere in the world. Although we expect to submit BLAs for our mRNA-based product candidates in the United States, and in the European Union, mRNA therapies have been classified as gene therapy medicinal products, other jurisdictions may consider our mRNA-based product candidates to be new drugs, not biologics or gene therapy medicinal products, and require different marketing applications. Securing regulatory approval requires the submission of extensive preclinical and clinical data and supporting information to the various regulatory authorities for each therapeutic indication to establish the product candidate's safety and efficacy. Securing regulatory approval also requires the submission of information about the product manufacturing process to, and inspection of manufacturing facilities by, the relevant regulatory authority. Any product candidates we develop may not be effective, may be only moderately effective, or may prove to have



UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

FORM 10-Q

REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT
For the quarterly period ended June 30, 2020
OR
REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT
For the transition period from _ to _
Commission File Number: 001-38753

moderna

Moderna, Inc.
(Exact Name of Registrant as Specified in Its Charter)

Delaware	81-3467528
(State or Other Jurisdiction of Incorporation or Organization)	(IRS Employer Identification No.)
200 Technology Square Cambridge, Massachusetts	02139
(Address of Principal Executive Offices)	(Zip Code)

(617) 714-6500
(Registrant's Telephone Number, Including Area Code)

Shortened Link: https://bit.ly/2NitVGI

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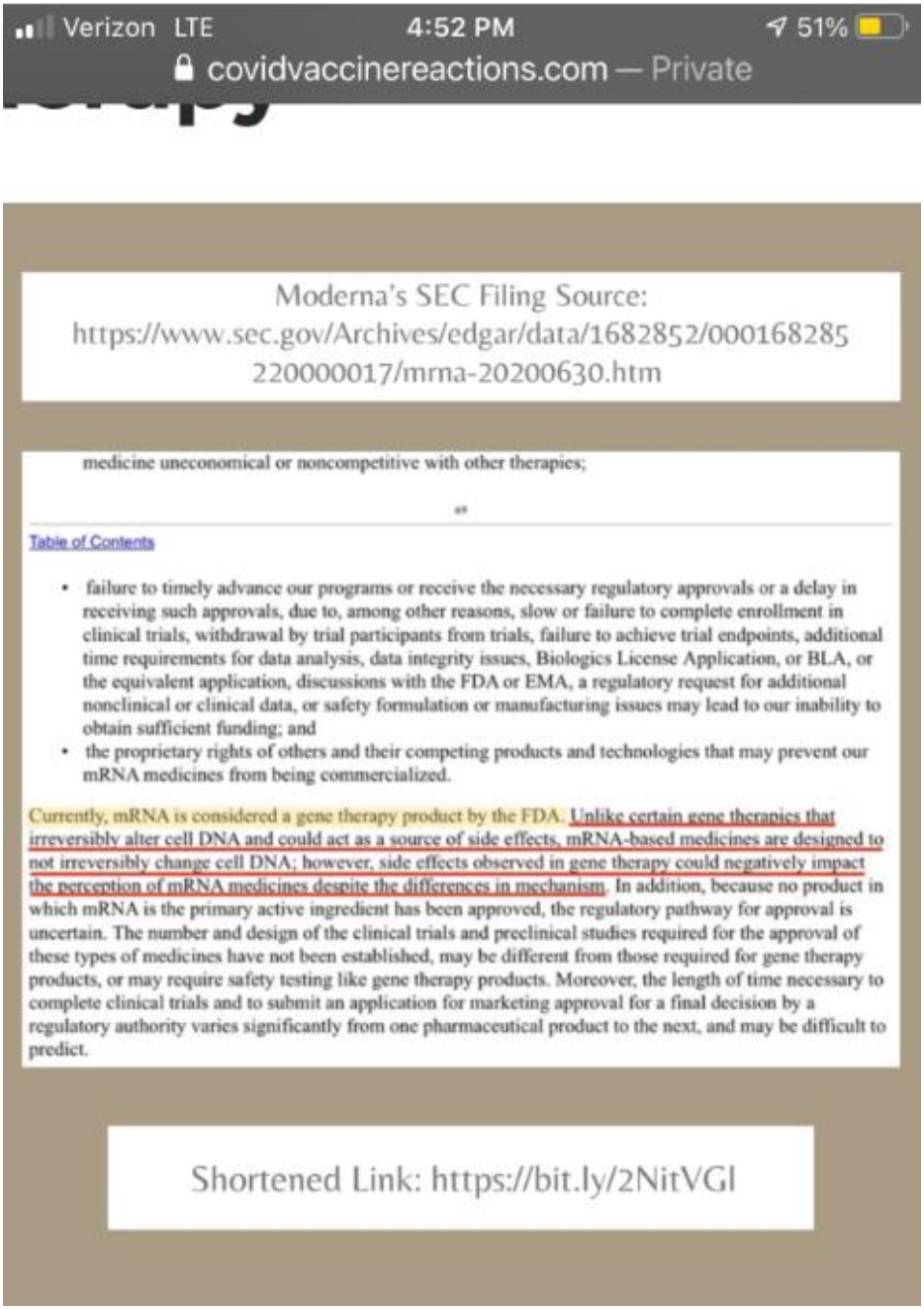

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Currently, mRNA is considered a gene therapy product by the FDA. Unlike certain gene therapies that irreversibly alter cell DNA and could act as a source of side effects, mRNA-based medicines are designed to not irreversibly change cell DNA; however, side effects observed in gene therapy could negatively impact the perception of mRNA medicines despite the differences in mechanism. In addition, because no product in which mRNA is the primary active ingredient has been approved, the regulatory pathway for approval is uncertain. The number and design of the clinical trials and preclinical studies required for the approval of

From the FDA's website

What is Gene Therapy?

Human gene therapy seeks to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use [1].

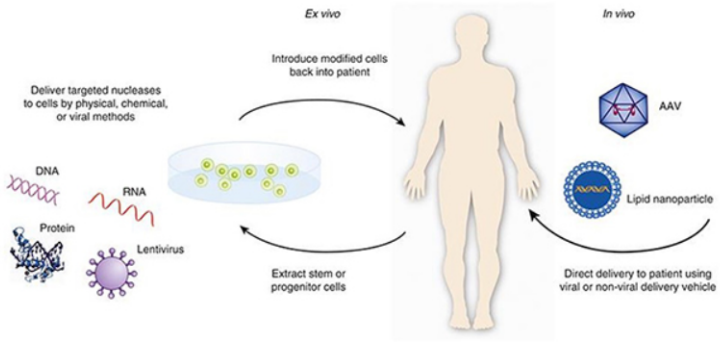
Gene therapy is a technique that modifies a person's genes to treat or cure disease. Gene therapies can work by several mechanisms:

- Replacing a disease-causing gene with a healthy copy of the gene
- Inactivating a disease-causing gene that is not functioning properly
- Introducing a new or modified gene into the body to help treat a disease

Gene therapy products are being studied to treat diseases including cancer, genetic diseases, and infectious diseases.

There are a variety of types of gene therapy products, including:

- **Plasmid DNA:** Circular DNA molecules can be genetically engineered to carry therapeutic genes into human cells.
- **Viral vectors:** Viruses have a natural ability to deliver genetic material into cells, and therefore some gene therapy products are derived from viruses. Once viruses have been modified to remove their ability to cause infectious disease, these modified viruses can be used as vectors (vehicles) to carry therapeutic genes into human cells.
- **Bacterial vectors:** Bacteria can be modified to prevent them from causing infectious disease and then used as vectors (vehicles) to carry therapeutic genes into human tissues.
- **Human gene editing technology:** The goals of gene editing are to disrupt harmful genes or to repair mutated genes.
- **Patient-derived cellular gene therapy products:** Cells are removed from the patient, genetically modified (often using a viral vector) and then returned to the patient.



Gene therapy products are biological products regulated by the FDA's Center for Biologics Evaluation and Research (CBER). Clinical studies in humans require the submission of an investigational new drug application (IND) prior to initiating clinical studies in the United States. Marketing a gene therapy product requires submission and approval of a biologics license application (BLA).

1 Long Term Follow-Up After Administration of Human Gene Therapy Products; Guidance for Industry, January 2020

So, why not call them what they are?

Here are some obvious reasons I can think of:

1. ***It is very likely that experimental gene therapy technology would not be able to be authorized for emergency use*** under the **Emergency Use Authorization (EUA)** Rule? But certainly "vaccines" could. Sleight of hand?

2. Another reason could be that ***the public would be much more likely to comply with a new "vaccine" than a new gene therapy technology***. Then the question becomes…Was that decision made to "save more lives" or to sell more product?

3. ***By calling them vaccines rather than gene therapy, they can get the buy-in of the public on the false narrative that these "vaccines" are necessary to reach herd immunity*.** The truth is, if they don't prevent infection and allow a vaccinated person that gets infected to transmit to others, they can't possibly help us get to herd immunity.

What about herd immunity? Where are we at?

The good new however is, that the U.S. is most likely at or very close to herd immunity. This is due to the number of people that have had the SARS-CoV-2 infection and not due to the vaccine. Let's assume that the 33 million PCR positive infections are really true infections and take the CDC's 8X figure of people that have had the infection and were never tested and considered in that 33 million positives number and add them to the 33 million number. It would mean that 91% of the population has had the infection. Now, I have to say that because the PCR test has a notoriously high level of false positives, there may have only been a fraction of those 33 million positive cases that truly had the infection. Let's assume that 70% of those 33 million were really infected with SARS-CoV-2, that would be 23,100,000 people infected. Eight times that number of untested infections would be another 184,800,000 infections. Added to the 23,100,000 PCR confirmed cases would total 207,900,000 total people that have been infected. Compared to 330 million people in the U.S. population, that equates to 63% of the population.

> **The R-naught (R_0) number** discussed below is the effective **Reproduction Number** of a virus or contagion. The number is the estimated number of people on average that will be infected by a person with the infection. For example, if one person infects 10 other people, the R-naught number is 10. If they infect 4 people, the R-naught number is 4. The higher the number, the more contagious the pathogen. Measles for example has been estimated to have an R-naught number somewhere between 12 and 18. Influenza depending on the strain is thought to be between 1.0 and 2. The common cold between 2 and 3. For an outbreak to subside, the (R_0) number must drop below 1.
>
> - **Herd immunity** is calculated by the following formula. 1 minus 1/the R-naught #, times 100 to get the percentage of the population that would need immunity to provide protection for the remainder of the population. The R-naught for SARS-CoV-2 has been estimated at between 2.0 and 2.5 especially earlier in the pandemic (although as the virus burns out it becomes lower and lower). For calculation, let's take the higher estimate of 2.5…..1 divided by 2.5 = 0.4. So, 1 minus 0.4 = 0.6. 0.6 times 100 = 60%. With a population of 330 million, that would mean that **198,000,000** people would need to have had the infection to protect the other 132 million people. Taking the lower hypothetical from above that **207,900,000** people have been infected,

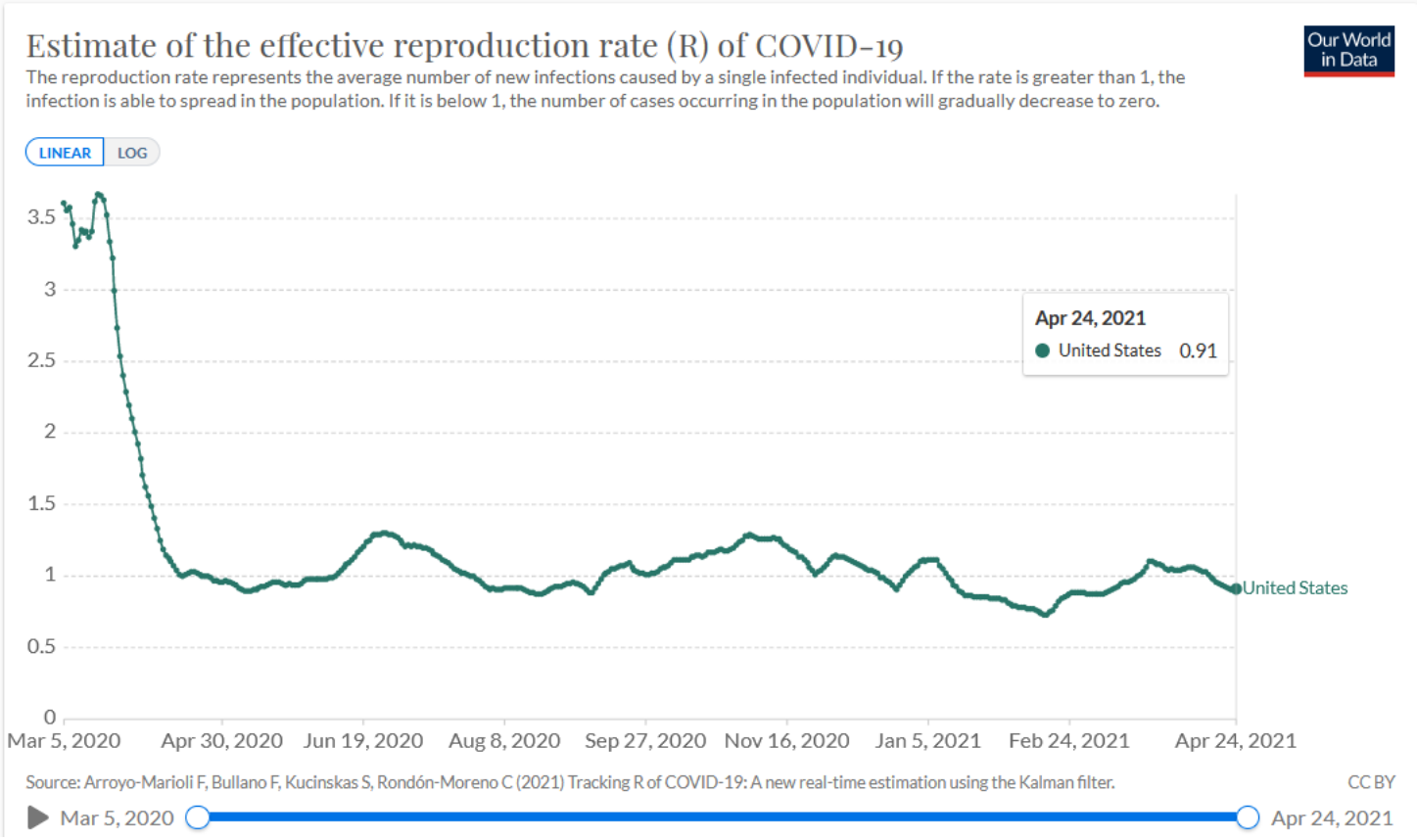
it would mean that we are over the number required to achieve herd immunity at a 60% coverage. Now there are certain things that have to be taken into consideration for this estimate to be accurate.

- Is the CDC's estimate of 8X number of infections over PCR confirmed cases accurate? https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1780/6000389

- What is the real number of CASES of COVID-19? Meaning how many people have really had the DISEASE COVID-19, not just had the infection and never developed the disease? Of the 32 million "cases" meaning positive PCR, how many of those were false positives and really influenza or other seasonal respiratory viruses. As we've seen in the beginning this issue of ***1200 Studies Newsletter*** as well as the last few issues, the flu is virtually gone this year. But where did it go?

Regardless of those specifics, suffice to say we are moving in the right direction and must be getting very close to population (herd) immunity. And this next graph makes the prospects even better!

Based on this graph from the ***Our World in Data COVID-19 Data Explorer*** the R-naught number for the U.S. is lower than previously projected. That is very good news with respect to herd immunity! (https://ourworldindata.org),

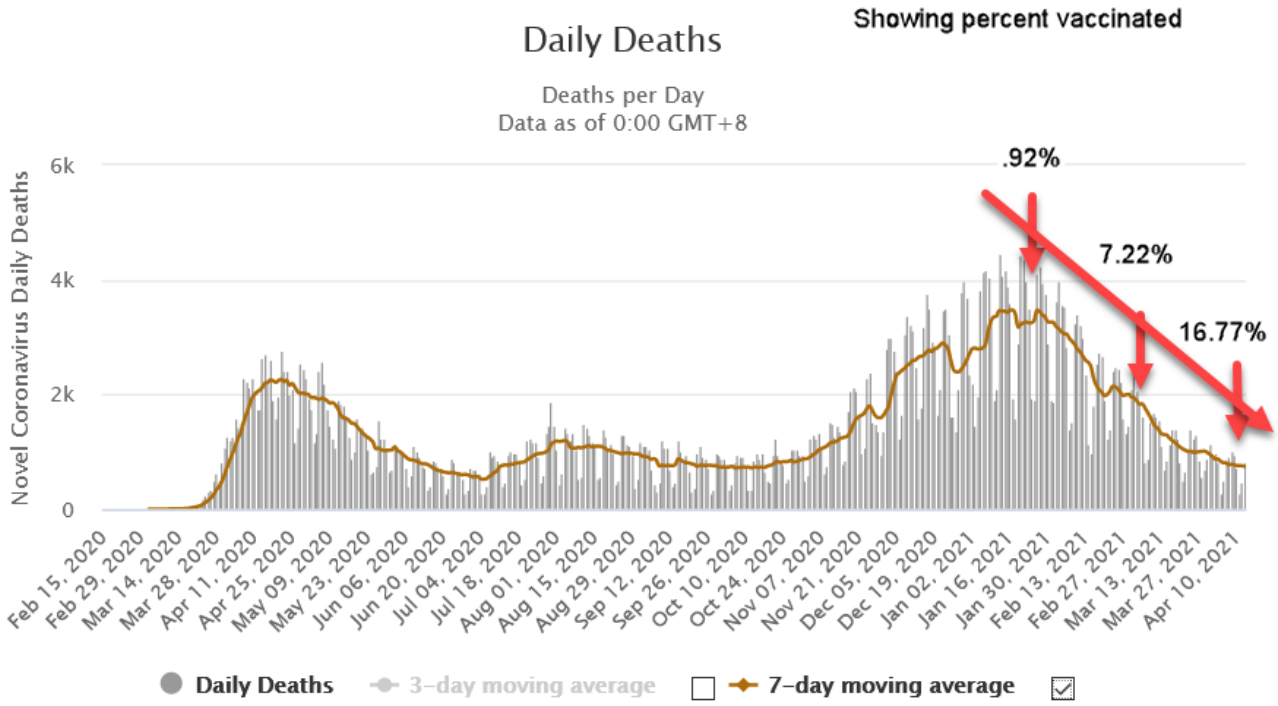


As of April 24th, the R-naught or Reproduction Rate of SARS-CoV-2 in the U.S. is under 1 at 0.91. That is a great sign and could be another indicator that we are reaching herd immunity.

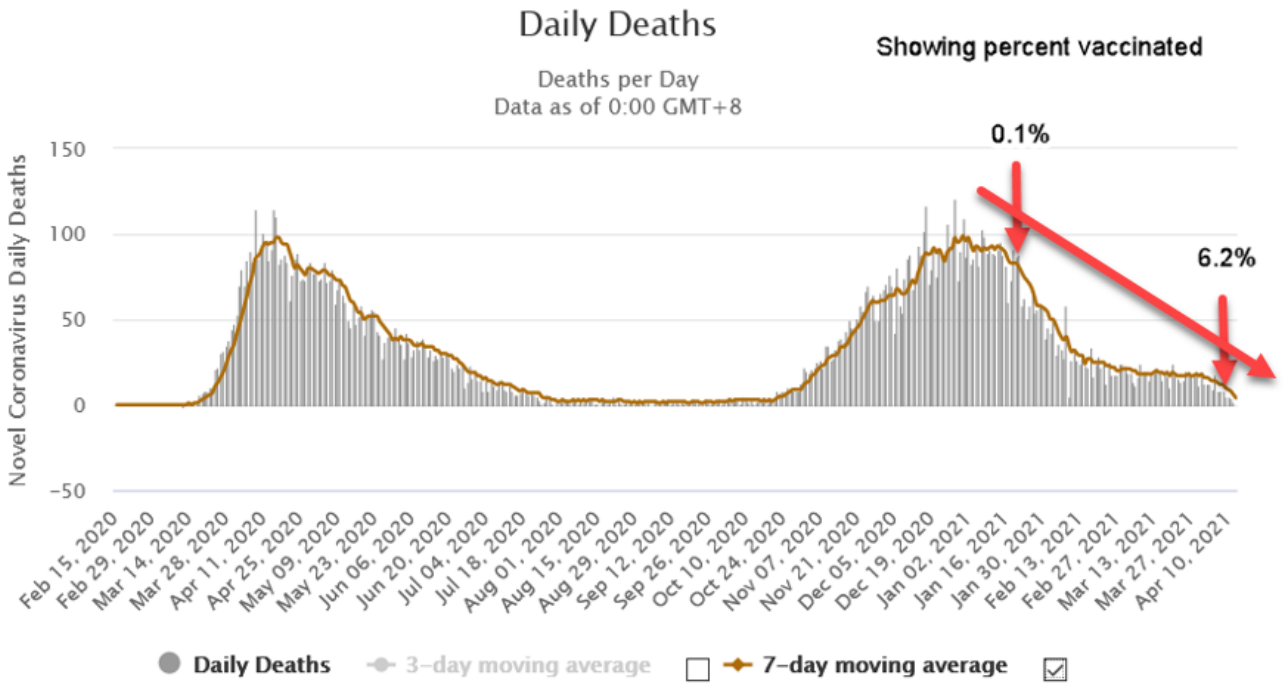
How much are the vaccines responsible for the drop in COVID-19 deaths?

As of April 8th, the U.S. has 16.77% of the population fully vaccinated. Compared to Sweden at only 6.2%.

Daily New Deaths in the United States



Daily New Deaths in Sweden



Very similar downward trajectory in the 7-day moving average of deaths, right?

Since Sweden, a country that never locked down and destroyed business and their economy, kept their kids in school and didn't inflict a huge emotional toll on their population is experiencing the same success in their death rates as the U.S. even without vaccine coverage that would explain that drop in mortality, there is no reason to believe the narrative about gene therapy treatments helping to end the pandemic.

More concerns over the blood clotting issues from the COVID-19 vaccines

An April 13th article in Natural News by Mike Adams titled **Vaccine antibodies CAUSE blood clots in the brain, lungs and heart… FDA calls halt to J&J vaccine as deaths accelerate** raises serious concerns over the large numbers of clotting issues seen not just with the Johnson and Johnson vaccine, but the other mRNA vaccines as well.

From the article:

In the wake of accelerating deaths from vaccine-induced blood clots, the FDA has now called a nationwide halt to the Johnson & Johnson covid-19 vaccine.

In truth, **all covid-19 vaccines cause deadly blood clots** for the simple reason that **spike protein structures are biologically active** and lead to blood coagulation (clotting) inside the body. These blood clots travel to the brain, heart, lungs and other organs, causing strokes, heart attacks (rapper DMX was killed this way), pulmonary embolisms (blood clots in the lungs) and other similar causes of death, none of which are officially listed as "vaccine" deaths.

The fact that mRNA vaccines hijack the body's cells to generate spike proteins which cause blood clotting is an open admission that **mRNA vaccines are death shots** — a form of vaccine euthanasia. And people who are foolish enough to take these vaccine shots are signing up for "vaccine suicide" as part of a global depopulation agenda.

Even worse, none of the vaccines actually do anything useful to reduce deaths from covid. As Dr. Richard Fleming recently told ***the War Room*** broadcast, the vaccine efficacy data from Pfizer, Moderna and Johnson & Johnson, "all show their vaccines make zero difference in stopping covid." From that article:
Fleming warned the effects could take a year and half to show in humans.

Fleming, who in the 1990s discovered inflammation causes cardiovascular disease, said man-made spike proteins in the vaccines also cause inflammation. The Johnson & Johnson vaccine was pulled for its link to blood clots in women.

The vaccines have "no statistically significant benefit," Fleming said, but cause "inflammation and blood clotting, Lewy bodies [associated with dementia], Mad Cow disease, and nothing to benefit."

Fleming said the Biden regime should call for immediate reevaluation of "whether there's any demonstrated efficacy" of the vaccines, "because there's not."

"Secondly, what are the potential consequences of having already vaccinated a substantial number of individuals in this country?" Fleming said.

In today's ***Situation Update podcast***, I cover the blood clotting problems with the vaccine, revealing why so many people are already dying from an experimental intervention the government lied about and insisted was safe:

Brighteon.com/b3132a4a-a952-43a4-8475-7372b91a8690

Deep vein thrombosis after Pfizer vaccine

An article published in Internal and Energency Medicine March 9th, 2021 titled **Deep vein thrombosis (DVT) occurring shortly after the second dose of mRNA SARS-CoV-2 vaccine**, describes a case of a 66 year-old woman who developed the blood clots after her second dose of vaccine.

From the report:

Venous thromboembolic (VTE) complications have been consistently reported to be increased in SARS-CoV-2 infection, most probably as the results of a thrombophilic state secondary to inflammation and immunethrombosis.

A 66-year-old woman received the first dose of mRNA Covid-19 vaccine (BNT162b2, Comirnaty, Pfizer/BioNTech) subcutaneously on January 4th, 2021, without any reported clinical problem; she was scheduled for the second dose on January 25th. Her medical history was unremarkable except for post-trauma left leg neuropathy. She never had previous thrombotic events; she had one successful delivery. Her body mass index was 23 kg/m2; she did not smoke or had no allergic problems; she intermittently took painkillers for the neuropathy. On January 26th, 24 h after the second vaccine dose, she received acetaminophen for persistent fever with chills, fatigue, malaise, and muscle pain. On January 27th, 48 h after the second vaccine dose,
persistent fever was still present, and acute right calf pain appeared in the absence of trauma. On January 28th, she was admitted for evaluation at the emergency room because of persistent pain and inability to walk. Physical examination was unremarkable except for mild edema in the right calf. Blood tests (Blood count, INR, PTT, fibrinogen, renal and hepatic function) were normal, as notably was the D-dimer measurement. A Color-Doppler ultrasound scan revealed the presence of deep vein thrombosis involving the right peroneal vein and extending up to the popliteal vein, without signs of venous insufficiency. Thrombophilia screening was otherwise negative except for the presence of heterozygous FV Leiden mutation. The patient started apixaban 10 mg bid for 1 week, followed by 5 mg bid, with rapid symptoms resolution.
End of excerpts

This report follows many such reports coming in from all over the world and was the reason two dozen European countries called a pause to the AstraZeneca vaccine.

Another report in the ***British Medical Journal (BMJ)*** published April 14th, 2021 titled **Thrombosis after covid-19 vaccination**

From the report:

During March, however, concerns were raised over possible thromboses after immunisation with the AstraZeneca vaccine. One of the first official reports from the European Medicines Agency, on 10 March, noted four cases of thrombosis in people immunised with a single batch of the vaccine in Austria, including at

least two severe cases and one death.[3] The batch was withdrawn from use. The following day reports emerged of a death in Denmark and the country suspended use of the vaccine to allow time for investigation. Several other countries followed suit.[4]

Subsequently, the focus of attention narrowed from thrombosis in general to cerebral venous sinus thrombosis (CVST), a rare condition with a background incidence of about 15 cases per million people each year according to recent studies from Australia and the Netherlands.[5] CVST is a rare cause of stroke that generally affects younger adults and women more than men. Important risk factors are pregnancy and hormonal contraception.[5]

Proving cause and effect is never easy, especially for rare events. Chance clusters of rare events occur quite commonly in observations or analyses of large groups.[6] Nevertheless, the balance of evidence was clearly shifting at the beginning of April. Increased reporting of CVST in the UK as well as in Europe, along with the almost total absence of cases after immunisation with Pfizer or Moderna vaccines were strong indicators that this may be a real association. That many of those affected also had thrombocytopenia, which is not normally found in CVST, was an additional pointer that this was not a random association.

Both European and UK medicines regulators reported their conclusions on 7 April.[7] From the EMA briefing we learnt that other blood clots associated with thrombocytopenia were also being reported following the AstraZeneca vaccine, including arterial thromboses and splanchnic vein thrombosis.[8] The EMA compared the clinical picture to a similar heparin induced thrombocytopenia,[9] and two recently published case series have confirmed this similarity.[10][11] All patients in each series had high levels of antibodies against antigenic complexes of platelet factor 4 (PF4), as seen in heparin induced thrombocytopenia. None of the patients had received heparin.[10][11] Further studies in two patients confirmed PF4 dependent platelet activation.[10] The authors coined the term vaccine induced immune thrombotic thrombocytopenia for this condition. Potential treatment options include high dose immunoglobulins and certain non-heparin anticoagulants.[10]

The UK's Medicines and Healthcare Products Regulatory Agency had received 79 reports of thrombosis associated with low platelets by 31 March, of which 44 were CVST.[12] Of these 79 cases, 51 (13 fatal) were in women and 28 (six fatal) in men. So far all of the UK cases have occurred after the first dose. The risk was higher in the younger age groups, starting at 1.1 serious harm events for 100 000 immunised people among those aged 20-29 years and falling to 0.2/100 000 in those aged 60-69. For comparison, in women taking hormonal contraceptives the risk of thrombosis is about 60/100 000 person years and risk of fatal pulmonary embolism is about 1/100 000.[13][14] In most adult age groups, the benefits of the AstraZeneca vaccine far outweigh the risks. The exception is the 20-29 year age group, for which the risk-benefit equation is more finely balanced when community transmission is low.

https://www.bmj.com/content/373/bmj.n958

A response to that article is VERY revealing

In an April 14th, 2021 ***BMJ*** **Rapid Response** to the **Thrombosis after covid-19 vaccination** article**,** much more important information about the increasing awareness of these events by physicians is discussed.

The title of the response is:

CoViD-19 post-vaccine menorrhagia, metrorrhagia or postmenopausal bleeding and potential risk of vaccine-induced thrombocytopenia in women

Dear Editor,

Many women across the world after receiving CoViD vaccines are complaining of irregularities in their menstrual bleeding; some experiencing heavy menstrual bleeding (menorrhagia), some bleeding before their periods were due or bleeding frequently (metrorrhagia/polymenorrhea), whereas some are complaining of postmenopausal bleeding.

As of 5th April 2021, there have been ~958 cases of post-vaccination menstrual irregularities, including vaginal haemorrhages, that were recorded in MHRA's adverse event reports. There were twice more cases of menstrual irregularities with CoViD Vaccine AstraZeneca than Pfizer (643 vs 315 respectively) [1]. It is anticipated that the actual numbers of cases are much higher than the numbers recorded in the pharmacovigilance systems as many women in different cultural context may have felt uncomfortable to talk about it, may not have thought that it was vaccine-related, or may have not been encouraged by their clinicians to make an official report into the adverse events reporting system.

There have been recent reports of haemorrhage, blood clots and thrombocytopenia following administration of CoViD-19 vaccines that have raised concerns over the safety of genetic vaccines for people with pre-existing coagulation disorders or those on certain medications. Regulatory bodies have also issued warnings to the patients and healthcare professionals to be vigilant and seek prompt medical assistance if they experienced typical symptoms of cerebral venous sinus thrombosis (CVST), a potentially fatal clot in the brain [2,3]. European Medicines Agency has also revised the summary of product characteristics and listed thrombocytopenia (very low platelets) as a 'common' side effect (i.e., 1 in 100 to 1 in 10) of Vaxzevria, i.e., the CoViD vaccine AstraZeneca [4]. The pharmacovigilance data also suggests that thrombocytopenia is also a frequent observation followed by mRNA CoViD vaccines such as Pfizer or Moderna.

The 'heavy menstrual bleeding' has been previously reported in females with underlying platelets disorders [5]. It is plausible that the vaccine-induced thrombocytopenia may be an explanation for the recent incidences of heavy menstrual bleeding experienced by women in different countries after the CoViD-19 vaccination. The significant loss of blood in many women may lead to severe anaemia, further exacerbate thrombocytopenia, and therefore may significantly increase the risk of haemorrhages and clots.

Clinicians and front-line healthcare workers are advised to encourage women to report heavy menstrual bleeding or other extraordinary bleeding events post-vaccination formally into the vaccine adverse events reporting system and seek prompt medical advice. Public health agencies and regulatory authorities are also requested to investigate these incidences and issue further warnings, as this can, possibly be an early sign of potentially fatal vaccine-induced prothrombotic thrombocytopenia leading to rare CVST events in younger women. There may be some women with pre-existing conditions or those on certain medications that may be at increased risk of experiencing post-vaccination severe adverse events and early warnings will help saving lives.

https://www.bmj.com/content/373/bmj.n958/rr-2

References:

[1] https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-...
[2] https://doi.org/10.1186/s40545-021-00315-w
[3] https://www.ema.europa.eu/en/news/covid-19-vaccine-astrazeneca-benefits-...
[4] https://www.ema.europa.eu/en/documents/product-information/vaxzevria-pre...
[5] https://www.sciencedirect.com/science/article/pii/S1083318816001637

Study shows the spike protein cause damage to the Blood-Brain-Barrier (BBB) and resultant brain inflammation

These findings have implications for the COVID-19 vaccines as they prompt our cells to make spike protein. Those manufactured spike proteins could migrate to the brain and trigger a cascade of events that may result in neurovascular injury, microthrombi (clots) and brain damage.

The study published December 2020 in the journal ***Neurobiology of Disease*** and titled **The SARS-CoV-2 spike protein alters barrier function in 2D static and 3D microfluidic in-vitro models of the human blood–brain barrier**, reveals a possible mechanism for the brain pathology caused by the SARS-CoV-2 Spike Protein.

From the Abstract:

As researchers across the globe have focused their attention on understanding SARS-CoV-2, the picture that is emerging is that of a virus that has serious effects on the vasculature in multiple organ systems including the cerebral vasculature. Observed effects on the central nervous system include neurological symptoms (headache, nausea, dizziness), fatal microclot formation and in rare cases encephalitis. However, our understanding of how the virus causes these mild to severe neurological symptoms and how the cerebral vasculature is impacted remains unclear. Thus, the results presented in this report explored whether deleterious outcomes from the SARS-CoV-2 viral spike protein on primary human brain microvascular endothelial cells (hBMVECs) could be observed. The spike protein, which plays a key role in receptor recognition, is formed by the S1 subunit containing a receptor binding domain (RBD) and the S2 subunit. First, using postmortem brain tissue, we show that the angiotensin converting enzyme 2 or ACE2 (a known binding target for the SARS-CoV-2 spike protein), is ubiquitously expressed throughout various vessel calibers in the frontal cortex. Moreover, ACE2 expression was upregulated in cases of hypertension and dementia.

Introduction of spike proteins to *invitro* models of the blood-brain barrier (BBB) showed significant changes to barrier properties. Key to our findings is the demonstration that S1 promotes loss of barrier integrity in an advanced 3D microfluidic model of the human BBB, a platform that more closely resembles the physiological conditions at this CNS interface. Evidence provided suggests that the SARS-CoV-2 spike proteins trigger a pro-inflammatory response on brain endothelial cells that may contribute to an altered state of BBB function. Together, these results are the first to show the direct impact that the SARS-CoV-2 spike protein could have on brain endothelial cells; thereby offering a plausible explanation for the neurological consequences seen in COVID-19 patients.

From the Discussion:

SARS-CoV-2 can induce microclots formation in the vasculature of periphery tissues and within the vessels of the CNS. In fact, Bryce et al.[32] found that 6 out of 20 cases had microthrombi and acute infarction in the brain. Here we report the evident breakdown of the BBB by SARS-CoV-2 spike protein, thus offering a possible avenue for counteracting the consequences of acute ischemic stroke observed in COVID-19 patients younger than 50 years old. However, future studies should place focus on interrogating the connection between virus-mediated barrier disruption and coagulation to determine the unique cerebrovascular mechanisms responsible for heightening the risk of strokes in COVID-19 patients.

Taking together our data of elevated MMP3, CCL5, CXCL10 and CAMs, we can speculate that SARS-CoV-2 is a potentially neuroinvasive virus as it turns on the machinery to facilitate the migration of infected immune cells as "Trojan horses" into the brain parenchyma.

To our knowledge, this is the first reported evaluation that examined the effects of the SARS-CoV-2 spike protein on the BBB. Our findings provide insight into the continued theme that this novel coronavirus triggers responses at the endothelium. Specifically, in regard to the brain endothelium, the SARS-CoV-2 spike protein induced destabilization of the BBB, promoted a pro-inflammatory status but did not appear to alter cell viability acutely. Dysfunction of the barrier offers a plausible explanation to the observed neurological complications seen in COVID-19. Lastly, the opening of the BBB, hints at the possible means in which the SARS-CoV-2 pathogen could also neuroinvade.

End of excerpts

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7547916/

Tiny country of Gibraltar sees unexpected increase in deaths in elderly population after vaccination with COVID-19 vaccines

In an article by Lance D. Johnson and published on Dr Eddy Bettermann MD's website titled, **Elderly population suddenly dying off for unexplained reasons, and it's no longer coded as covid-19**, the sudden deaths in the elderly of Gibraltar immediately after the vaccination program began is called the worst loss of life there in over 100 years.

Around the world, medical authorities are seeing a spike in elderly deaths, after covid-19 vaccination. Gibraltar, a nation located at the southern tip of Spain, is suffering from an unexplained surge in elderly deaths. In the second week of January, a subset of the elderly population suddenly started to die off. The new wave of unexplained elderly deaths is occurring at nearly three times the magnitude of covid-19 deaths that were recorded during 2020.

The new, unexplained surge in elderly deaths is occurring approximately forty times faster when compared to the overall timeline of covid-19 deaths that occurred since a pandemic was first declared. This surge in elderly deaths occurred after 5,847 doses of experimental mRNA injections were administered to the citizens of Gibraltar. In just one week, 17 percent of the country's population had been inoculated with the first dose of Pfizer's mRNA experiment.

Before the vaccine experiment began, the covid-19 related death toll accounted for ten people. After the vaccine rollout, the total number of deaths had skyrocketed to forty-five people. In the first eight days of the vaccination program, thirty-five seniors suddenly passed away.

After the first week of vaccination, Chief Minister Fabian Picardo said, "This is now the worst loss of life of Gibraltarians in over 100 years. Even in war, we have never lost so many in such a short time."

Vaccine-induced deaths to be blamed on new "covid-variant"

In 2020, medical examiners would have easily labeled these sudden deaths as covid-19, but now these deaths are somehow unexplained, with no definitive cause. Before the covid-19 vaccines were unleashed, seniors

died of covid-19. Now seniors are dying of natural causes again, right after being vaccinated. It won't be long before a surge in elderly deaths around the world is blamed on a new variant of SARS-CoV-2, with medical authorities calling for new vaccines, more doses, and mRNA updates. Isn't it suspicious that a deadly covid-variant became headline news suddenly after the vaccine rollout?

Norway deaths

Gibraltar isn't the only nation to report on the sudden spike in senior deaths. In Norway, twenty-nine senior citizens suddenly passed away in the first two weeks after the first dose of the vaccine. In the hours after vaccination, and sometimes minutes after, these seniors shared similar side effects, including but not limited to: persistent malaise and extreme exhaustion; severe allergic, including anaphylactic, reactions; multi-system inflammatory syndrome; psychological disturbances; seizures; convulsions; and paralysis, including Bell's Palsy. The Norwegian Medicines Agency declared that "all deaths are linked to this [Pfizer's] vaccine" because it was the only intervention that preceded the sudden elderly deaths.

https://dreddymd.com/2021/02/18/elderly-population-suddenly-dying-off-for-unexplained-reasons-and-its-no-longer-coded-as-covid-19/

That story coincides with a ***Mercola.com*** article titled, **Seniors Dying After COVID Vaccine Labeled as Natural Causes**. I want you to catch the irony in that title. Throughout the COVID-19 pandemic, nearly all elderly deaths, no matter what the actual cause of death were being called a COVID death. Now, after people are vaccinated and die suddenly and unexpectedly, the deaths are all being called "natural" or "unexplained."

From the article:

Around the world, reports are pouring in of people dying shortly after receiving the COVID-19 vaccine. In many cases, they die suddenly within hours of getting the shot. In others, death occurs within the span of a couple of weeks.

One notable case is baseball legend Hank Aaron, 86, who died January 22, 2021, 17 days after publicly getting vaccinated for COVID-19.[1,2] He said at the time that he hoped other Blacks would follow his lead and get their vaccines too.

According to news reports, he died "peacefully in his sleep" and no cause of death had been announced. Aaron was famous for being the home-run king of baseball, and broke Babe Ruth's record when he hit homerun No. 715; he had hit 755 by the time he retired from the sport.

My comment: *Hank Aaron had been used by the media-pharmaceutical complex to promote that people get vaccinated with the experimental COVID-19 vaccines. As a role model for millions and especially the African American community, Aaron's endorsement carried a lot of weight. He was quoted as saying… "It makes me feel wonderful. I don't have any qualms about it at all … I feel quite proud of myself for doing something like this … It's just a small thing that can help zillions of people in this country."*

He was filmed getting his first dose as he encouraged minorities to join in and get the life-saving vaccine. He didn't make it to the next appointment for his second dose because he suddenly died "in his sleep" seventeen days after getting the first dose.

Vaccine Rollout Coincides with Outbreak

Other areas are also reporting "outbreaks" of COVID-19, resulting in increased death tolls, after the rollout of vaccinations. Case in point: In Auburn, New York, a COVID-19 outbreak began December 21, 2020, in a ***Cayuga County nursing home.***[8,9] Before this outbreak, no one in the nursing home had died from COVID-19. The next day, December 22, they started vaccinating residents and staff. The first death was reported December 29, 2020. Between December 22, 2020, and January 9, 2021, 193 residents (80%) received the vaccine, as did 113 staff members.

As of January 9, 2021, 137 residents had been infected and 24 had died. Forty-seven staff members had also tested positive for SARS-CoV-2 and one was on life-support.

Considering we're also seeing cases in which healthy young and middle-aged individuals die within days of receiving the vaccine, it's not inconceivable that the vaccine might have something to do with these dramatic rises in deaths among the elderly in various parts of the world. In fact, I'd expect it.

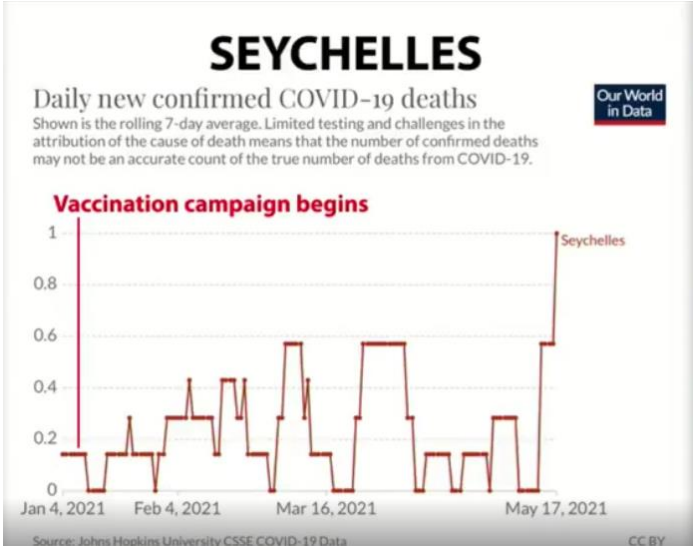
End of excerpts
https://articles.mercola.com/sites/articles/archive/2021/02/02/covid-vaccine-death-seniors.aspx

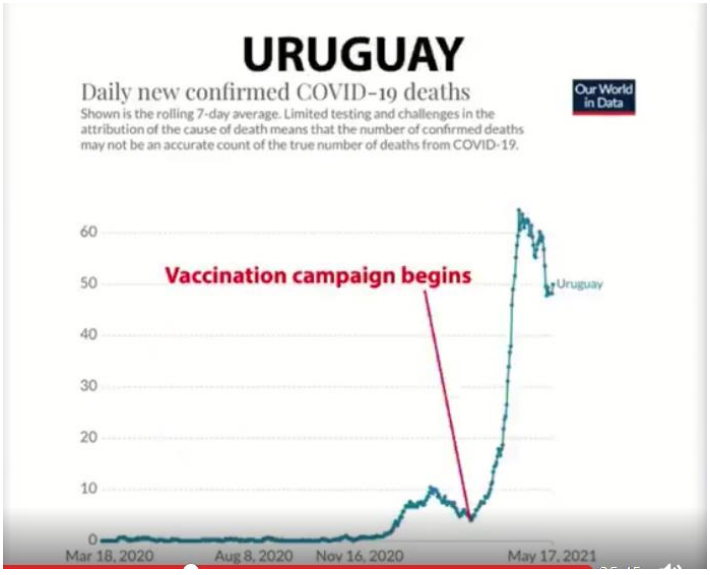
Update July 04th, 2021

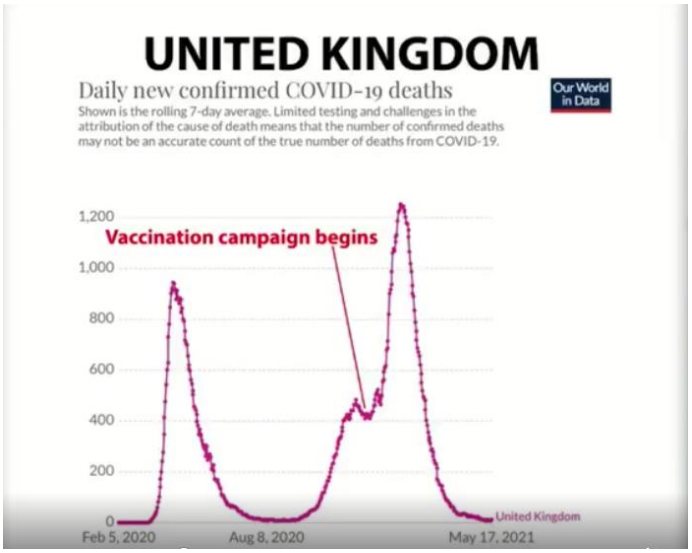
18 countries deaths spike after vaccine campaigns begin- See the Graphs

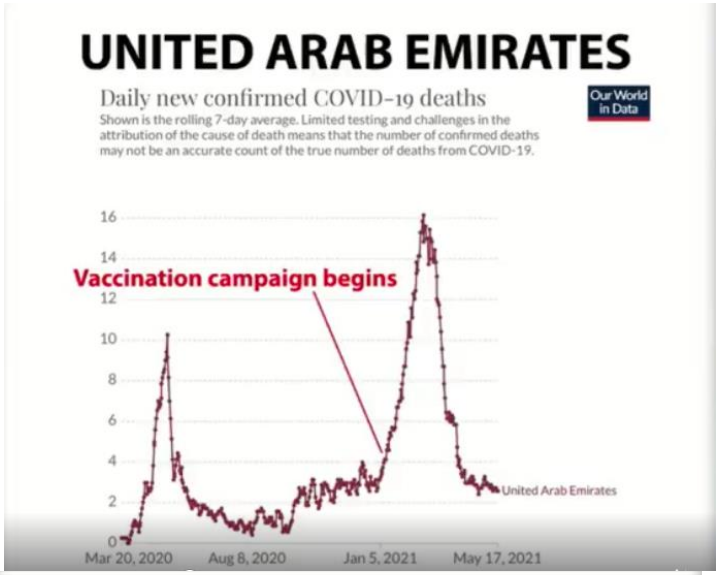
In each of these graphs, look at where the mass vaccination campaigns started and then see what happened with the death rates shortly thereafter. Then ask yourself. Are the vaccines really safe and effective?

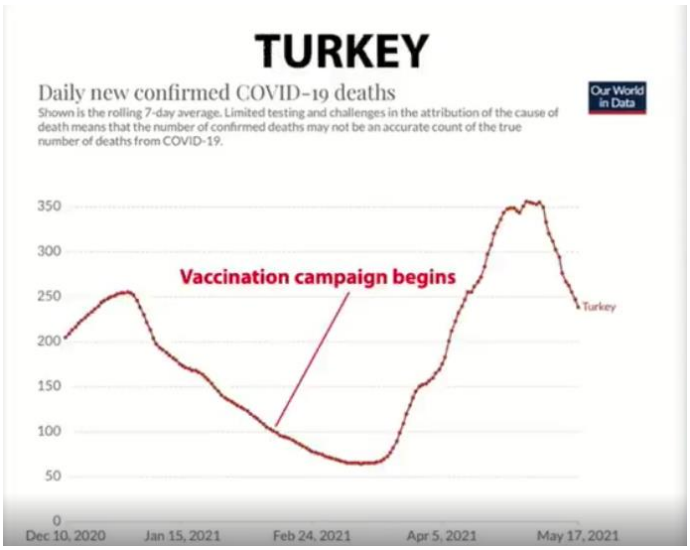
Get ready to have your mind blown!

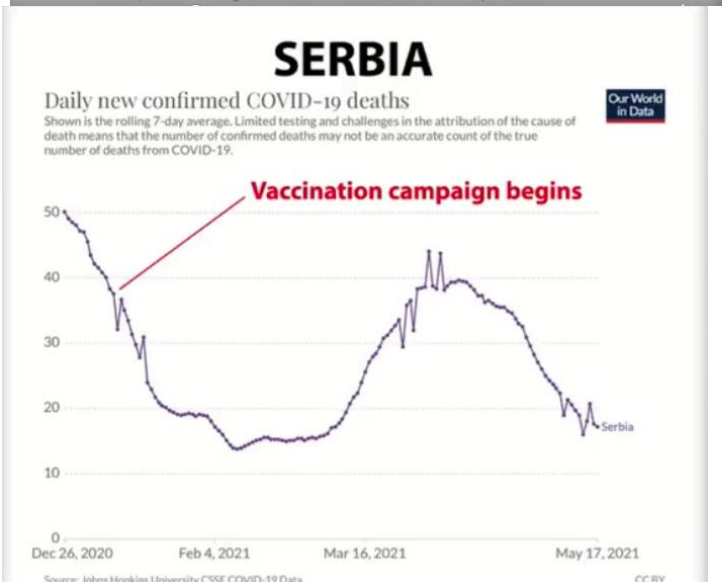


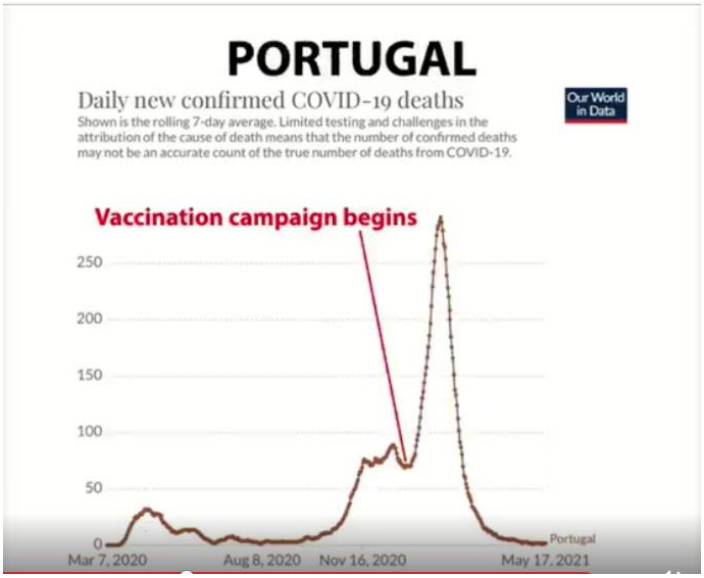



UNITED KINGDOM
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
1,200
1,000
800
600
400
200
0
United Kingdom
Feb 5, 2020
Aug 8, 2020
May 17, 2021


UNITED ARAB EMIRATES
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
16
14
12
10
8
6
4
2
0
United Arab Emirates
Mar 20, 2020
Aug 8, 2020
Jan 5, 2021
May 17, 2021


TURKEY
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
350
300
250
200
150
100
50
0
Turkey
Dec 10, 2020
Jan 15, 2021
Feb 24, 2021
Apr 5, 2021
May 17, 2021


SERBIA
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
50
40
30
20
10
0
Serbia
Dec 26, 2020
Feb 4, 2021
Mar 16, 2021
May 17, 2021


PORTUGAL
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
250
200
150
100
50
0
Portugal
Mar 7, 2020
Aug 8, 2020
Nov 16, 2020
May 17, 2021

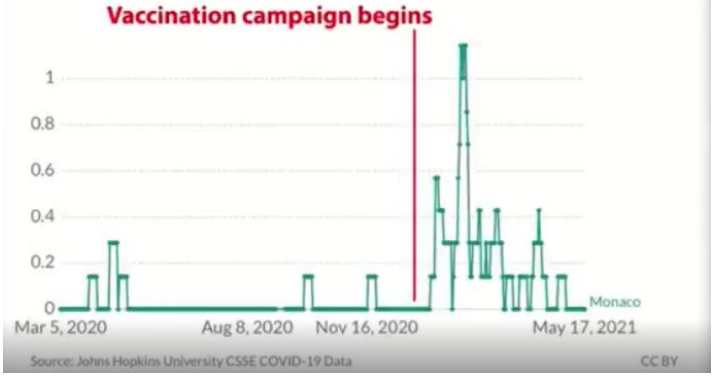

NORTH MACEDONIA
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination campaign begins
40
30
20
10
0
North Macedonia
Mar 11, 2020
Aug 8, 2020
Nov 16, 2020
May 17, 2021

MONACO

Daily new confirmed COVID-19 deaths

Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.

Our World in Data



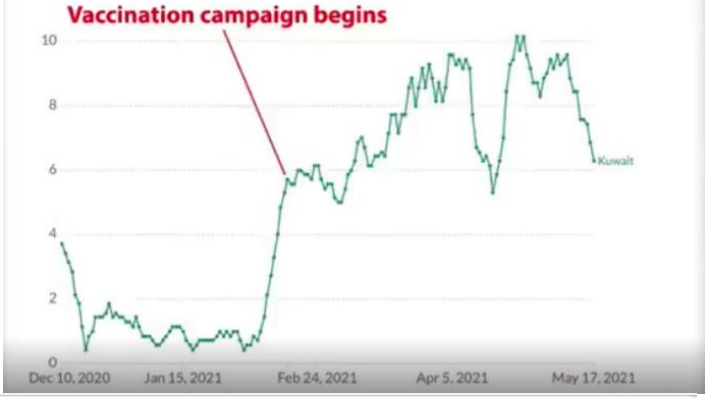
Source: Johns Hopkins University CSSE COVID-19 Data CC BY

KUWAIT

Daily new confirmed COVID-19 deaths

Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.

Our World in Data

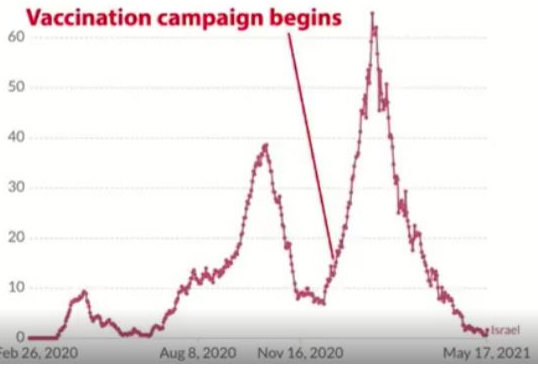


ISRAEL

Daily new confirmed COVID-19 deaths

Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.

Our World in Data

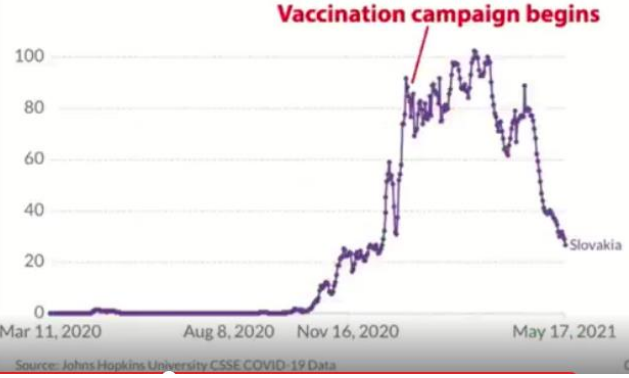


SLOVAKIA

Daily new confirmed COVID-19 deaths

Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.

Our World in Data



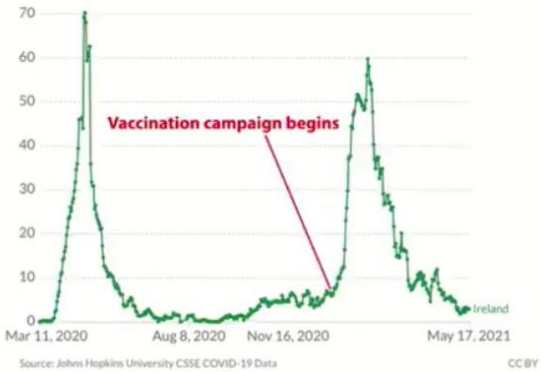
Source: Johns Hopkins University CSSE COVID-19 Data CC BY

IRELAND

Daily new confirmed COVID-19 deaths

Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.

Our World in Data



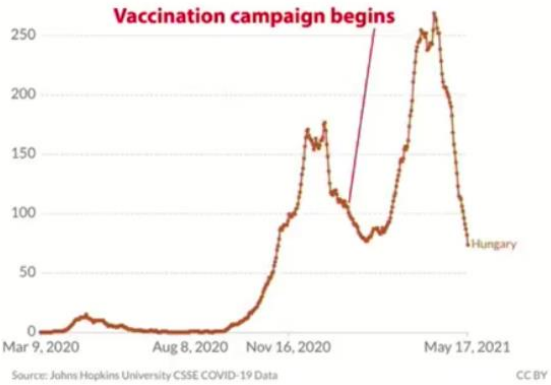
Source: Johns Hopkins University CSSE COVID-19 Data CC BY

HUNGARY

Daily new confirmed COVID-19 deaths

Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.

Our World in Data



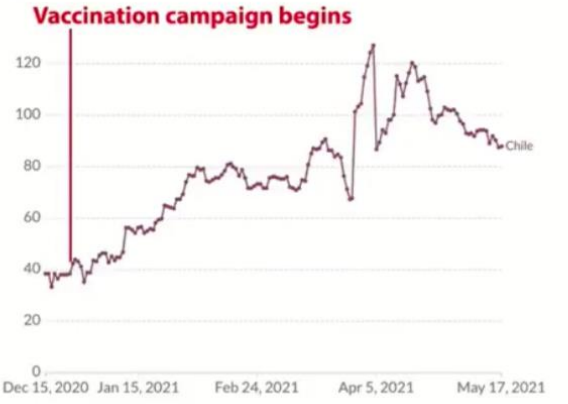
Source: Johns Hopkins University CSSE COVID-19 Data CC BY

CHILE

Daily new confirmed COVID-19 deaths

Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.

Our World in Data



Source: Johns Hopkins University CSSE COVID-19 Data

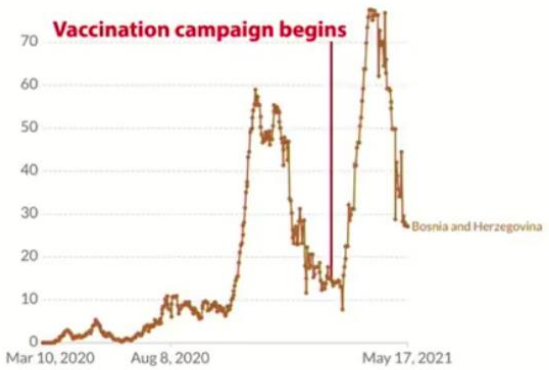
CC BY

BOSNIA & HERZEGOVINA

Daily new confirmed COVID-19 deaths

Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.

Our World in Data



Source: Johns Hopkins University CSSE COVID-19 Data

CC BY

BANGLADESH

Daily new confirmed COVID-19 deaths

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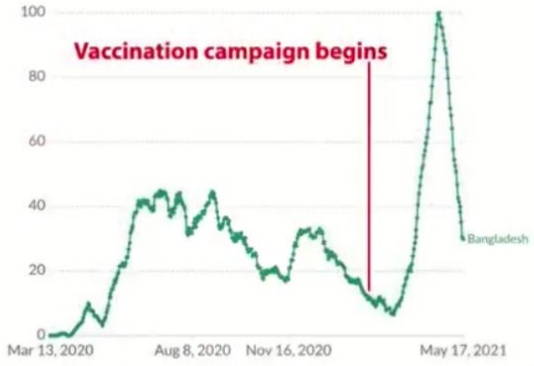
Our World in Data



Source: Johns Hopkins University CSSE COVID-19 Data

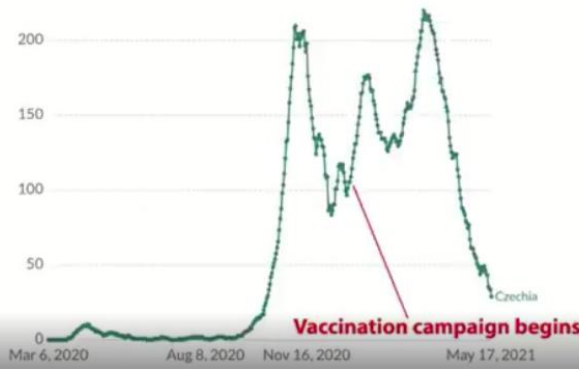
CC BY

CZECHIA

Daily new confirmed COVID-19 deaths

Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.

Our World in Data



INDIA

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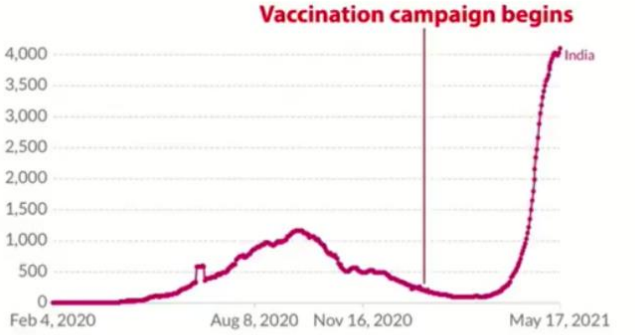

Source: Johns Hopkins University CSSE COVID-19 Data

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More concerns of Antibody Dependent Enhancement

It is feared that the greatest number of deaths will not occur for some time to come in those that are vaccinated with the COVID-19 "vaccines"

Many scientists and researchers warn that the potential for ***Antibody Dependent Enhancement (ADE)***, AKA ***Pathogenic Priming*** as well as other autoimmune and immune dysregulation effects from the vaccines can lead to a large number of delayed deaths from the vaccines.
In these excerpts from an article on the ***Children's Health Defense*** website, the concerns over ADE are expressed.

From the article

In the development of vaccines against coronaviruses like SARS-COV-1 and MERS in the early 2000's, researchers found evidence of a serious problem. Teams of U.S. and foreign scientists vaccinated animals with the four most promising vaccines. At first, the experiment seemed successful as all the animals developed a robust antibody response to coronavirus. However, when the scientists exposed the vaccinated animals to the wild virus, the results were horrifying. Vaccinated animals suffered hyper-immune responses including inflammation throughout their bodies, especially in their lungs.

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

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

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

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

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

End of excerpts

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

Here is a study from the Journal *Human Vaccines and Immunotherapeutics* that demonstrated this very deadly phenomenon

Immunization with inactivated Middle East Respiratory Syndrome coronavirus vaccine leads to lung immunopathology on challenge with live virus

This study from the journal ***Human Vaccines and Immunotherapeutics*** 2016 demonstrates the biggest concern and main reason why attempts to make a coronavirus vaccine have previously failed. That is the phenomenon of immune enhancement or sometimes called pathogenic priming. This is where vaccinated subjects later when exposed to the wild virus develop an over reactive immune response leading to a hyper-inflammatory pathological condition. This can lead to severe and even fatal results.

The abstract:

"To determine if a hypersensitive-type lung pathology might occur when mice were given an inactivated MERS-CoV vaccine and challenged with infectious virus as was seen with SARS-CoV vaccines, we prepared and vaccinated mice with an inactivated MERS-CoV vaccine. Neutralizing antibody was induced by vaccine with and without adjuvant and lung virus was reduced in vaccinated mice after challenge. Lung mononuclear infiltrates occurred in all groups after virus challenge but with increased infiltrates that contained eosinophils and increases in the eosinophil promoting IL-5 and IL-13 cytokines **only in the vaccine groups**. **Inactivated MERS-CoV vaccine appears to carry a hypersensitive-type lung pathology risk from MERS-CoV infection that is similar to that found with inactivated SARS-CoV vaccines from SARS-CoV infection**."
https://pubmed.ncbi.nlm.nih.gov/27269431/

An excellent paper by Dr. James Lyons-Weiler published April 2020 in the ***Journal of Translational Autoimmunity*** titled, **Pathogenic priming likely contributes to serious and critical illness and mortality in COVID-19 via autoimmunity** raises the concerns about pathogenic priming and future development of autoimmunity as a consequence of COVID-19 reinfection or vaccine administration.
My comment: Now 8 months after this paper was released, we know that as true reinfection is extremely rare. And, based on studies looking at both humoral and innate immunity it is very promising as to long-term immunity after infection. We will certainly know more in 2-3 years.

From the article
SARS-CoV-2 has some unexplained pathogenic features that might be related to the table of putative pathogenic priming peptides. Exposure to these specific peptides - via either infection or vaccination - might prime patients for increased risk of enhanced pathogenicity during future exposure due either to future pandemic or outbreaks or via universal vaccination programs. While the mechanisms pathogenesis of COVID-19 are still poorly understood, the morbidity and mortality of SARS has been extensively studied. Thus, the involvement of pathogenic priming in reinfection by COVID-19 is a theoretical possibility; of course no vaccine against SARS-CoV-2 has yet been tested in animals and therefore we do not yet know if pathogenic priming is in fact expected. Such studies should be undertaken before use of any vaccine against SARS-CoV-2 is used in humans.
https://pubmed.ncbi.nlm.nih.gov/32292901/

My comment: And as we all know, the mRNA vaccines that are now being injected into the public, have skipped this very important step of sufficient animal studies looking at the very possible risk of pathogenic priming.

A very important consideration in the discussion regarding kids and these experimental products

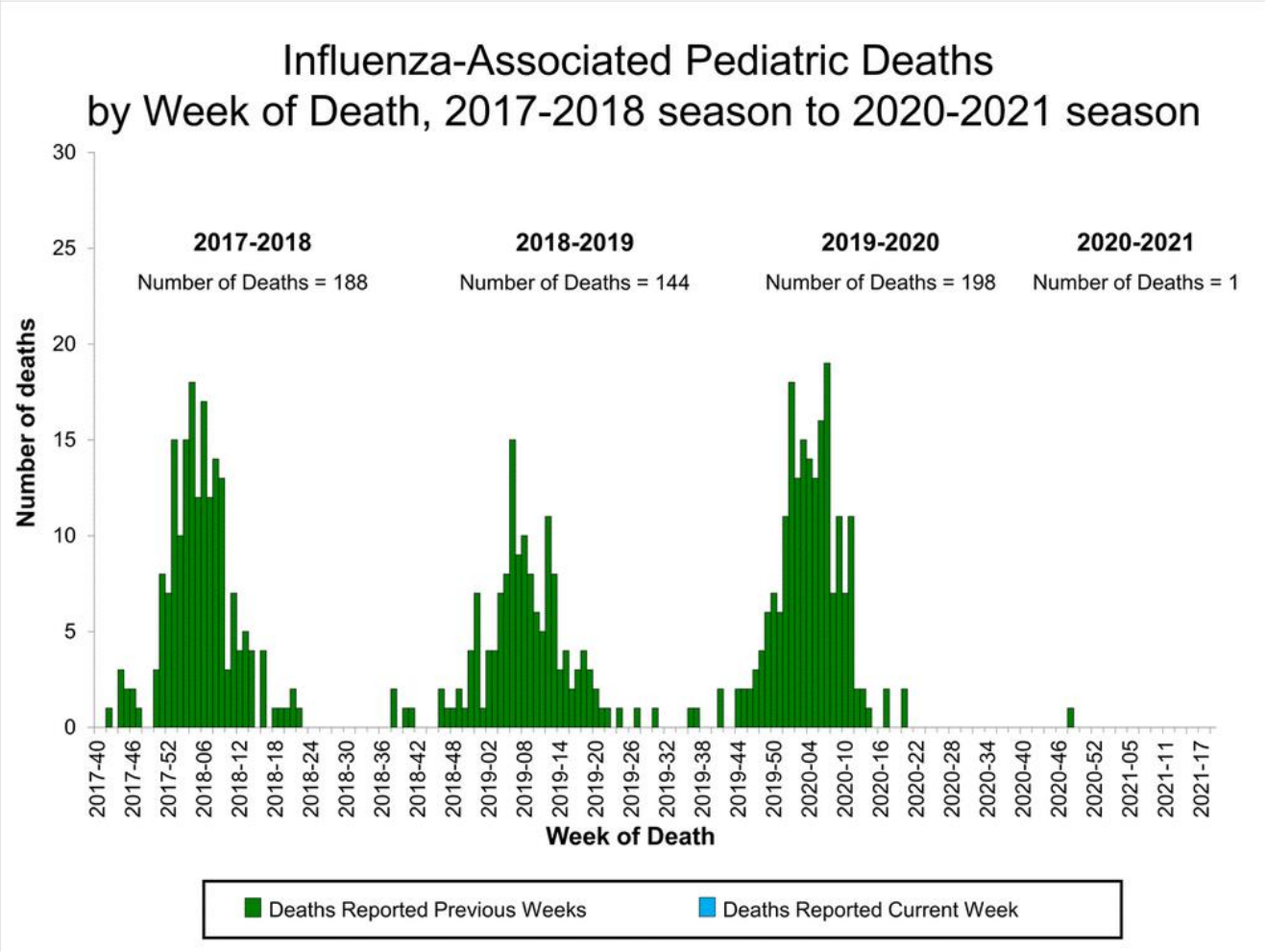
The survival rate for COVID-19 in children is 99.998%

This is critical to understand. COVID-19 appears by all measures to be less deadly to children than the seasonal flu. And, during the 2020-2021 flu season it appears that the flu was almost non-existent, dominated by the SARS-CoV-2 virus. Even so, deaths in children were very low.

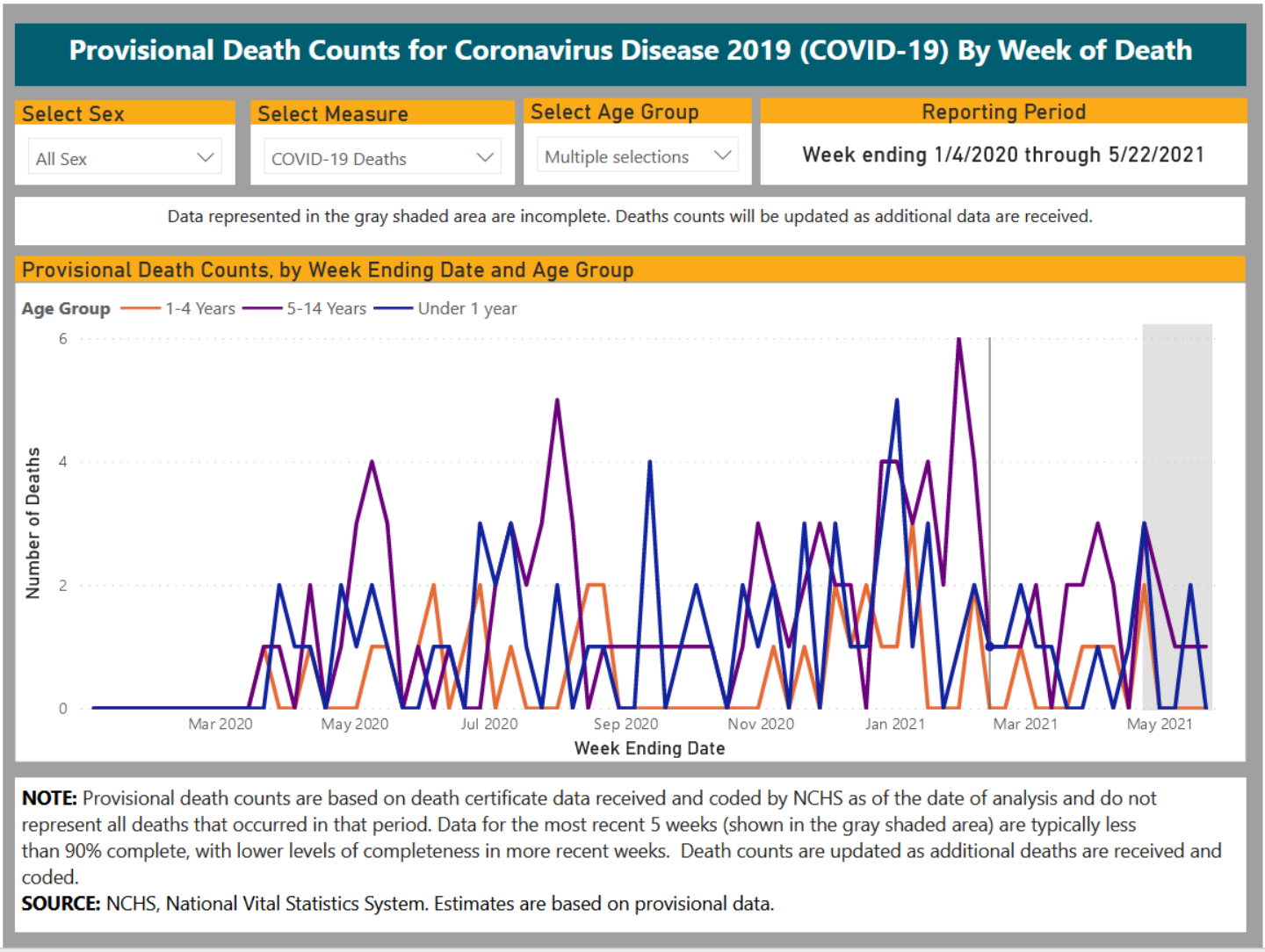
The number of pediatric deaths from the flu have dropped 99.5% this year

Looking at the chart below it is obvious that just like all flu cases and deaths, pediatric deaths from the flu are at an all-time low. Why is that? Some would claim that it is because of the masks and social distancing. Well, if that were the case, how do you explain the surge of COVID-19 cases and deaths this past winter? If the masks and distancing were effective against the flu, they certainly would have been effective against the SARS-CoV-2 virus. But that just wasn't the case. As I have previously covered in many stories backed by evidence from many studies, masks have been ineffective at stopping this virus, just like they have been proven ineffective against influenza and other respiratory viruses over the last 40 years. It could be argued that lockdowns and severely restricting movement of people could slow the spread of an outbreak as has been shown in various areas of the world throughout the pandemic, but that policy is simply not sustainable and creates massive collateral damage in society. Once those areas eventually opened up the virus spread as it would have in the absence of lockdowns.

Looking at the chart below is a graphic reminder of how dominant viruses will increase mortality in populations that are susceptible to respiratory viruses, as we have seen with SARS Co V2. As with the very elderly and sickly who normally succumb to influenza and influenza like illnesses every winter season, pediatric deaths will show a similar phenomenon. Those children with underlying conditions that make them susceptible to severe outcomes or death from any pathogenic respiratory virus will be more susceptible to the dominant strain or strains during any given season. Had SARS-CoV-2 never arrived on the scene, we most likely would have seen flu related death numbers in children similar to the previous seasons.



To reinforce the point that the masks and distancing have not been the X-factor with controlling flu related deaths this past winter in children, take a look at this chart showing the pediatric deaths throughout the pandemic. As you can see, the highest numbers of deaths "with COVID" occurred this past January and February, exactly when we would normally see the flu deaths peak in children as demonstrated by the graph above. But note for reference that the numbers of deaths displayed on the Y-axis on the left peak out at 6 deaths in the age 5-14 age group, so we are not talking about large numbers of children.



https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm#SexAndAge

In total, the CDC says that there have been 300 pediatric deaths in children "involving COVID" as of May 26th, 2021. But remember that involves 2 full respiratory seasons and 7 months of COVID spread in between. If you average the 3 prior flu seasons in the flu death chart on the previous page, you will get an average of 177 deaths per flu season in the pediatric population. One would expect approximately 354 flu deaths in children over the course of 2 flu seasons, which is less than what have occurred during COVID. Another argument I would make is that we have caused a population wide immunosuppression in our children by forcing them to wear masks at school and in public. Numerous studies have shown the immunosuppressive effects of face coverings worn consistently. Not only that, but the lack of social connection, propagation of fear and paranoia, and decreased amounts of outdoor activities and exercise would have all contributed to an increase in susceptibility to viral illness in the pediatric population, resulting in a higher number of severe cases and deaths than would have occurred otherwise.

In summary:

- **"Flu" cases and deaths parallel the same seasonal pattern as we have seen with COVID.** (other than the summer surge we saw in areas that did not have a strong initial surge back in March and April of 2020 due to lockdowns and other factors. Remember, you can't hide from a virus. You simply delay the

inevitable)

- **Despite masks and social distancing, we saw the same spikes during this past winter from COVID that we would typically see during the usual flu season.**

- **COVID-19 is less lethal to children than the seasonal flu.**

***As a side note.** The CDC also reported in the link above that there have been a total of 44,788 pediatric deaths during the same time period. That means that deaths involving COVID in the pediatric population account for just 0.67% of all deaths in children.
https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm#SexAndAge

Yet, we are acting like unless we vaccinate all of them with the experimental "vaccines", they will be at risk. It is ridiculous, especially due to the fact that in addition to an incredibly low risk of severe complications and death in children, a very large percentage of their population have had COVID-19 and recovered. That means they cannot get it again and will serve as a buffer for the other children that have not contracted COVID-19. Injecting a child that has had COVID-19 and recovered, especially in light of their low risk and unknowns of the effects short and long-term in children should be medical malpractice. Not only that, but to not even suggest that children should be tested for antibodies and T-cell immunity before vaccinating them is another example of the UNscientific approach we are following in nearly every area of this whole fiasco. Considering all of those variables it is complete insanity in my opinion to move forward with these experimental products that have no long-term safety record and could very well pose a higher risk of short- and long-term adverse effects in children than the virus itself.

July 1st, 2021 Update

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.

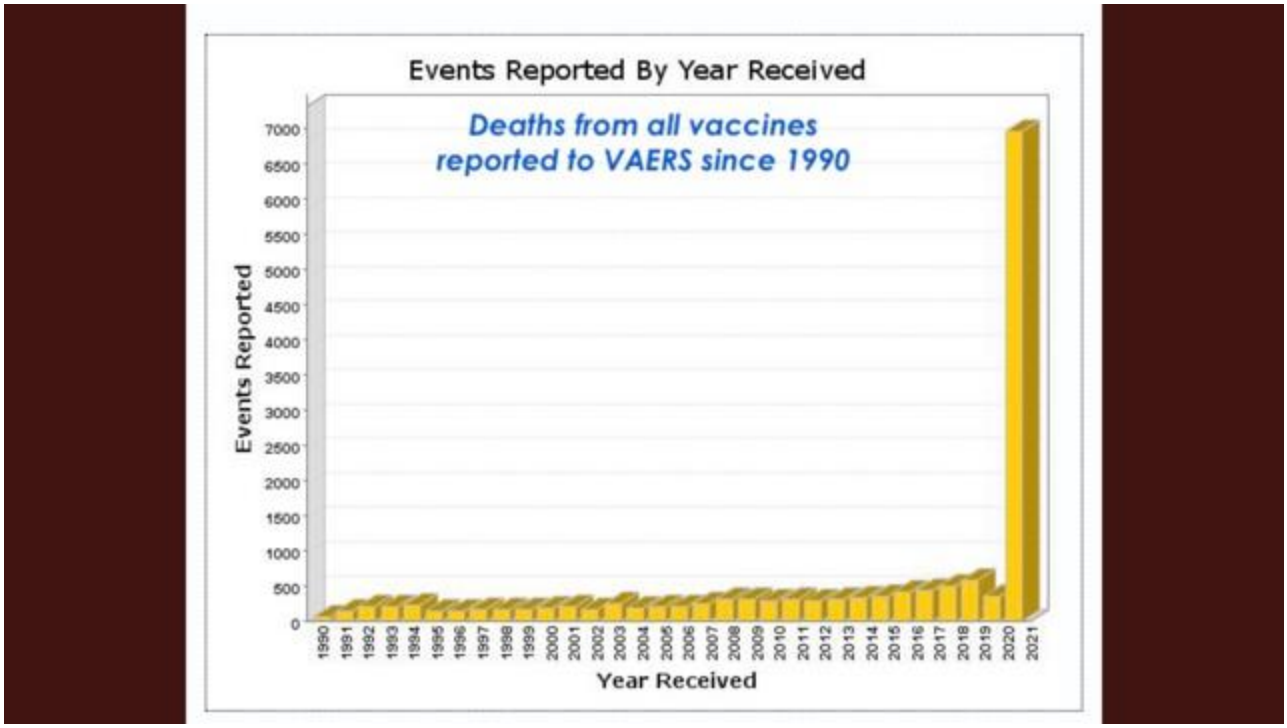
It's an abomination that we are going to subject children in this country with an unknown health risk when they are about as close to zero risk from COVID as it can get. And don't give me the "we have to vaccinate the kids to get to herd immunity" BULL S_ _ _. They are grasping at straws and they know 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 support the legal challenges underway by 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.

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 graph on this page to see how the death rates from the COVID-19 vaccines (as of first of July 2021) compared to all the other vaccines combined for the last 30 years.



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.

The table on the next page 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	Septicer	Malignant	Diabetes n	Alzheimer	Influenza a	Chronic lo	Other dise	Nephritis,	Symptoms, signs and abnormal c	Diseases	Cerebrova	COVID-19 (U(	COVID-19 (U(
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

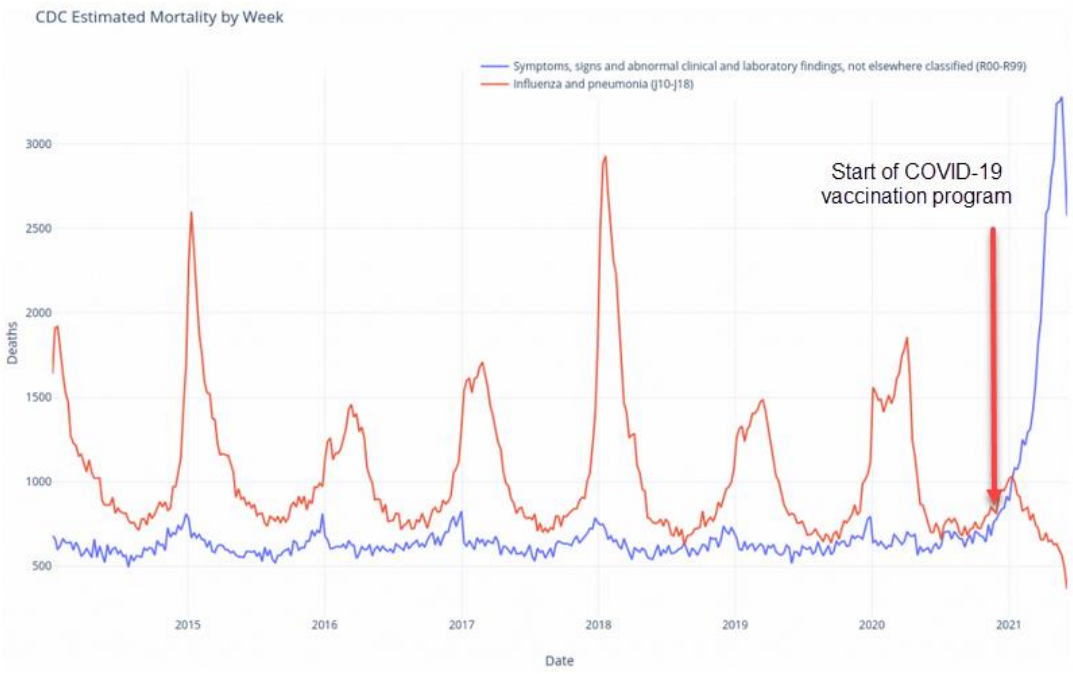
https://data.cdc.gov/NCHS/Weekly-Provisional-Counts-of-Deaths-by-State-and-S/muzy-jte6

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.

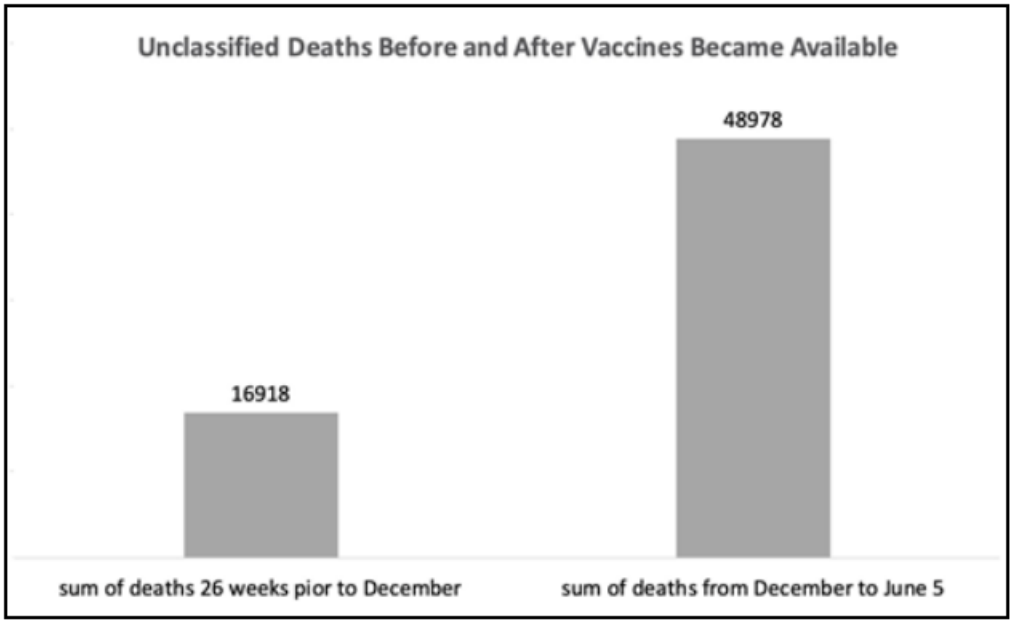


(Addition June 22, 2021) It's important to note the R00-R99 codes will adjust later, i.e. re-attributed to COVID-19 or diseases of heart deaths. I do a bit of an analysis into that topic in a follow up article, Changes in the CDC Counts of Deaths by State and Select Cause. Yes, the R00-R99 are increasing 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/

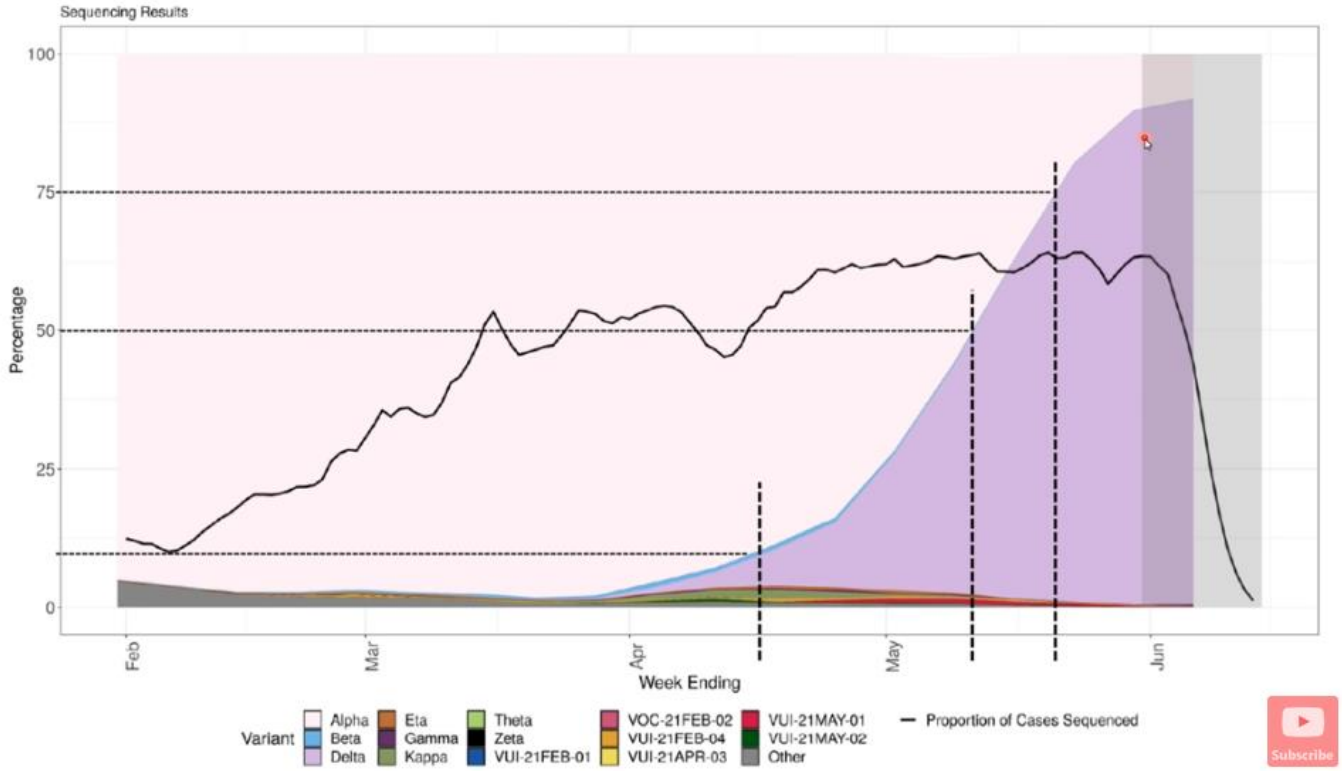
Speaking of variants, is the Delta Variant the scary boogieman that people are being told it is?

In mid-June, the UK announced another 30 days of lockdowns- (at least)

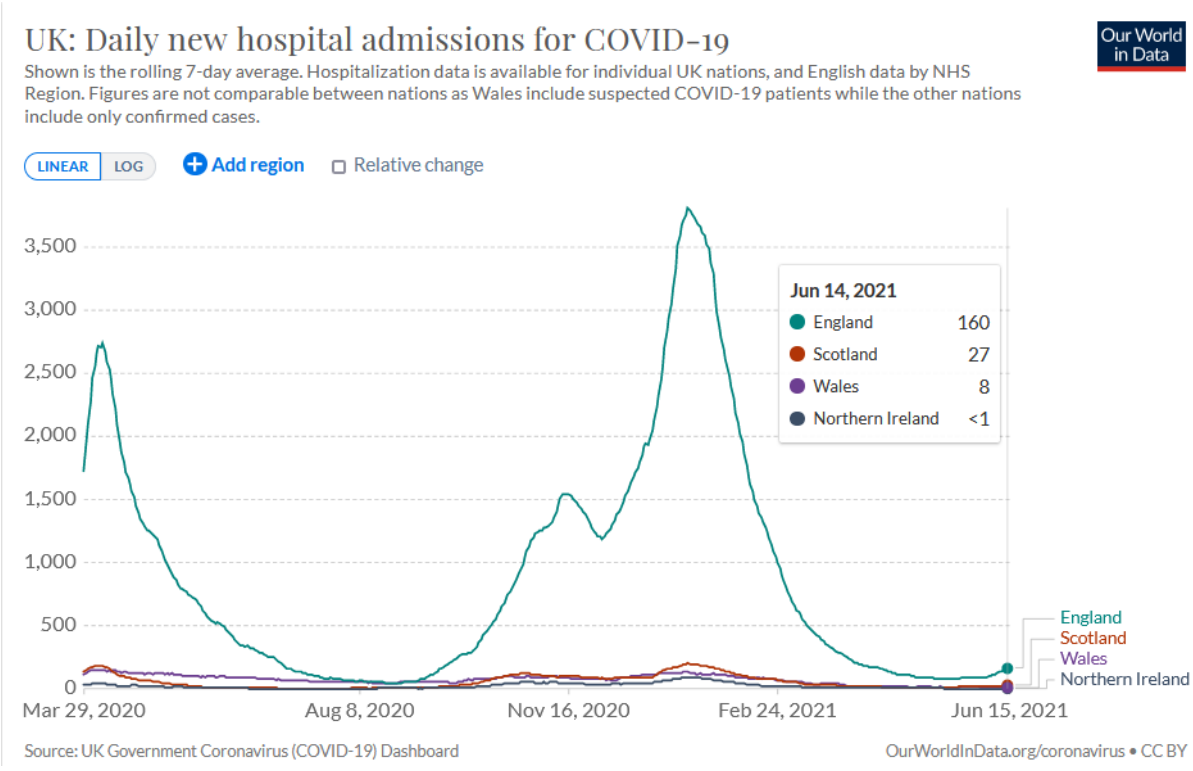
On the next page is the real-world data from England.

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).



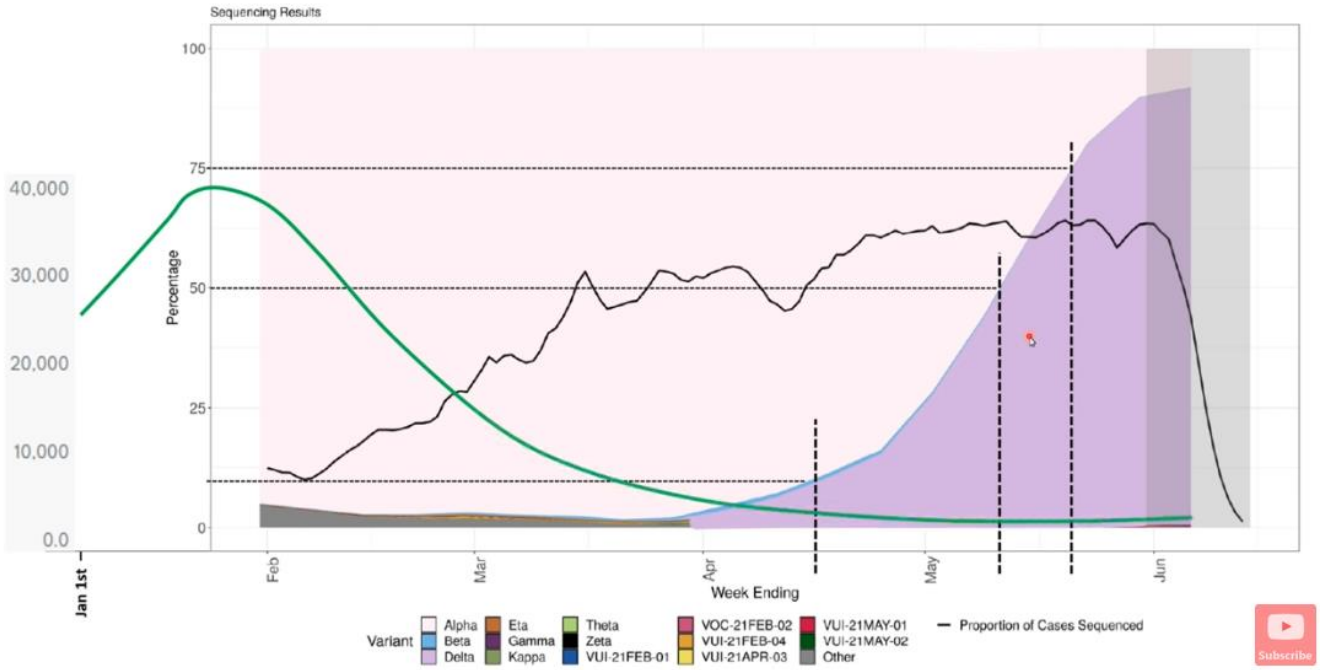
But what are the real-world effects on hospitalizations and deaths? Here is a graph looking at that…



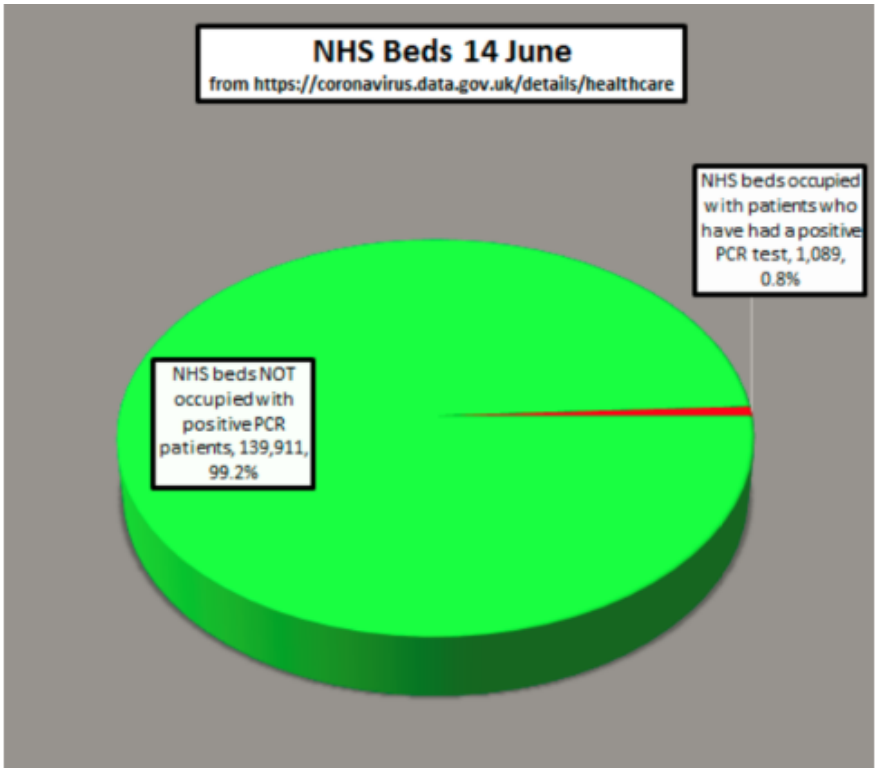
As you can see, zilch, nada, nothing to be panicked about.

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.

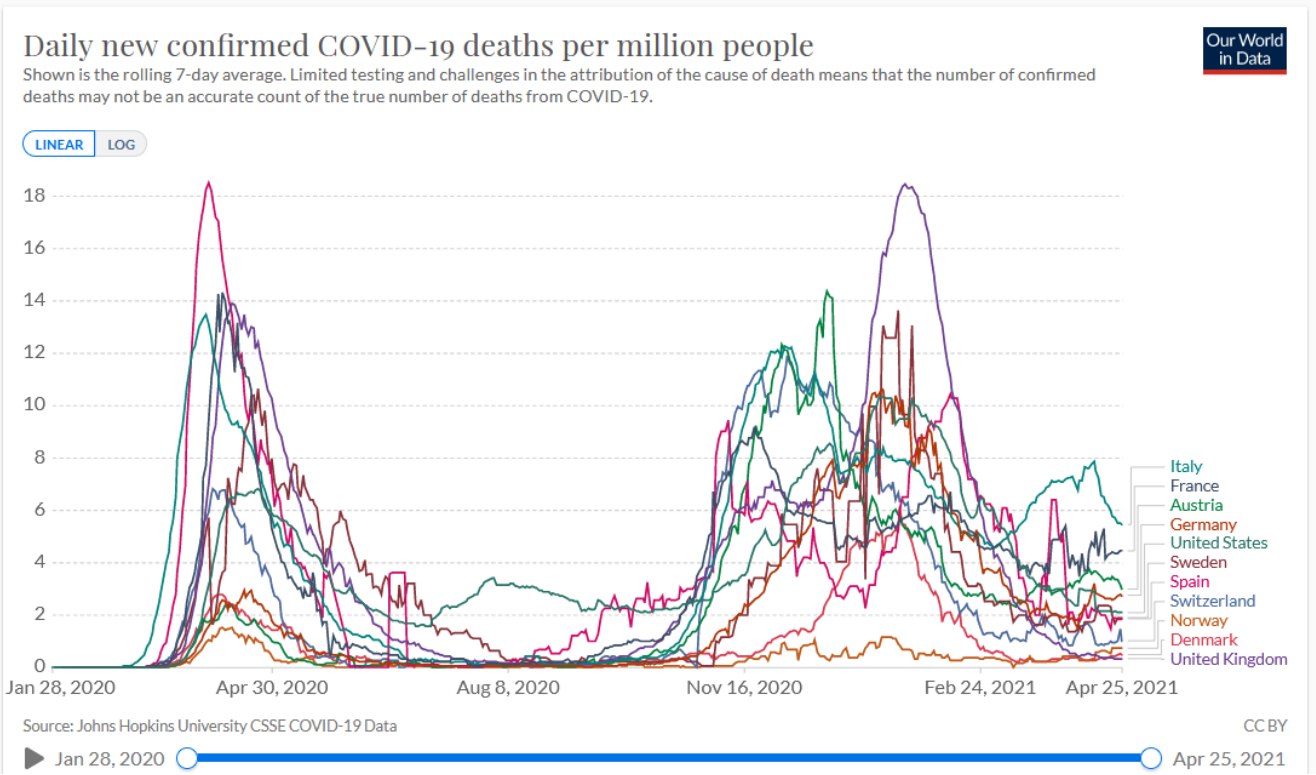
https://www.youtube.com/watch?v=TtOu7jx3snQ

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.

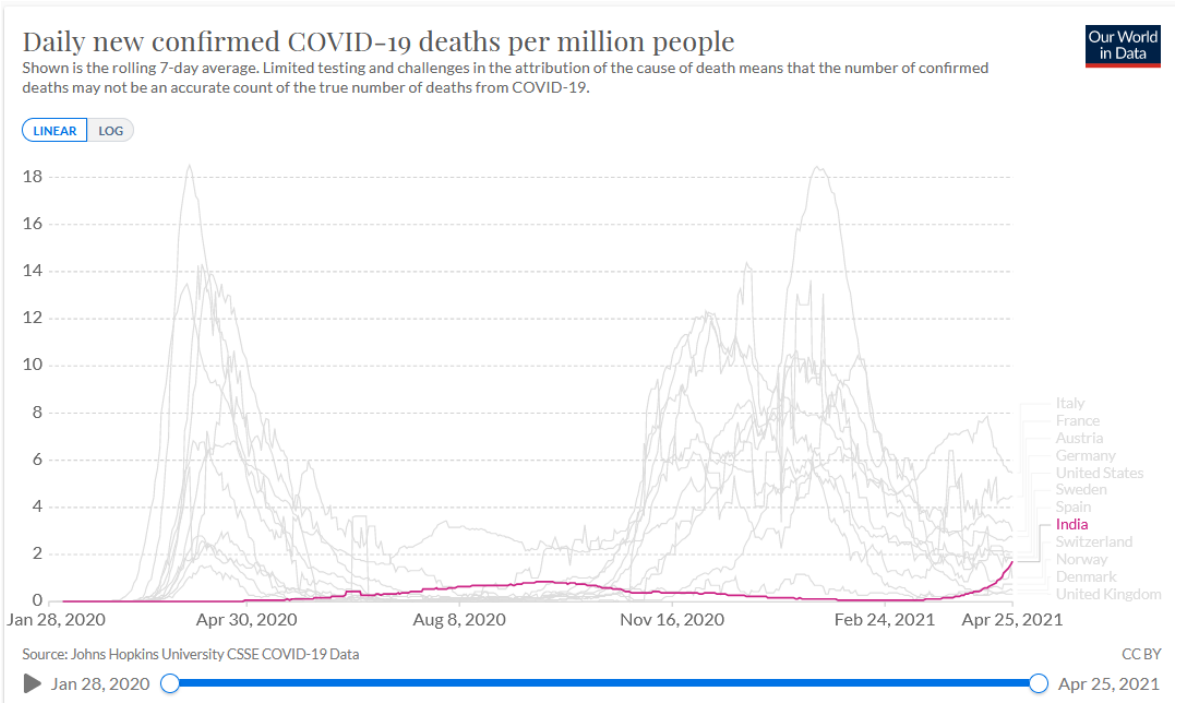
Since Delta IS the Indian Variant and India was hit hard this spring, shouldn't we be concerned?

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.

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

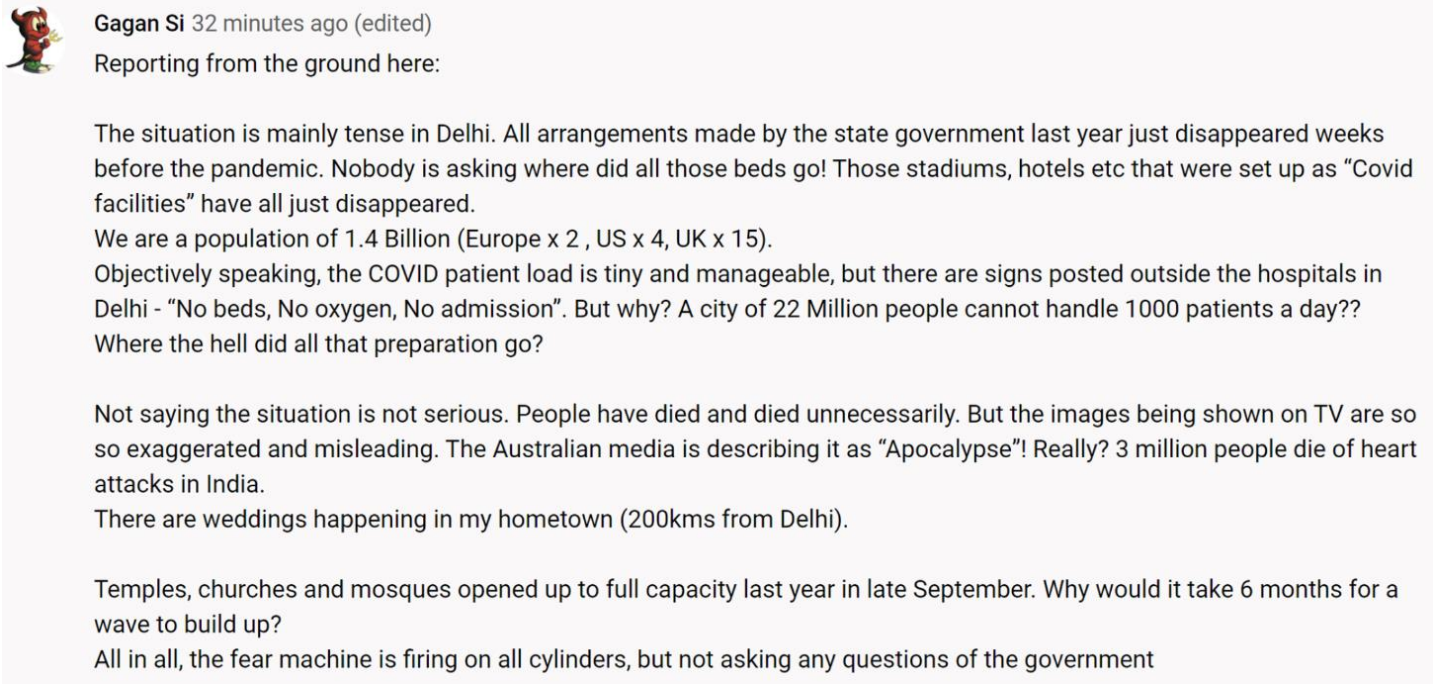


Then I showed India superimposed over the other countries.



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

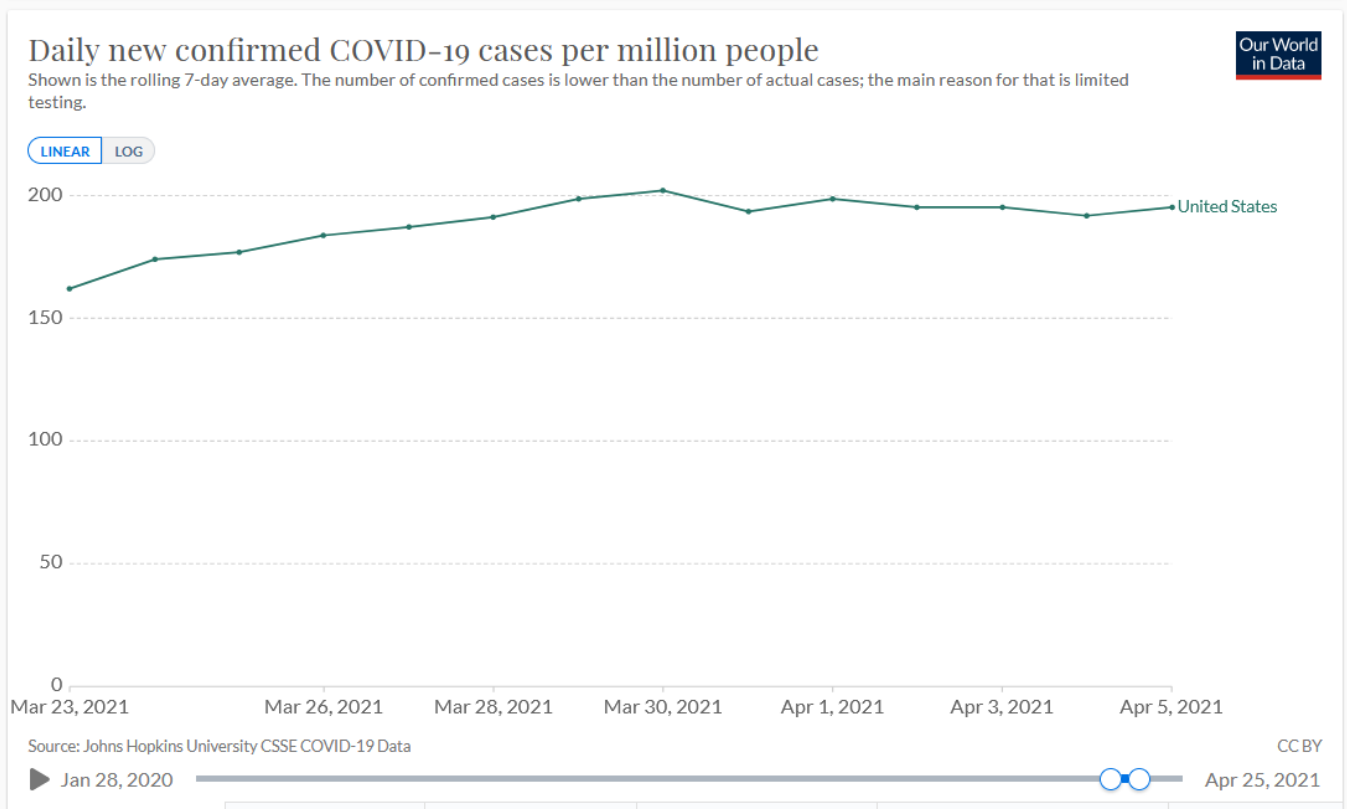
How about the mainstream media's sensationalized reporting? Is there any basis for it? Let's look at how they've handled previous variants.

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?

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.

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.**

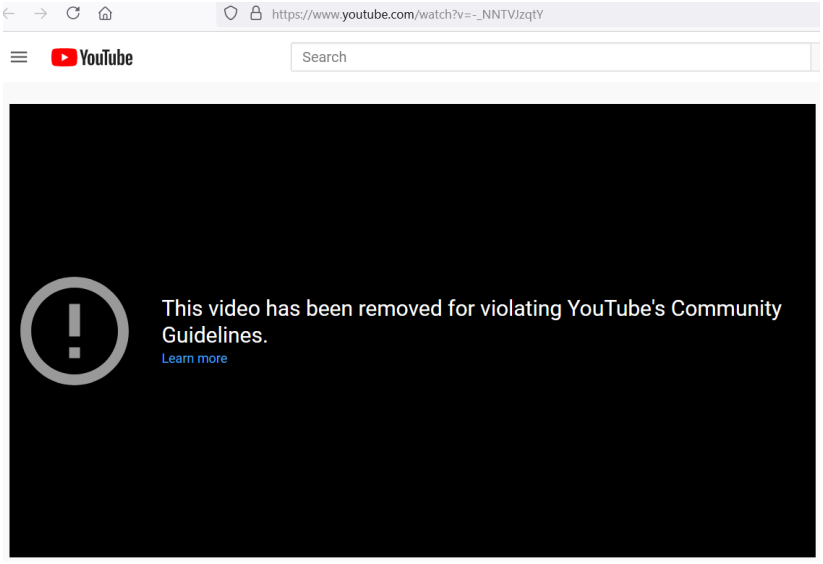
Dr. Malone specializes in clinical research, medical affairs, regulatory affairs, project management, proposal management (large grants and contracts), vaccines and biodefense. This includes writing, developing, reviewing and managing vaccine, bio-threat and biologics clinical trials and clinical development 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.**

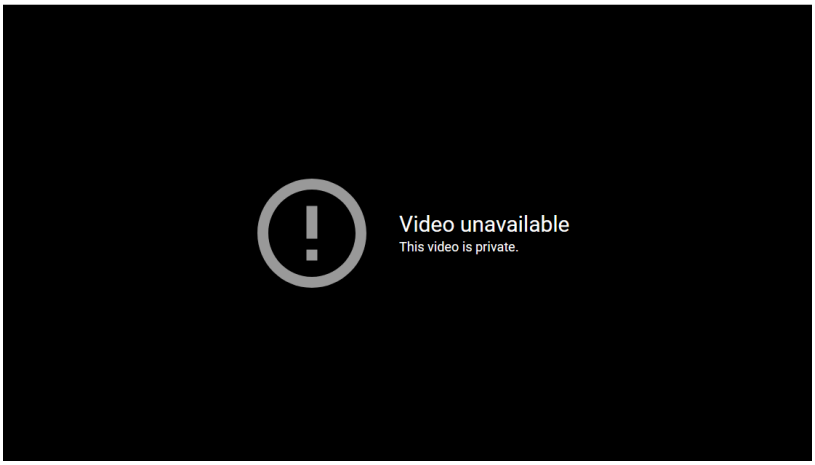
He received his medical training at Northwestern University (MD) and Harvard University (Clinical Research Post Graduate) medical school, and in Pathology at UC Davis.

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.**

Then 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.

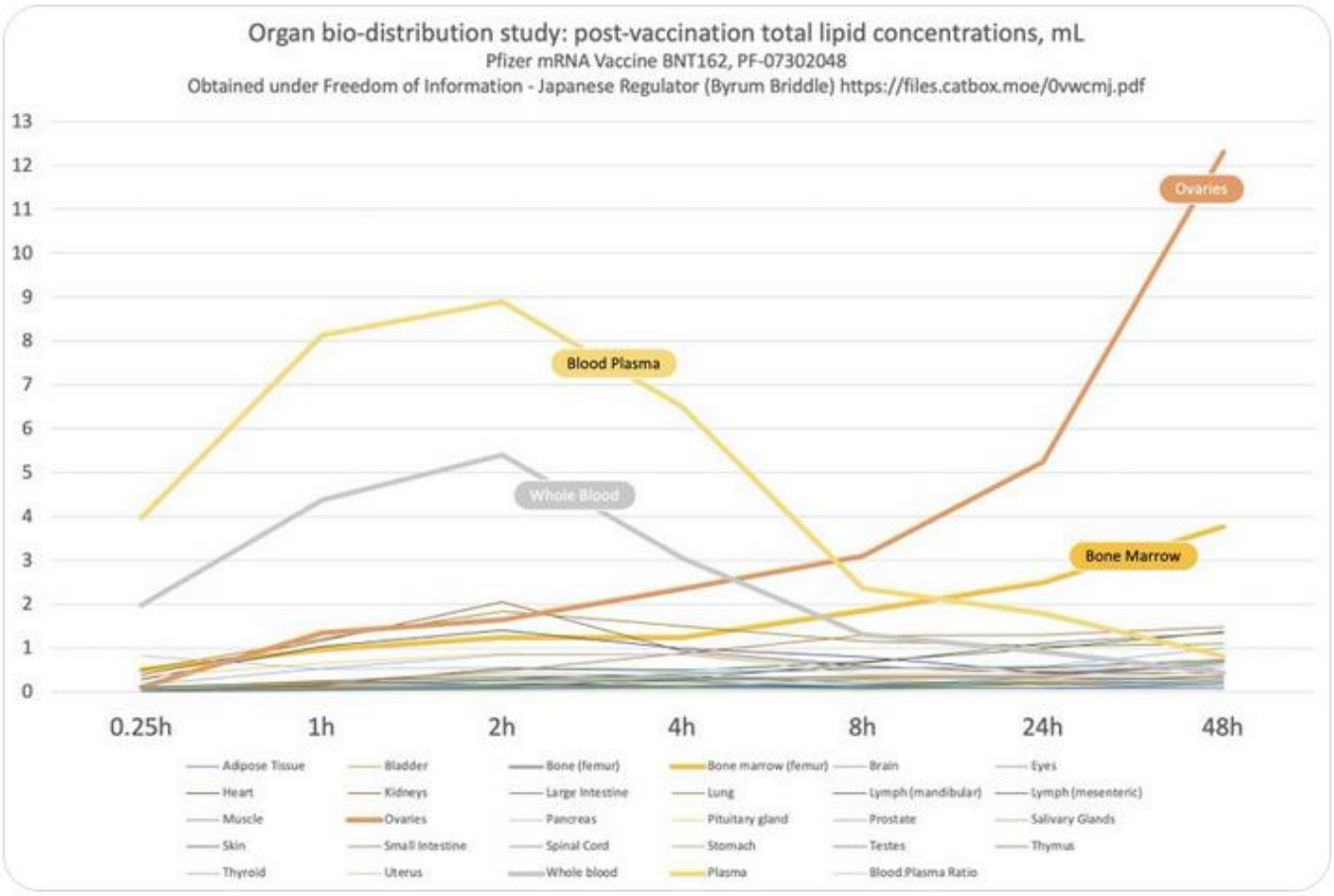
The virus will effectively outsmart the highly specific antigen-based vaccines being used and tweaked, depending on the circulating variants. All of this could lead to a hockey stick-like increase in serious and potentially lethal cases — in effect, an out-of-control pandemic.

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 on the next page…



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.

Continued next page…

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 the 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. See them on the next page…

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

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

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	%	*no./total no. (%)*
Pregnancy loss among participants with a completed pregnancy		
Spontaneous abortion <20 wk[15-17]	10~~–26~~	104/≤127 (≥82%) ~~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

* 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,

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No potential conflict of interest relevant to this letter was reported.

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4. Obstetricians ACo, Gynecologists. ACOG practice bulletin no. 200: Early pregnancy loss. *Obstetrics and gynecology* 2018;132:e197-e207.

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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…

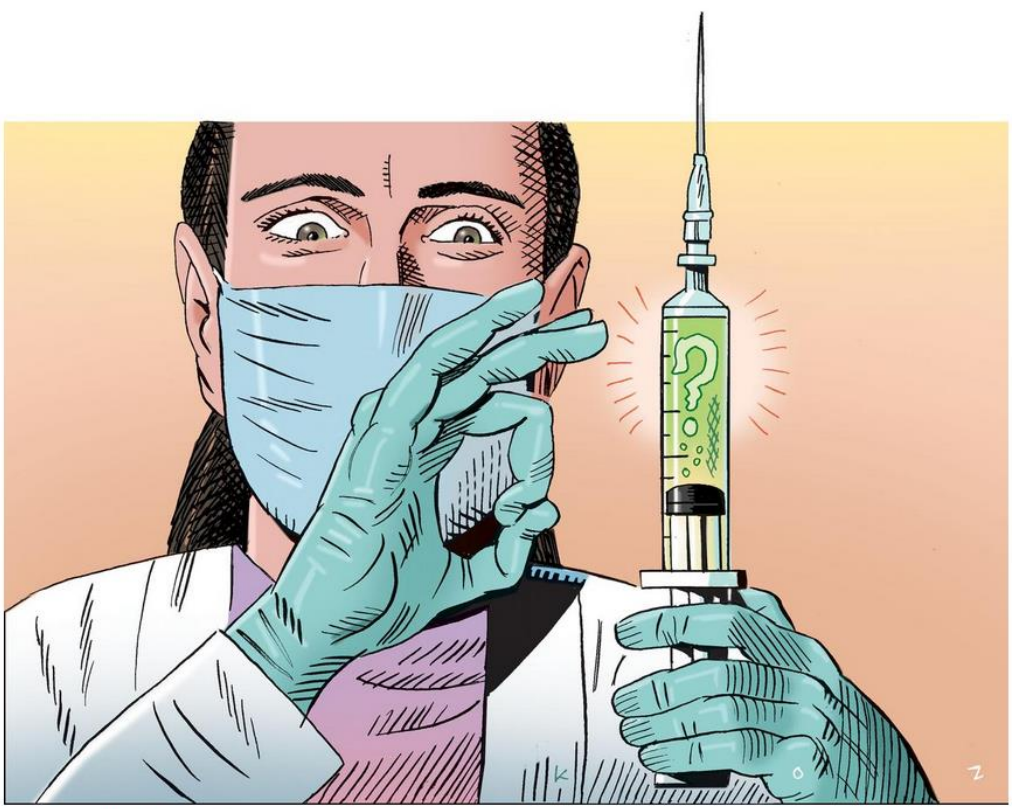


ILLUSTRATION: MARTIN KOZLOWSKI

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."

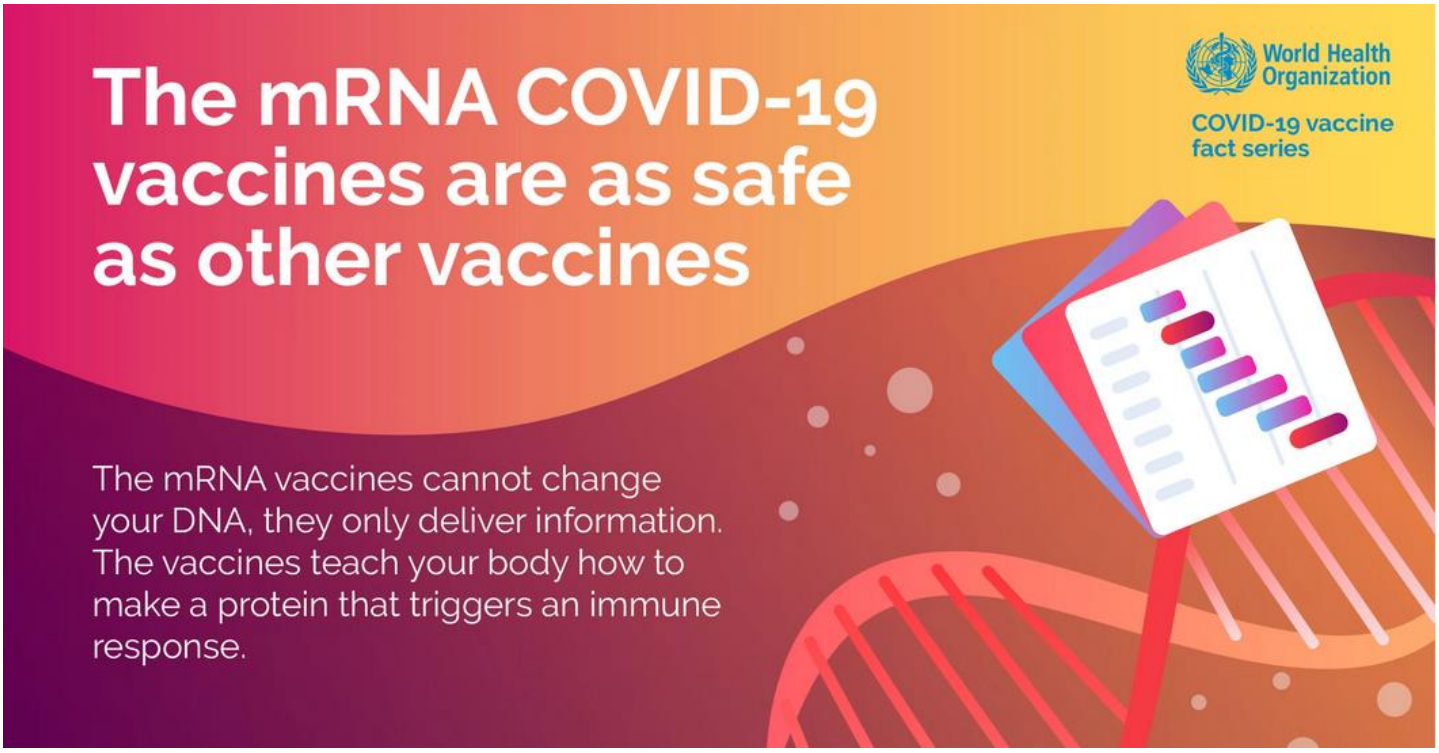
"Analyses to confirm or dismiss these findings should be performed using large data sets of health-insurance companies and healthcare organizations. The CDC and FDA are surely aware of these data patterns, yet neither agency has acknowledged the trend."

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

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 in the next few pages….



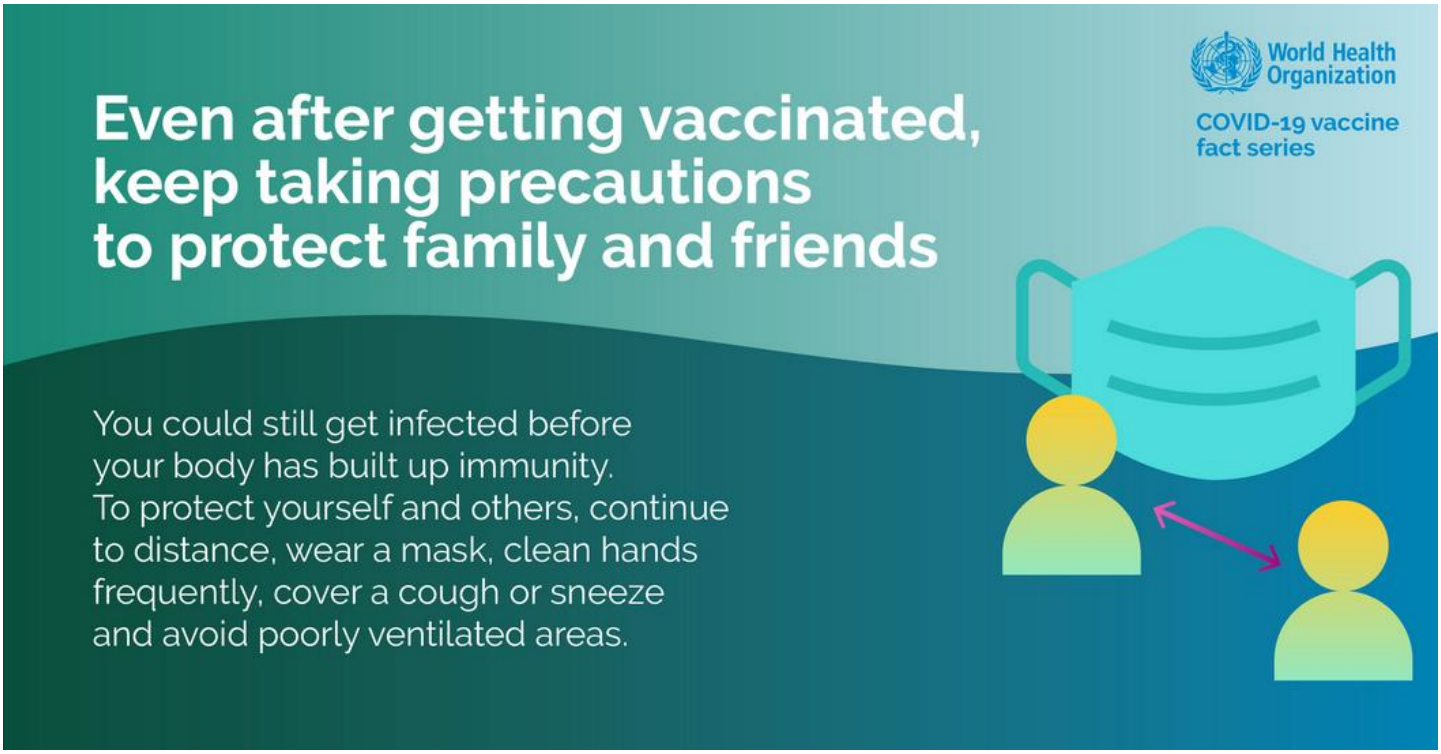
As safe as other vaccines? Just check the VAERS reports (which we know are highly under-reported) and read the MedScape medical professional comments from the link found in this newsletter. Then tell me what you think about this egregious statement.

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.

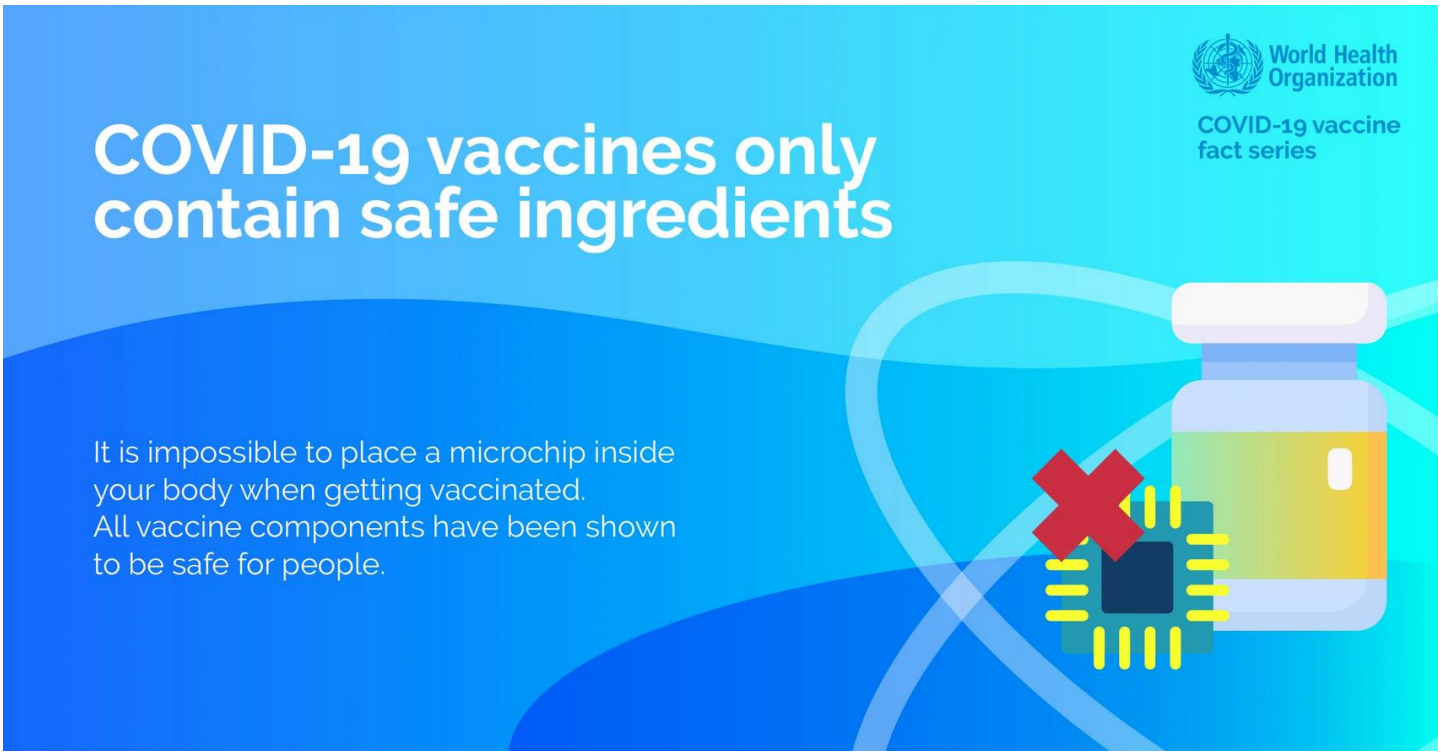
The statement above is a joke! We know from numerous studies many of which I've covered in previous newsletters and some of them in this newsletter, that natural immunity is far superior to vaccine immunity. Those who have been vaccinated are at far greater risk of becoming infected by mutant strains. 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.

Continued next page…

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.



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

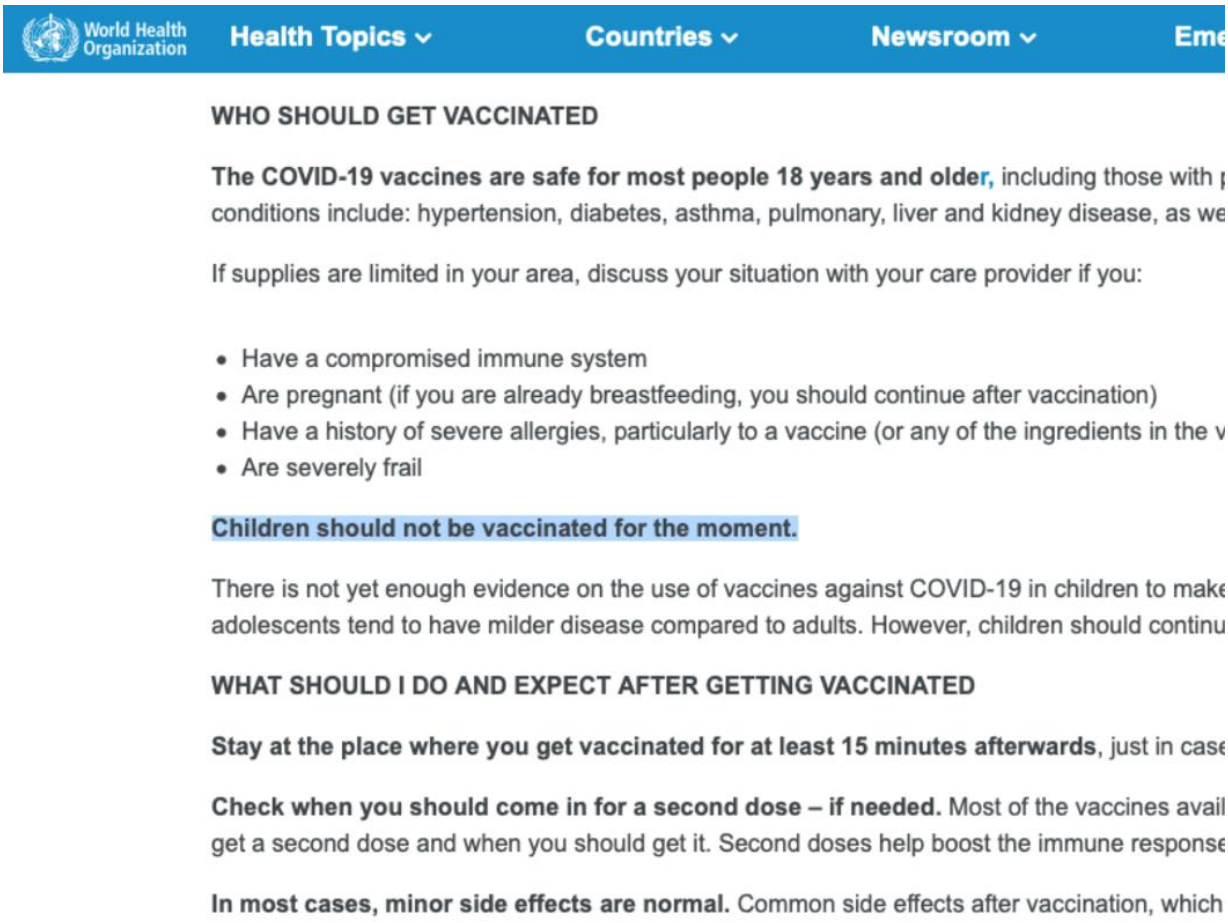
https://www.who.int/emergencies/diseases/novel-coronavirus-2019/covid-19-vaccines/advice

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 W.H.O. 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.



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WHO SHOULD GET VACCINATED

The COVID-19 vaccines are safe for most people 18 years and older, including those with
conditions include: hypertension, diabetes, asthma, pulmonary, liver and kidney disease, as we

If supplies are limited in your area, discuss your situation with your care provider if you:

- Have a compromised immune system
- Are pregnant (if you are already breastfeeding, you should continue after vaccination)
- Have a history of severe allergies, particularly to a vaccine (or any of the ingredients in the v
- Are severely frail

Children should not be vaccinated for the moment.

There is not yet enough evidence on the use of vaccines against COVID-19 in children to make
adolescents tend to have milder disease compared to adults. However, children should continu

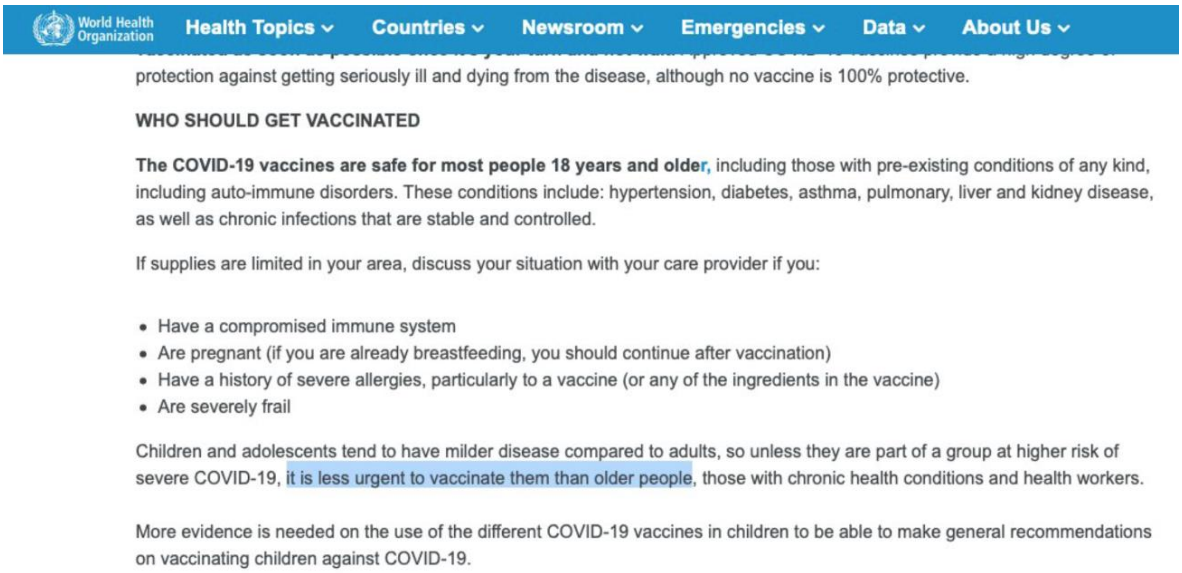
WHAT SHOULD I DO AND EXPECT AFTER GETTING VACCINATED

Stay at the place where you get vaccinated for at least 15 minutes afterwards, just in case

Check when you should come in for a second dose – if needed. Most of the vaccines avail
get a second dose and when you should get it. Second doses help boost the immune response

In most cases, minor side effects are normal. Common side effects after vaccination, which

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



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protection against getting seriously ill and dying from the disease, although no vaccine is 100% protective.

WHO SHOULD GET VACCINATED

The COVID-19 vaccines are safe for most people 18 years and older, including those with pre-existing conditions of any kind, including auto-immune disorders. These conditions include: hypertension, diabetes, asthma, pulmonary, liver and kidney disease, as well as chronic infections that are stable and controlled.

If supplies are limited in your area, discuss your situation with your care provider if you:

- Have a compromised immune system
- Are pregnant (if you are already breastfeeding, you should continue after vaccination)
- Have a history of severe allergies, particularly to a vaccine (or any of the ingredients in the vaccine)
- Are severely frail

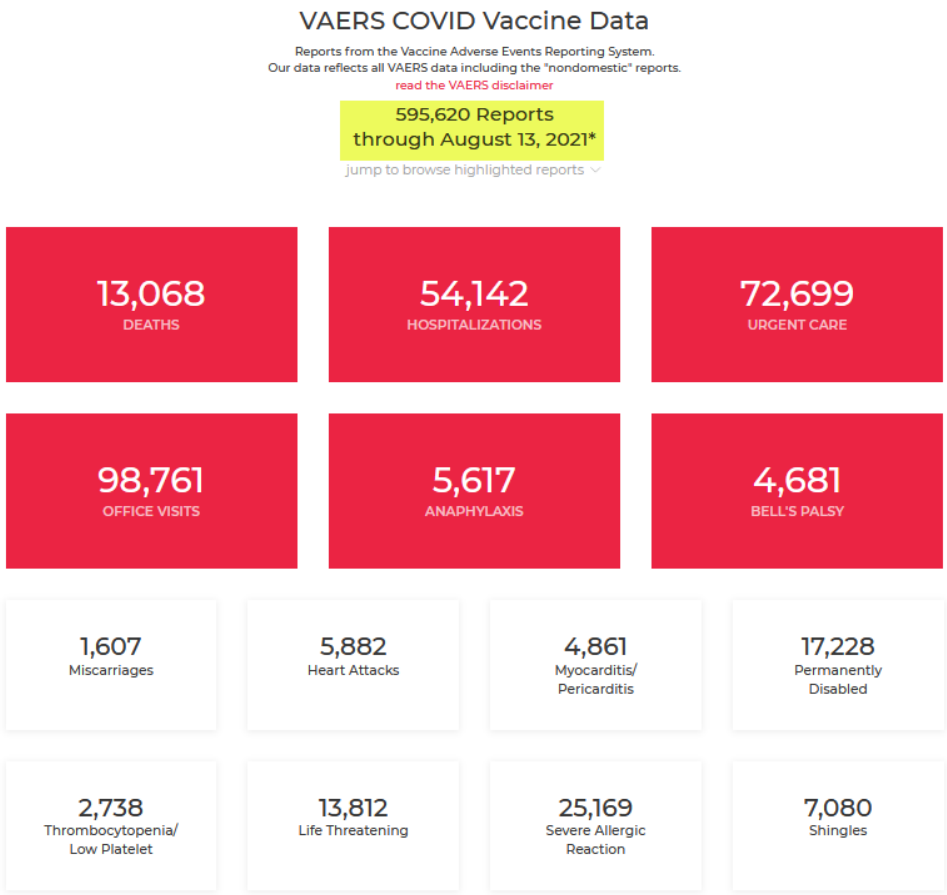
Children and adolescents tend to have milder disease compared to adults, so unless they are part of a group at higher risk of severe COVID-19, it is less urgent to vaccinate them than older people, those with chronic health conditions and health workers.

More evidence is needed on the use of the different COVID-19 vaccines in children to be able to make general recommendations on vaccinating children against COVID-19.

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.

August 01, 2021 update

Latest VAERS update as of August 13th, 2021- A catastrophic number of casualties



Study shows that spike protein from the SARS-CoV-2 virus or from the spike protein generating vaccines damage heart tissue in unexpected ways

The study is a June 2021 pre-print release on ***BioRxiv*** titled, **Selectively expressing SARS-CoV-2 Spike protein S1 subunit in cardiomyocytes induces cardiac hypertrophy in mice.**

This study shows at least in mice, that the spike protein induces inflammation of the cardiomyocytes (heart muscle cells) independently of the ACE-2 binding action. This seems to go a long way in explaining the wide array of cardiac symptoms including myocarditis after the COVID-19 injections. As you will read, the spike protein does not interact with murine (mouse) ACE-2, therefore they know that this is a separate and distinct reaction from the ACE-2 binding which it is most known for.

Abstract

Cardiac injury is common in hospitalized COVID-19 patients and portends poorer prognosis and higher mortality. To better understand how SARS-CoV-2 (CoV-2) damages the heart, it is critical to elucidate the biology of CoV-2 encoded proteins, each of which may play multiple pathological roles. For example, CoV-2

Spike glycoprotein (CoV-2-S) not only engages ACE2 to mediate virus infection, but also directly impairs endothelial function and can trigger innate immune responses in cultured murine macrophages. Here we tested the hypothesis that CoV-2-S damages the heart by activating cardiomyocyte (CM) innate immune responses. HCoV-NL63 is another human coronavirus with a Spike protein (NL63-S) that also engages ACE2 for virus entry but is known to only cause moderate respiratory symptoms. We found that CoV-2-S and not NL63-S interacted with Toll-like receptor 4 (TLR4), a crucial pattern recognition receptor that responsible for detecting pathogen and initiating innate immune responses. Our data show that the S1 subunit of CoV-2-S (CoV-2-S1) interacts with the extracellular leucine rich repeats-containing domain of TLR4 and activates NF-kB. To investigate the possible pathological role of CoV-2-S1 in the heart, we generated a construct that expresses membrane-localized CoV-2-S1 (S1-TM). AAV9-mediated, selective expression of the S1-TM in CMs caused heart dysfunction, induced hypertrophic remodeling, and elicited cardiac inflammation. Since CoV-2-S does not interact with murine ACE2, our study presents a novel ACE2-independent pathological role of CoV-2-S, and suggests that the circulating CoV-2-S1 is a TLR4-recognizable alarmin that may harm the CMs by triggering their innate immune responses

https://www.biorxiv.org/content/10.1101/2021.06.20.448993v1

Known harms of the spike protein

Here are four studies that demonstrate that the spike protein that the COVID shots that force our cells to make are toxins and have multiple deleterious effects in the body.

A recent experimental study showed that the SARS-CoV2 spike protein is sufficient to produce endothelial damage [see reference 23 below]. 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 [reference 24]. The spike protein also contains domains that may bind to cholinergic receptors, thereby compromising the cholinergic anti-inflammatory pathways, enhancing inflammatory processes [reference 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 [reference 26].

23. Lei, Y.; Zhang, J.; Schiavon Cara, R.; He, M.; Chen, L.; Shen, H.; Zhang, Y.; Yin, Q.; Cho, Y.; Andrade, L.; et al. SARS-CoV-2 Spike Protein Impairs Endothelial Function via Downregulation of ACE 2. Circ. Res. **2021**, 128, 1323–1326. [CrossRef] [PubMed]

24. Kowarz, E.; Krutzke, L.; Reis, J.; Bracharz, S.; Kochanek, S.; Marschalek, R. “Vaccine-Induced COVID-19 Mimicry” Syndrome: Splice reactions within the SARS-CoV-2 Spike open reading frame result in Spike protein variants that may cause thromboembolic events in patients immunized with vector-based vaccines (non-peer reviewed preprint). Res. Sq. **2021**. [CrossRef]

25. Farsalinos, K.; Eliopoulos, E.; Leonidas, D.D.; Papadopoulos, G.E.; Tzartos, S.; Poulas, K. Nicotinic Cholinergic System and COVID-19: In Silico Identification of an Interaction between SARS-CoV-2 and Nicotinic Receptors with Potential Therapeutic Targeting Implications. Int. J. Mol. Sci. **2020**, 21, 5807. [CrossRef] [PubMed]

26. Seneff, S.; Nigh, G. Worse than the disease? Reviewing some possible unintended consequences of the mRNA vaccines against COVID-19. Int. J. Vaccine Theory Pract. Res. **2021**, 2, 38–79.

The lies are so blatant, can we ever believe our CDC and media again?

The talking points about 99% of the cases and 99% of the hospitalizations and "it is now a pandemic of the unvaccinated is being regurgitated 24/7. But is it true? It appears that we are now having to rely on outside governments and their published data to understand what is really happening with regard to cases, hospitalizations and deaths in the vaxxed vs the unvaxxed. I've already given other examples in this newsletter, but it warrants more evidence because the pharma-controlled messaging is in full court press mode.

One of the countries whose data completely contradicts our CDC and media reporting is the country of Israel. Israel is a very interesting case study because they made a deal with Pfizer to use their vaccine exclusively in their country. This makes their population a very interesting case study.

This table shows the confirmed cases of COVID-19 from July 4th through July 10th in people who have been fully vaccinated as compared to unvaccinated. As can be clearly seen the vast majority of cases are in people who have been fully vaccinated. This runs completely contrary to what we are being told here in the US.

Israel Confirmed Cases, July 4th – July 10th, Vaccinated* vs. Unvaccinated**

Age Group	Cases, Vaccinated	Cases, Unvaccinated	Percent of Cases Vaccinated	Percent of Population*** Vaccinated
20-29	217	61	78%	77%
30-39	248	84	75%	82%
40-49	356	54	87%	85%
50-59	237	26	90%	89%
60-69	227	14	94%	91%
70-79	143	12	92%	95%
80-89	42	6	88%	91%
קבוצת גיל	נדבקים מחוסנים	נדבקים לא מחוסנים	אחוז נדבקים מחוסנים	אחוז מחוסנים באוכלוסיה

ישראל, מקרי קורונה מאומתים, 4 ביולי עד 10 ביולי, מחוסנים לעומת לא מחוסנים

Source: Israel Ministry of Health Dashboard
https://datadashboard.health.gov.il/COVID-19/general
** Vaccinated – 2 shots.*
*** Unvaccinated – No shots.*
**** Excluding population with 1 shot.*

*****Thanks to my friend Mark for that graphic. You can follow Mark's podcast on ***YouTube*** at **Coffee with MarkZ**

According to a ***Jerusalem Post*** article July 17th titled, **More than 1,000 Israelis test positive for COVID,** their Prime Minister Bennett is quoted as saying the "vaccine is 'significantly less' effective against the Delta variant".

From the article: At the moment, around 60% of the patients in serious conditions have been vaccinated. Moreover, according to Hebrew University researchers who advise the government, around 90% of newly infected people over the age of 50 are fully vaccinated.

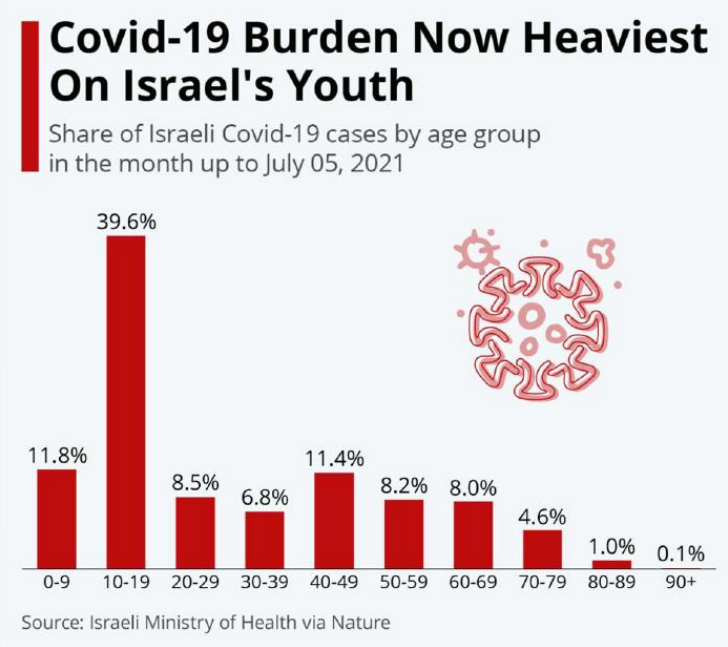
The article also said the following: "The reproduction rate (R), the number of people a sick person infects, stood at 1.37 – meaning that Covid-19 is spreading again." Parts of my brain perked up when I read this. A reproduction number (R0 for R-naught) above 1 means that there is spread of a pathogen as each infected person is expected would infect on average 1.37 people in this case. An R0 below 1 means the spread of the virus is in decline. When I read this, parts of my brain perked up. The estimated (R0) for SARS-CoV-2 has been

around 2.5 throughout most of the pandemic. That is very close to the common cold, influenza and influenza like viruses. So, a current rate of 1.37 is a much slower rate of spread. Yet we are all being told that the Delta Variant is so much more contagious. If that were true, the R0 number would be much higher than the 2.5 rate of the original Wuhan version. As an example of a very contagious virus is the measles virus. It is estimated to have an R0 number of between 16 and 18. Regardless, things don't add up.

https://www.jpost.com/breaking-news/for-first-time-since-march-855-new-coronavirus-cases-in-israel-674084

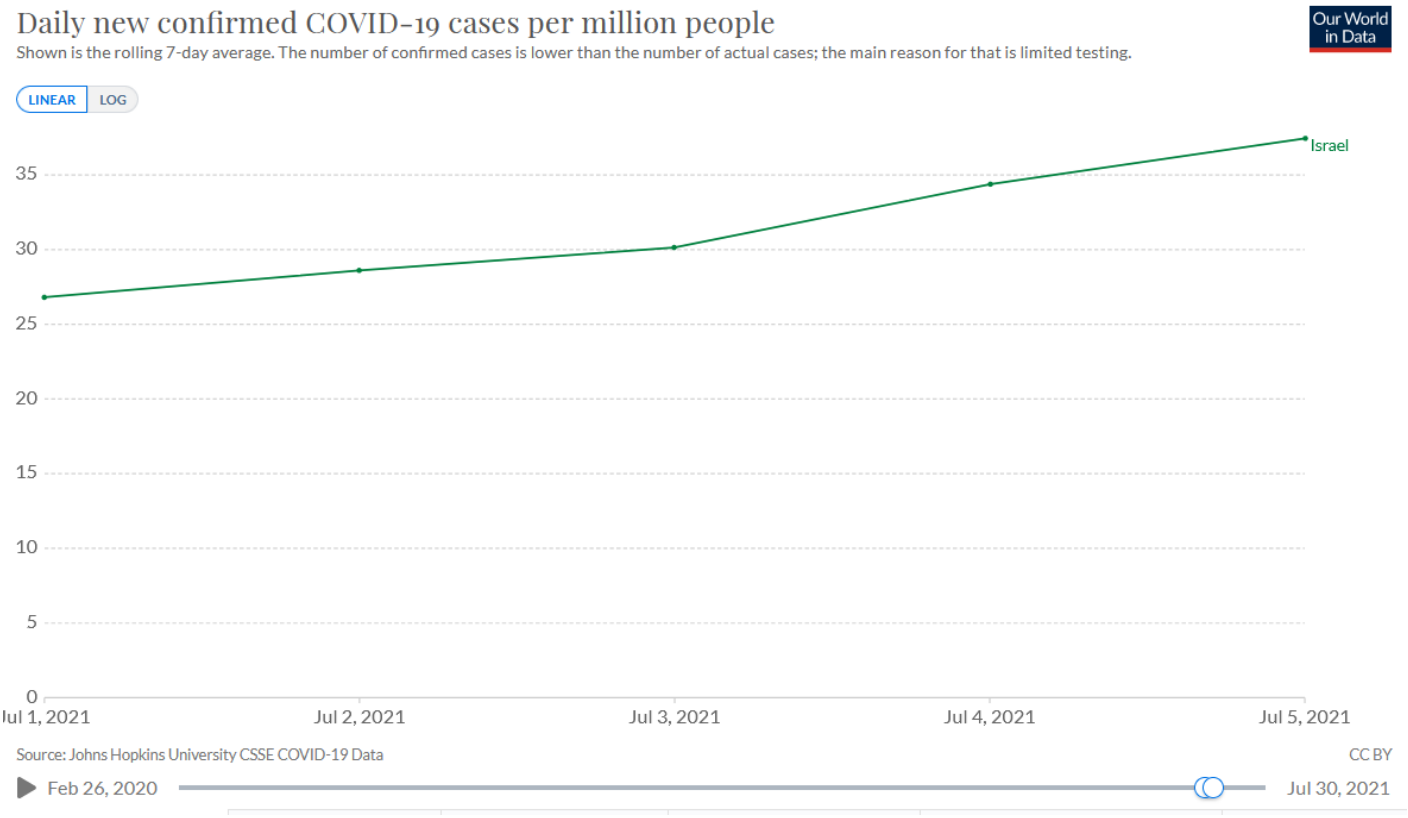
What about an increased number of cases in young people as we are hearing about?

This graph looking at the data from Israel is an example of typing something that doesn't need to be hyped.



Look at that headline on that graphic and then let's demolish it. So, 39.6% looks like a big number in the 10–19 year-old age group right? Not so fast. Notice the graph says that these numbers are for the month of July up until July 5th. That means these numbers represent five days in the first week of July. So, I did a little checking. I asked myself how many total cases were there in the increase of cases from July 1st to July 5th? That came out to 94 total cases. So that 39.6% figure represents only 37 cases. With such a low number of cases many factors could skew those numbers. Did they happen to be doing more testing with middle and high school children that particular week for example? Regardless, this is making something look like a BIG problem in the way it is portrayed, when is absolutely not.

This next graph is from ***Our World in Data*** showing the number of cases from July 1st to July 5th, 2020. On the left side representing July 1st there were 26.79 cases per million population. Population of Israel is 8.8 million. So that represents 236 cases. On the far right the graft reaches 37.45 cases per million people. Multiply that times 8.8 million and you get 330. So, the increase in the number of cases between July 1st & July 5th was only 94 (less than 20 per day).

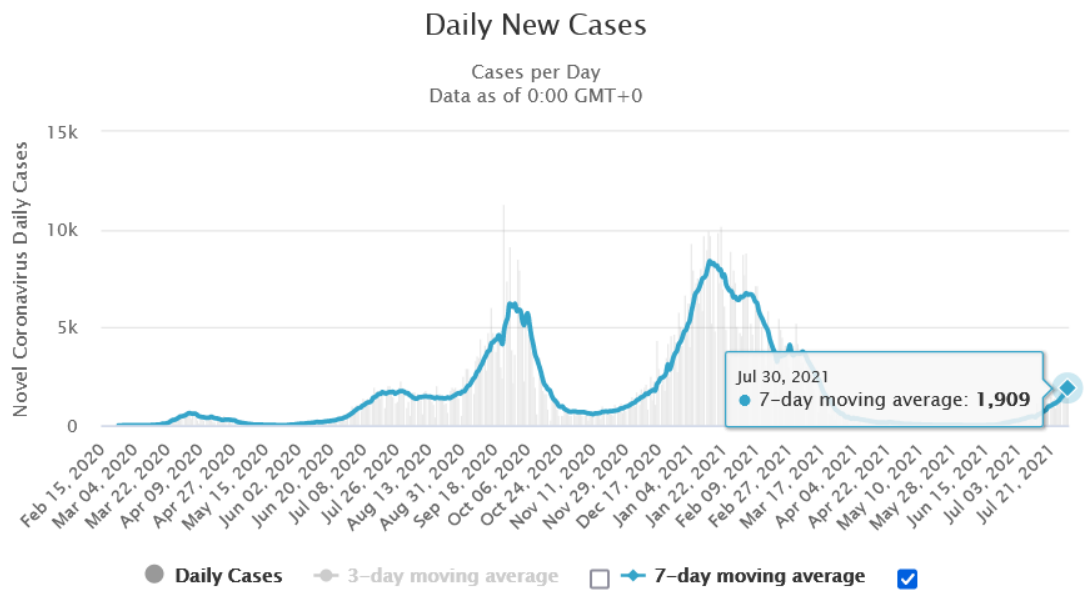


The reality is that young people are still doing extremely well against this virus and it is not only irrational to use scare tactics like this in reporting, it is corrupt and disingenuous. We will talk a lot more about all of that kind of reporting and behavior in this issue of 1200 Studies newsletter.

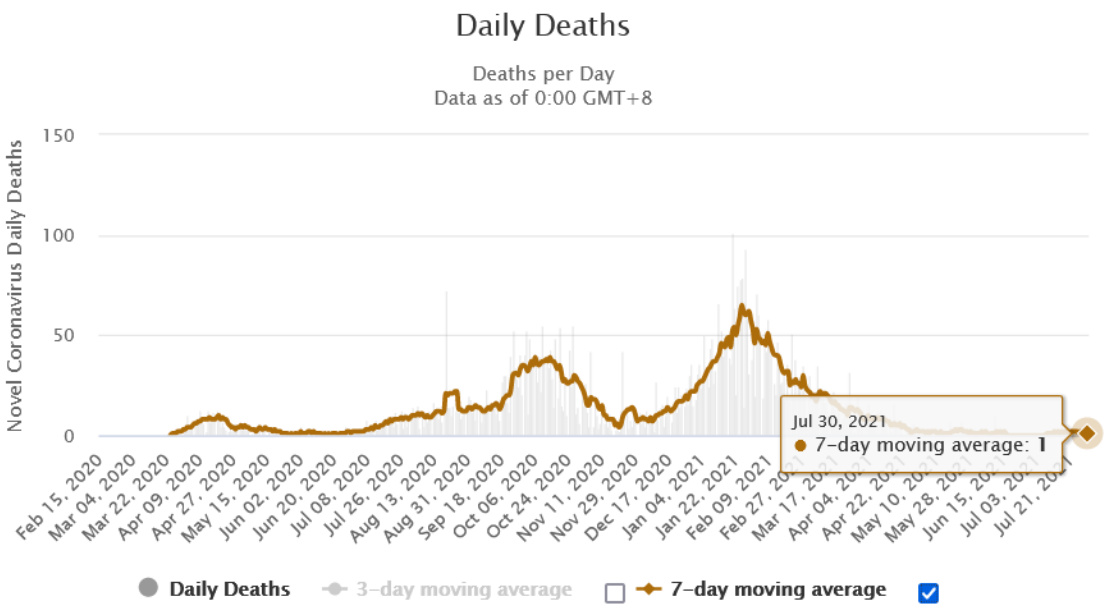
On the next page…As an example of the non-story that the image showing cases by age is presenting, let's look at what is really happening with case and death rates in Israel?

Here are the numbers for Cases and Deaths as of July 15th in Israel. Cases are up slightly, but deaths are flatlined (pun intended).

Daily New Cases in Israel



Daily New Deaths in Israel



That is a seven-day moving average of ONE death per day. As you can see, really nothing going on! The fearmongering with taking things like using that graph out of context is outrageous. If young people get the infection and recover (which 99.998% of them will), it helps us get to herd immunity faster. And in addition, they will be less susceptible to future variants. What is important is the real-world impact on hospitalizations

and deaths? Because most young people hardly know they are infected, and if they do it typically runs its course like a cold or flu.

One more point I just can't let go before we move on. If you take that 7-day average of one death per day and divide it into by the 7-day average number of cases, you get a **Case Fatality Rate (CFR)** of 0.00052. That is a CFR of 0.05%. That is INCREDIBLY LOW!!!

Yet, pharma is ready to capitalize on the lack of durability of their products

Then you have this article from Forbes. It shows that pharma is already looking to capitalize on the fact that they have made a crappy product that doesn't provide lasting protection.

https://www.forbes.com/sites/jonathanponciano/2021/07/11/declining-vaccine-efficacy-particularly-among-older-individuals-prompting-pfizers-emergency-booster-request-former-fda-chief-says/

And here in the U.S. **Pfizer to ask US regulators to authorize booster of its COVID-19 vaccine.**
https://www.israelnationalnews.com/News/News.aspx/309537

Fact checked false information. The unvaccinated are 99% of hospitalizations and deaths

As another example of the false narrative that nearly all deaths are in unvaccinated people, this is from the report from England discussed above. It is a table showing that 43% of deaths associated with the Delta Variant from February 1st, 2021 through June 14th, 2021 are in fully vaccinated people (see highlighted part).

SARS-CoV-2 variants of concern and variants under investigation

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001359/Variants_of_Concern_VOC_Technical_Briefing_16.pdf

Table 4. Attendance to emergency care and deaths by vaccination status among Delta confirmed cases (sequencing and genotyping) in England, 1 February 2021 to 14 June 2021.

	Total	Cases with specimen date in past 28 days*	Unlinked	Unvaccinated	<21 days post dose 1	≥21 days post dose 1	≥14 days post dose 2
Delta cases since 1 Feb 2021 ¥	60,624	53,177	7,461	35,521	4,094	9,461	4,087
Cases with an A&E visit§ (excluding cases with the same specimen and attendance dates)‡	1,555	NA	14	1,038	116	285	102
Cases with an A&E visit§ (including cases with the same specimen and attendance dates)	2,176	NA	24	1,446	155	378	173
Cases where presentation to A&E resulted in overnight inpatient admission§ (excluding cases with the same specimen and admission dates)‡	488	NA	7	324	30	87	40
Cases where presentation to A&E resulted in overnight inpatient admission§ (including cases with the same specimen and admission dates)	806	NA	10	527	50	135	84
Deaths^	73	NA	2	34	1	10	26 43%

Data sources: Emergency care attendance and admissions from Emergency Care Dataset (ECDS), deaths from PHE daily death data series (deaths within 28 days)

And an article from Israel titled, **Natural infection vs vaccination: Which gives more protection?**
Shows statistics that natural infection is better for future protection than the vaccines. The study it reports on states that 40% of infections in the latest wave starting in May are in people vaccinated versus less than 1% in the people that have already had COVID and recovered. Another win for natural immunity!

From the article

Coronavirus patients who recovered from the virus were far less likely to become infected during the latest wave of the pandemic than people who were vaccinated against COVID, according to numbers presented to the Israeli Health Ministry.

Health Ministry data on the wave of COVID outbreaks which began this May show that Israelis with immunity from natural infection were far less likely to become infected again in comparison to Israelis who only had immunity via vaccination.

More than 7,700 new cases of the virus have been detected during the most recent wave starting in May, but just 72 of the confirmed cases were reported in people who were known to have been infected previously – that is, less than 1% of the new cases.

Roughly 40% of new cases – or more than 3,000 patients – involved people who had been infected despite being vaccinated.

With a total of 835,792 Israelis known to have recovered from the virus, the 72 instances of reinfection amount to 0.0086% of people who were already infected with COVID.

By contrast, Israelis who were vaccinated were 6.72 times more likely to get infected after the shot than after natural infection, with over 3,000 of the 5,193,499, or 0.0578%, of Israelis who were vaccinated getting infected in the latest wave.

https://www.israelnationalnews.com/News/News.aspx/309762

Another twist in the skewing of the numbers

An article published in ***The Hill*** July 7th, 2021, titled **Top health expert says vaccinated people are spreading delta variant** reveals several things including what the subtitle says, **"The CDC currently does not require vaccinated individuals to undergo regular testing"**. One is that a key reason why cases in unvaccinated seem to be climbing at a higher rate proportionally, is that the CDC is recommending the vaccinated people NOT be tested regularly. We all have heard of school or workplace situations where unvaccinated people have to be tested twice a week or some interval, but vaccinated people are not. The article even states that vaccinated individuals can still get the virus and spread the virus. I have been reporting on that from before the vaccinations began. So, this non-sensical recommendation by the CDC is contributing the spread of the virus and increase in COVID-19 cases, hospitalizations and ultimately many deaths.

From the article

Some experts, however, warn that vaccinated individuals may still be capable of contracting and transmitting COVID-19.

Speaking to Insider, Christopher Murray, the director of the **Institute for Health Metrics and Evaluation (IHME)**, said that not testing vaccinated people — as **the U.S. Centers for Disease Control and Prevention (CDC)** recommends — may be overlooking some transmission.

"We actually have states where hospitalizations are going up more than cases," Murray said, adding that **"we're probably missing a bunch of transmission in vaccinated individuals."** (bold emphasis mine)

My comment: Dah! It's all making sense now. I was asking myself, why are the vaccines failing in other countries leading to high percentages of cases and people being admitted to hospitals, even dying from COVID being in vaccinated individuals, yet we are being told that 99% of people here in the U.S. being admitted to hospitals and dying are unvaccinated. Well, if you don't test the vaccinated when they come to the hospital, you would get very skewed numbers! So the next question is, why would they not test the vaccinated? The CDC knows that the vaccines don't protect against infection or transmission. So why in the world wouldn't they want to know what percent of vaccinated individuals are represented in cases, hospitalization numbers and deaths? Is it because it would reveal the false narrative that the vaccines are going to "help us get back to normal"? Is it because it would encourage vaccine hesitancy? Is it because it would expose the lies that have been told to the public ad nauseum about the vaccine's effectiveness? (See my article from my June newsletter on the Actual Risk Reduction (ARR) and Number Needed to Vaccinate (NNV) to benefit one person). Regardless of the reason, it shows either the corruption or the incompetency of the CDC. Neither bode well for encouraging the trust of the American people.

https://thehill.com/changing-america/well-being/longevity/561994-top-health-expert-says-vaccinated-people-are-spreading

The CDC isn't counting vaccinated people that get tests outside the hospital as positive cases. No wonder the numbers are lop-sided.

In addition to the prior story, as of May 2021, the CDC decided not to track breakthrough cases in people that have been vaccinated unless they are hospitalized or have died.

How does this make any sense? Unless you are trying to make the vaccines APPEAR more effective than they are.

The article is titled, **CDC narrows monitoring of breakthrough COVID-19 cases** and was written by Mackenzie Bean from ***BeckersHospitalReview.com***- Published Monday, May 10th, 2021

The CDC changed how it tracks breakthrough COVID-19 cases among fully vaccinated Americans this month, spurring concerns from scientists about the potential for inadequate data, reports *Bloomberg*.
The agency switched from monitoring all reported breakthrough cases to only ones that result in hospitalization or death as of May 1, Tom Clark, MD, head of the vaccine evaluation unit for the CDC's vaccine task force, told Bloomberg. The CDC's goal is to improve the quality of data collected for severe cases that have the greatest clinical and public health importance.

Some scientists have said the change may mean missing out on data needed to understand why and how breakthrough cases happen.

"We shouldn't be narrowing the focus, we should be broadening and develop a systematic plan," Eric Topol, director of the Scripps Research Translational Institute in La Jolla, Calif., told *Bloomberg*.
The CDC opted to change its strategy after finding few concerning patterns in the current data, Dr. Clark said. He added that the agency is also planning future vaccine research to compare disease severity and the frequency of variant infections among vaccinated and unvaccinated participants.

As of April 26, there have been 9,245 reports of breakthrough cases among more than 95 million Americans vaccinated, according to the CDC.

End of article

https://www.beckershospitalreview.com/public-health/cdc-narrows-monitoring-of-breakthrough-covid-19-cases.html

Public health experts blaming low vaccination rates for delta variant's spread, but much of the published data are blaming the vaccines for pushing the virus to mutate or "escape" the vaccines.

To further expand on the false narrative of the Delta Variant is being driven by the unvaccinated, ***Natural News*** added details to this story in their July 14th, 2021 article titled, **Fully vaccinated Americans are SPREADING covid's delta variant, health expert warns.**

From the article

To Murray, ***(that is Christopher Murray from IHME as referenced above)***, transmission among the vaccinated population explains why states with high vaccination rates like Washington, New York, Illinois and California are seeing a surge in coronavirus cases.

According to CDC data, the prevalence of the delta variant in the U.S. has doubled since late June and early July, when it made up 26 percent of new cases. Now it makes up nearly 52 percent of all recent infections.

The delta variant has been detected in all 50 states. Along with the four aforementioned states, the variant is also spiking in states like Missouri, Kansas, Iowa, Connecticut and Arkansas. Health experts claim without evidence that the low vaccination rate of some of these states is responsible for the recent surge in cases.

"We're already starting to see places with low vaccination rates starting to have relatively big spikes from the delta variant," said Dr. Ashish Jha, dean of the Brown University School of Public Health.

But Connecticut is the fourth most vaccinated state in the country, with 73.3 percent of its adult residents fully vaccinated. Both Iowa and Kansas also have more than 50 percent of their adult residents fully vaccinated. Missouri and Arkansas have fully vaccinated adult populations of over 40 percent.

Similar situations can be found in other settings with high vaccination rates. Los Angeles County and New York City are experiencing surges in coronavirus cases. Over 60 percent of residents aged 16 and up in Los Angeles County are fully vaccinated. Nearly 67 percent of all adults in New York are fully vaccinated as well.

https://www.naturalnews.com/2021-07-14-fully-vaccinated-americans-spreading-coronavirus-delta-variant.html

This is a list of just some of the highly credible sources that have stated publicly that they feel the virus is mutating because of vaccine pressure.

Dr. Robert Malone- One of the original inventors of the Messenger RNA technology

Dr. Geert Vandenbossche- Senior Program Officer of ***Global Alliance for Vaccines and Immunization (GAVI),*** Global Project Director Influenza Vaccines ***Bill and Melinda Gates Foundation***

Dr. Michael Yeadon- former Chief Scientific Officer (Allergy & Respiratory Research) with **Pfizer.**

Dr. Peter McCullough- Vice Chief of Medicine at ***Baylor University Medical Center***, Dallas. He has 1000 publications and > 500 citations in the ***National Library of Medicine.***

And the list goes on and on…

And here is a couple quotes from an article that Geert Vanden Bossch has posted on his website…

…mass vaccination promotes natural selection of increasingly vaccine immunity (VI)-escaping variants in the vaccinated part of the population. Taken together, mass vaccination conducted on a background of high infectivity rates enables more infectious, increasingly VI-escaping variants to expand in prevalence. This evolution inevitably results in inclining morbidity rates in both, the non-vaccinated and vaccinated population and precipitates the emergence of circulating viral variants that will eventually fully resist vaccine-mediated immunity (VMI). This is why mass vaccination campaigns should not be conducted during a pandemic of a highly mutable virus, let alone during a pandemic of more infectious variants (unless transmission-blocking vaccines are used!). It is critical to understand that a rapid decline in viral infectivity rates that is not achieved by natural infection but merely results from expedited mass vaccination campaigns will only *delay* abrupt propagation of emerging, fully vaccine-resistant viral variants and hence, only delay the occurrence of a high wave of morbidity and mortality.

This is to say that mass vaccination campaigns conducted during a pandemic of more infectious variants will precipitate resistance of more infectious Sars-Cov-2 variants to S-based Covid-19 vaccines.

Last but not least, it must be emphasized that those calling themselves ‘experts’ while pretending that this pandemic is ‘a pandemic among the non-vaccinated’ are devoid of any scientific insight in the evolutionary dynamics of Sars-CoV-2 as currently shaped by a combination of high viral infectivity and vaccine coverage rates. Neither the vaccinated (who merely believed the vaccine would protect them from Covid-19 disease) nor the non-vaccinated (who simply believe there is no need for them to take the vaccine in order to stay protected) are to be blamed for the escalation of this pandemic. **Mass vaccination is the one and only culprit.** *(Emphasis mine)*

Note: A copy of this letter has been sent to WHO, NIH, CDC, the Bill & Melinda Gates Foundation, GAVI, CEPI, FDA, EMEA and to R&D leaders from Pfizer, Moderna, Astra-Zeneca, J&J, Novavax and GSK

End of excerpts

https://www.geertvandenbossche.org/post/a-last-word-of-caution-to-all-those-pretending-the-covid-19-pandemic-is-toning-down

Yet our “health” officials continue to use misinformation to accuse those sharing accurate data and science of spreading misinformation

Does your head hurt yet? The word misinformation has been so overused that it has literally become synonymous to “opposing information”. You know the saying when you point your finger at someone else, you have three fingers pointing right back at you. And as Jesus said in the Sermon on the Mount, “You hypocrite, first take the log out of your own eye, and then you will see clearly to take the speck out of your brother’s eye.”

So, with the last stories in mind clearly showing government data and what out officials are telling us, consider this next article titled, Surgeon General Declares War on COVID 'Misinformation'.

From the article

Dr. Vivek Murthy, the U.S. Surgeon General, says COVID-19 "misinformation is an urgent threat to public health."

Murthy, in his first surgeon general’s advisory, said that "health misinformation" continues to put "lives at risk" and prolong the pandemic, NPR is reporting.

He called for a war against the "health misinformation." "COVID has really brought into sharp focus the full extent of damage that health misinformation is doing," Murthy told NPR.

Surgeon general's advisories are reserved for significant public health challenges that demand immediate attention.

As Surgeon General, my job is to help people stay safe and healthy, and without limiting the spread of health misinformation, American lives are at risk ... tackling this challenge will require an all-of-society approach, but it is critical for the long-term health of our nation."

End of excerpts

https://www.newsmax.com/us/murthy-covid-advisory-misinformation/2021/07/15/id/1028753/

European countries with the lowest vaccination rates appear to be faring the best

This is a Tweet from July 16th showing ***Our World in Data*** and ***Johns Hopkins*** data.

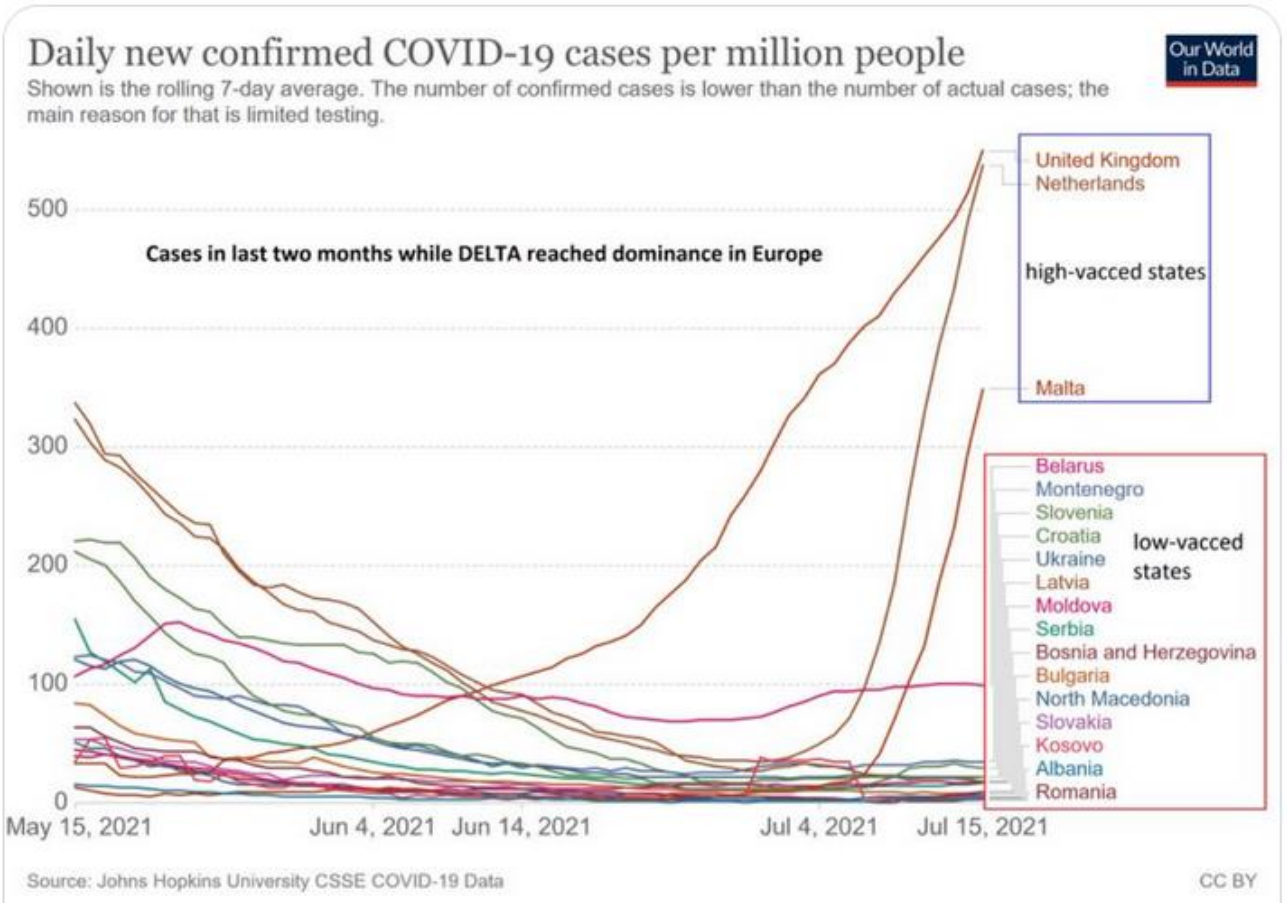
Corona Realism
@holmenkollin

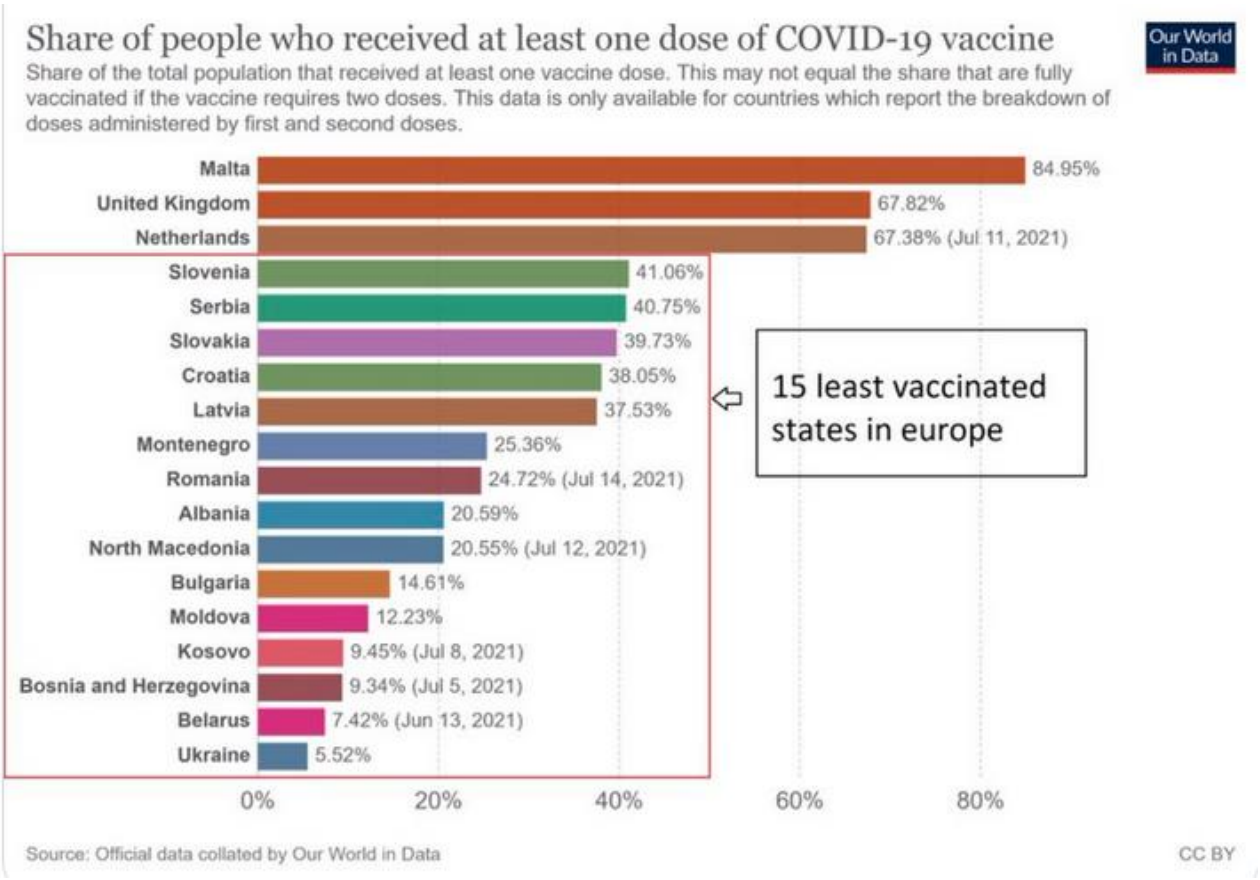
Something really odd is going on:

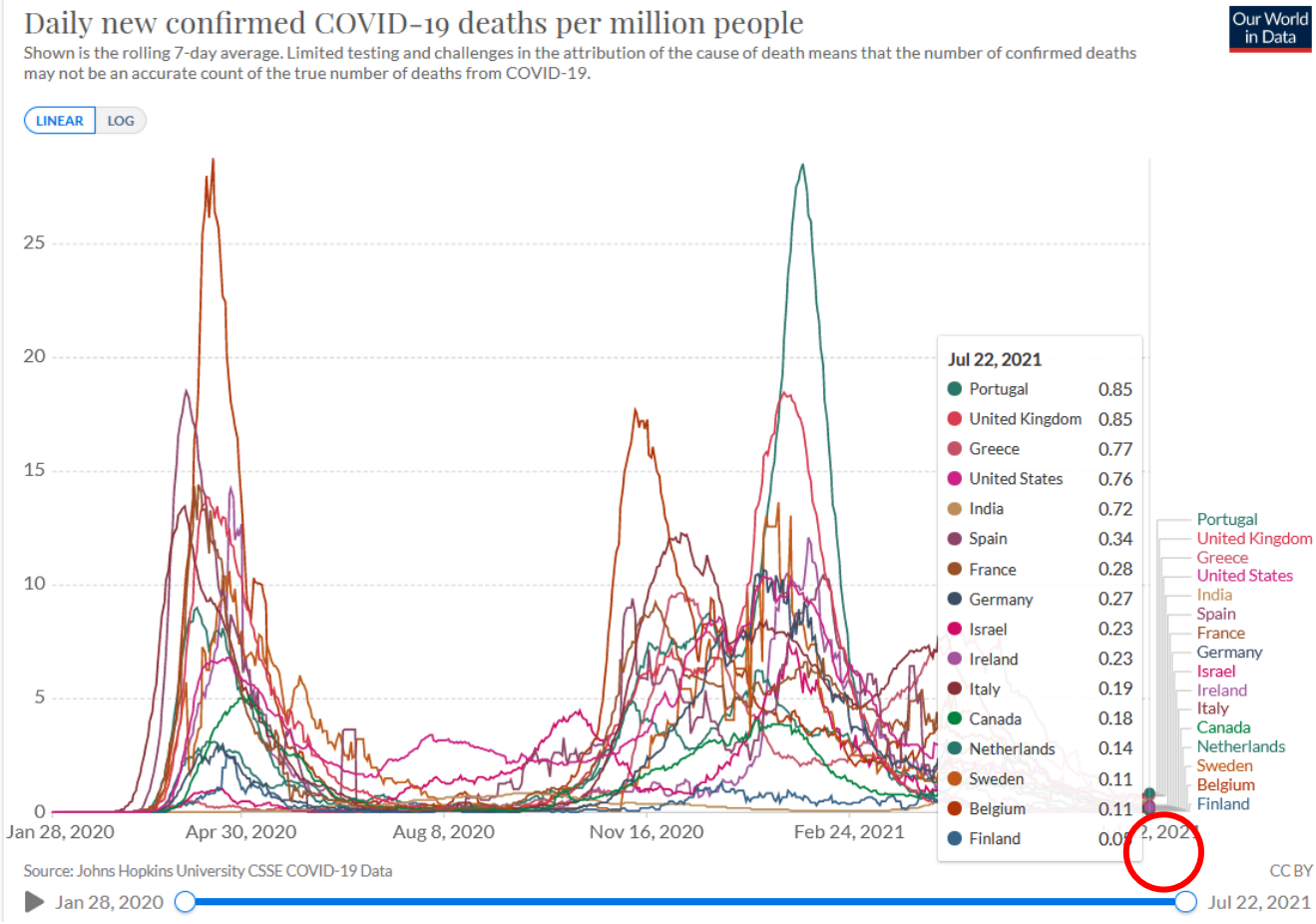
In Europe we are seeing surges at many places where most of the population has already been vaccinated.

At the same time, the 15 least vaccinated countries don't seem to face any problem.

At some point, denying this problem will get painful.




Share of people who received at least one dose of COVID-19 vaccine
Share of the total population that received at least one vaccine dose. This may not equal the share that are fully vaccinated if the vaccine requires two doses. This data is only available for countries which report the breakdown of doses administered by first and second doses.
Our World in Data
Malta 84.95%
United Kingdom 67.82%
Netherlands 67.38% (Jul 11, 2021)
Slovenia 41.06%
Serbia 40.75%
Slovakia 39.73%
Croatia 38.05%
Latvia 37.53%
Montenegro 25.36%
Romania 24.72% (Jul 14, 2021)
Albania 20.59%
North Macedonia 20.55% (Jul 12, 2021)
Bulgaria 14.61%
Moldova 12.23%
Kosovo 9.45% (Jul 8, 2021)
Bosnia and Herzegovina 9.34% (Jul 5, 2021)
Belarus 7.42% (Jun 13, 2021)
Ukraine 5.52%
15 least vaccinated states in europe
0%
20%
40%
60%
80%
Source: Official data collated by Our World in Data
CC BY


Daily new confirmed COVID-19 deaths per million people
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
LINEAR
LOG
25
20
15
10
5
0
Jan 28, 2020
Apr 30, 2020
Aug 8, 2020
Nov 16, 2020
Feb 24, 2021
Jul 22, 2021
Portugal 0.85
United Kingdom 0.85
Greece 0.77
United States 0.76
India 0.72
Spain 0.34
France 0.28
Germany 0.27
Israel 0.23
Ireland 0.23
Italy 0.19
Canada 0.18
Netherlands 0.14
Sweden 0.11
Belgium 0.11
Finland 0.0
Portugal
United Kingdom
Greece
United States
India
Spain
France
Germany
Israel
Ireland
Italy
Canada
Netherlands
Sweden
Belgium
Finland
Source: Johns Hopkins University CSSE COVID-19 Data
CC BY
Jan 28, 2020
Jul 22, 2021

Notice the fear mongering is once again about case numbers and not deaths? How many people are dying from COVID-19 now as compared to other times of the pandemic?

On the graph above, you can see through the list of countries with the highest mortality rates in order and see the lines converging down near the baseline on the far right as of July 22nd, 2021. When you look at the course of the whole pandemic and you see the huge fluctuations in spikes, you can really get an appreciation for where we are now in comparison. The levels of deaths per million population as of the end of July are almost negligible as compared to nearly every other part of the pandemic.

Back to the denial and censorship of official government published data that doesn't fit the narrative spoon fed to the public. I guess we are at the point where official government data posted on its own website, peer-reviewed studies published in scientific journals and top experts from universities like Harvard, Stanford and Oxford becomes misinformation because it doesn't fit the talking points that are designed to keep the people in fear and make them do whatever the government decides is in their best interest. What happened to the America I grew up in, where people were allowed to think critically, have differing viewpoints, debate those viewpoints and express their sincerely held beliefs, evidence-based facts and published research results without fear of reprisal from the government or the tech giants that they recently revealed they are coaching about what should be considered "misinformation"?

This study details another mechanism for clotting caused by the COVID-19 vaccines other than the spike protein toxin that they force your cells to make

A peer-reviewed study in ***Nature*** published July 7th, 2021, titled **Antibody epitopes in vaccine-induced immune thrombotic thrombocytopenia**, sheds light on one of the mechanisms for which COVID-19 vaccines can cause blood clotting in the body (the thrombo part of the name). In a previous newsletter topic, I presented a study that showed how the spike protein itself can contribute to clotting disorders. In this case it's not the spike protein itself but an antibody reaction that develop against the spike protein in the vaccine cross-react with Platelet Factor IV (PF4) by combining with it and causing the activation of platelets, clumping of the platelets and thus the clotting disorder. As a result, prostaglandins and clotting factors are released. Inflammation occurs, monocytes (white blood cells) rush in and platelets begin aggregating and clumping together. Ironically, this clumping of platelets throughout the body produces a net reduction of overall platelets circulating freely in the body and thus can also contribute to bleeding disorders in that way (the cytopenia part of the name). The Platelet Factor IV complexes also begin to clump together.

In this case the AstraZeneca adenovirus vector vaccine was evaluated. This is the same type of vaccine as the Johnson & Johnson's vaccine. Because the reaction was cross-reactivity by the antibodies produced against the spike protein in the vaccine, the same thing mechanism could potentially happen with Pfizer or Moderna's M RNA vaccines.

A key element of this is study, is that they found that the antibodies can produced between 5 and 90 days after the shot, with a peak at 30-45 days. The occurrence of the clotting seems to be highest at 14-40 days with a mean of 28 days. So oftentimes people equate a vaccine adverse reaction as something that happens within 24 to 48 hours after an injection. This is not the case with this mechanism. The blood clots can form up to four weeks after the shot. This is critically important to realize when considering if these injuries are related to the vaccine itself.

The abstract

Vaccine-induced immune thrombotic thrombocytopenia (VITT) is a rare adverse effect of COVID-19 adenoviral vector vaccines1–3. VITT resembles heparin-induced thrombocytopenia (HIT) as it is associated with platelet-activating antibodies against platelet factor 4 (PF4)4; however, patients with VITT develop thrombocytopenia and thrombosis without heparin exposure. The objective of this study was to determine the binding site on PF4 of antibodies from patients with VITT. Using alanine scanning mutagenesis5, we determined the binding of VITT anti-PF4 antibodies (n=5) was restricted to 8 surface amino acids, all of which were located within the heparin binding site on PF4, and the binding was inhibited by heparin. In contrast, HIT sampled (n=10) bound to amino acids corresponding to 2 different sites on PF4. Using biolayer interferometry, we demonstrated VITT anti-PF4 antibodies had a stronger binding response against PF4 and PF4/heparin complexes than HIT antibodies; albeit, with similar dissociation rates. Our data indicates VITT antibodies can mimic the effect of heparin by binding to a similar site on PF4, allowing PF4 tetramers to cluster and form immune complexes, which in turn causes Fcγ receptor IIa (FcγRIIa; also known as CD32a)-dependent platelet activation. These results provide an explanation for VITT-antibody-induced platelet activation that could contribute to thrombosis.

Concluding remarks

In this report, we show that anti-PF4 antibodies in patients with VITT can induce platelet activation through Fc γ RIIa receptors in the presence of PF4, without heparin. However, other serum factors could also contribute to platelet activation. Previous studies found that antibodies from patients with VITT were able to activate platelets and cause platelet aggregation in the presence of adenoviral particles in a dose-dependent manner1,23,24. Thus, it is possible that platelet activation caused by anti-PF4 antibodies in patients with VITT is not the only factor that leads to the development of thrombotic events. HIT is also propagated by various pro-thrombotic mechanisms that could also be important in VITT, including Fc-receptor polymorphisms25, monocyte activation and tissue factor production26, and the generation of procoagulant microparticles10.

This study offers an explanation for VITT-mediated platelet activation. The patients with VITT in our study exhibited similar antibody characteristics to one another and their antibodies bound PF4 at the same site as heparin. VITT antibodies form immune complexes without the addition of heparin or other co-factors, and activate platelets and potentially other cells through Fc γ RIIa receptors, which, in turn, could initiate coagulation at multiple points to cause thrombocytopaenia and thrombosis.

End of excerpts

For the science geeks like me, you can see a well-done video about this mechanism by Dr. Mobeen Syed (Dr. Been of Dr Been Medical Lectures) here: https://www.youtube.com/watch?v=WsRgRP1Oou0

The epitopes of the spike protein can trigger an autoimmune reaction that will target Platelet Factor IV, there are legitimate concerns about the same happening to other proteins in the body

To look at this topic I turned to a paper by ***Vinu Arumugham*** from January 2020, prior to the pandemic. His paper is titled, **Analyzing 23000+ epitopes covering 82 autoimmune diseases in the Immune Epitope Database, 57% have only one and 78% have up to two amino acid residue differences compared to animal,**

fungal or plant peptides present in vaccines; an unmistakable signature of the role of vaccines in their etiologies.

One reason I feel it is important to explore this risk is that many experts in the various fields of medicine and different scientific disciplines have expressed concerns about the COVID-19 vaccines increasing the risk of autoimmunity later in the body. One particular reason for concern, is that we have also seen that these genetically engineered spike proteins in the vaccines do not always make it through the manufacturing process intact. A significant percentage of those spike proteins end up being pieces or fragments of the complete spike protein. More about this in this issue. That greatly increases the risk of these fragments matching some of the proteins within our bodies and potentially triggering an autoimmune reaction.

First, I think a definition of epitope would be in order. This definition is from ***Pacific Immunology's*** website.

What is an Epitope?

An epitope refers to the specific target against which an individual antibody binds.

When an antibody binds to a protein, it isn't binding to the entire full-length protein. Instead, it is binding to a to a segment of that protein known as an epitope. In general, an epitope is approximately five or six amino acids in length. So, a typical full-length protein sequence actually contains many different epitopes against which antibodies can bind.

And, for any given protein sequence, one will typically find that multiple unique antibodies will recognize the protein. Each of these antibodies binds to a specific epitope located on that protein.

Abstract from Vinu's paper

The ***National Institute of Allergy and Infectious Diseases (NIAID)*** sponsors the Immune Epitope Data Base (IEDB). IEDB contains epitopes identified from the medical literature and organized by diseases and categories of diseases. All epitopes (23000+) associated with 82 autoimmune diseases in humans were analyzed.

The role of animal, plant, fungal proteins contained in vaccines in the etiology of autoimmune diseases have been described in humans and animals. BLASTP was used to analyze IEDB derived epitopes for sequence alignment to animal, plant, fungal (APF) proteins present in vaccines and biologics. Specifically, the search was performed against bovine, chicken, porcine, guinea pig, African green monkey, Chinese hamster, murine, peanut, soy, wheat, corn, sesame and *Saccharomyces cerevisiae* proteomes.

The results show that 57% of epitopes differed by exactly one amino acid residue from an APF peptide. 78% of the epitopes differed by up to two amino acid residues from an APF peptide. The rest of the epitopes were either identical or differed by more than two amino acid residues.

A majority of IEDB epitopes analyzed were 9-mer peptides. Comparing randomly selected 9-mer human peptides with APF proteomes, the probability of single amino acid residue difference (SAARD) outcomes was derived. This was used to estimate the probability that actual IEDB SAARD alignments to APF peptides were merely a chance outcome. The estimates show that the probability that the observed IEDB alignments to APF being merely a chance outcome are vanishingly small. So the results

make it absolutely clear that APF proteins in vaccines cause all these autoimmune diseases.

Introduction

Vaccines contain thousands of residual animal, plant and fungal (APF) proteins from the manufacturing process (1–6). 293 chicken proteins were identified in the influenza vaccine (7), for example. Actin and vimentin proteins were detected in the Priorix Tetra vaccine (8). Immunization with homologous xenogeneic antigens resulting in autoimmune diseases has been known for at least 40 years (9). Vaccines that contain bovine proteins caused autoimmunity in dogs (10). We previously described the immunological mechanism involved in autoimmunity induction by immunization with homologous xenogeneic antigens (11).

End of excerpts

His paper goes through a number of complex calculations and interpretations that are way above my knowledge or skills to interpret. And even though this paper does not specifically address the COVID-19 vaccines, the theory and mechanisms of which of the ways that the body can misinterpret sequences of amino acids or proteins as foreign have been well established for many years. If his assertions are right regarding other vaccines with proteins injected into the body and I have no reason to doubt that they are as I have read other papers by him and found him to make use of sound scientific analysis and to be a credible researcher, it further supports the worries of many other scientists from around the world expressing similar concerns.

America's Frontline Doctors files a motion for preliminary injunction against continuation of the COVID-19 shots

On July 19th, 2021, ***America's Frontline Doctors*** filed a **PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION** in U.S. Federal Court for the Northern District of Alabama in an effort to halt the COVID-19 vaccination program. I have read the full 67 pages and am extremely impressed with the comprehensive nature of and evidence-based substantiation for their request. I am not going to include the whole document here but would like to highlight some of the key components for you. I have pasted sections 1-6 in here so you can get a good idea of the great case they are making. And if you are a freedom and Constitutional loving and supporting American, trust me when I say you are going to love the job they did! Please consider donating to their efforts.

References cited are given at the end of this topic.

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(1) 21 U.S.C. § 360bbb–3(b)(1)(C): There is No Emergency

On February 4, 2020, the Department of Health and Human Services ("DHHS") Secretary declared, pursuant to § 360bbb–3(b)(1)(C), that SARS-CoV-2 created a "public health emergency." This initial emergency declaration has been renewed repeatedly and remains in force today. The emergency declaration is the necessary legal predicate for the issuance of the Vaccine EUAs, which have allowed the mass use of the Vaccines by the American public, even before the completion of the standard regimen of clinical trials and FDA approval.

The emergency declaration and its multiple renewals are illegal, since in fact there is no underlying emergency. Assuming the accuracy of Defendants' COVID-19 death data, SARS-CoV-2 has an overall survivability rate of 99.8% globally, which increases to 99.97% for persons under the age of 70, on a par with the seasonal flu. However, Defendants' data is deliberately inflated. On March 24, 2020, DHHS changed the

rules applicable to coroners and others responsible for producing death certificates and making "cause of death" determinations — **exclusively for COVID-19**. The rule change states: "COVID-19 should be reported on the death certificate for all decedents where the disease caused *or is assumed to have caused or contributed* to death." In fact, DHHS statistics show that 95% of deaths classed as "COVID-19 deaths" involve an average of four additional co-morbidities. The CDC knew "…the rules for coding and selection of the underlying cause of death are expected to result in COVID-19 being the underlying cause more often than not."

Similarly, the actual number of COVID-19 "cases" is far lower than the reported number. DHHS authorized the emergency use of the polymerase chain reaction ("PCR") test as a diagnostic tool for COVID-19, with disastrous consequences. The PCR tests are themselves experimental products, authorized by the FDA under separate EUAs. PCR test manufacturers use disclaimers like this in their product manuals: "[t]he FDA has not determined that the test is safe or effective for the detection of SARS-Co-V-2." Manufacturer inserts furnished with PCR test products include disclaimers stating that the PCR tests should NOT be used to diagnose COVID-19. This is consistent with the warning issued by the Nobel Prize winning inventor of the PCR test that such tests are not appropriate for diagnosing disease.

The way in which the PCR tests are administered guaranties an unacceptably high number of false positive results. Cycle Threshold Value ("CT value") is essentially the number of times that a sample (usually from a nasal swab) is magnified or amplified before a fragment of viral RNA is detected. The CT Value is exponential, and so a 40-cycle threshold means that the sample is magnified around a trillion times. The higher the CT Value, the less likely the detected fragment of viral RNA is intact, alive and infectious.5

Virtually all scientists, including Dr. Fauci, agree that any PCR test run at a CT value of 35-cycles or greater is useless. Dr. Fauci has stated (emphasis below added):

> ***What is now evolving into a bit of a standard is that if you get a cycle threshold of 35 or more that the chances of it being replication competent are miniscule****…We have patients, and it is very frustrating for the patients as well as for the physicians…somebody comes in and they repeat their PCR and it's like 37 cycle threshold…you can almost never culture virus from a 37 threshold cycle. So I think if somebody does come in with 37, 38, even 36, you gotta say, you know, it's dead nucleotides, period. In other words, it is not a COVID-19 infection.6*

A study funded by the French government showed that even at 35-cycles, the false positivity rate is as high as 97%. Despite this, a majority of the PCR tests for COVID-19 deployed under EUAs in the United States are run at 35-45 cycles in accordance with manufacturer instructions. Under the EUAs issued by the FDA, there is no flexibility to depart from the manufacturer's instructions and change the way in which the test is administered or interpreted. The chart below shows that all major PCR tests in use in the United States are run at cycles of up to 35 or higher.

Manufacturer	Manufacturer's Recommended Cycle Threshold
Xiamen Zeesan SARS-CoV-2 Test Kit (Real-time PCR)	45 cycles
Opti Sars CoV-2 RT-PCR Test	45 cycles
Quest SARS-CoV-2rRT-PCR Test	40 cycles
CDC 2019-Novel Coronavirus Real Time (RT-PCR Diagnostic Panel) Test	40 cycles
Wren Labs COVID-19 PCR Test	38 cycles
LabCorp COVID-19 RT-PCR Test	35 cycles

Further, the Defendants and their counterparts in state governments used the specter of "asymptomatic spread" — the notion that fundamentally healthy people could cause COVID-19 in others — to justify the purported emergency. But there is *no credible scientific evidence* that demonstrates that the phenomenon of "asymptomatic spread" is real. On the contrary, on June 7, 2020, Dr. Maria Von Kerkhov, head of the WHO's Emerging Diseases and Zoonosis Unit, told a press conference that from the known research, asymptomatic spread was "very rare." "From the data we have, it still seems to be rare that an asymptomatic person actually transmits onward to a secondary individual." She added for emphasis: "it's very rare." Researchers from Southern Medical University in Guangzhou, China, published a study in August 2020 concluding that asymptomatic transmission of COVID-19 is *almost non-existent*. "Asymptomatic cases were least likely to infect their close contacts," the researchers found. A more recent study involving nearly 10 million residents of Wuhan, China found that there were no — zero — positive COVID-19 tests amongst 1,174 *close contacts* of asymptomatic cases, *indicating the complete absence of asymptomatic transmission*.

On September 9, 2020, Dr. Fauci was forced to admit in an official press conference:

> *Even if there is some asymptomatic transmission, in all the history of respiratory borne viruses of any type, asymptomatic transmission has never been the driver of outbreaks. The driver of outbreaks is always a symptomatic person, even if there is a rare a symptomatic person that might transmit, an epidemic is not driv en by asymptomatic carriers. Even if there is a rare a symptomatic person that might transmit, an epidemic is not driven by asymptomatic carriers* [7].

(2) § 360bbb–3(c)(1): There is in Fact no Serious or Life-Threatening Disease or Condition

Once an emergency has been declared and while it remains in force, the DHHS Secretary can issue and maintain EUAs "**only if**" (emphasis added) certain criteria are met. One of these criteria is that there is in fact (not simply perceived, projected or declared) "a serious or life threatening disease or condition." For the reasons set forth above in the prior section, SARS-CoV-2 and COVID-19 do not constitute a "serious or life threatening disease or condition" within the meaning of the statute. It also bears noting that the legal purpose of an emergency declaration is to bypass checks and balances typically required under law due to a crisis and that the use of such a declaration for such an arbitrary purpose could undermine the balance of power between the various branches of government.

(3) § 360bbb–3(c)(2)(A): The Vaccines Do Not Diagnose, Treat or Prevent SARS-CoV-2 or COVID-19

The DHHS Secretary can issue and maintain the Vaccine EUAs "**only if**" they are "effective" in diagnosing, treating or preventing a disease or condition.

Centers for Disease Control and Prevention ("CDC") data shows that the Vaccines are not effective in treating or preventing SARS-CoV-2 or COVID-19. Deaths from COVID-19 in those who have received the recommended dosages of the Vaccines increased from 160 as of April 30, 2021 to 535 as of June 1, 2021. Further, a total of 10,262 SARS-CoV-2 "breakthrough infections" of those who have already received the full recommended dosage of the Vaccines were reported to the CDC from 46 states and territories between January 1, 2021 and April 30, 2021.

In studying the effectiveness of a medical intervention in randomized controlled trials (often called the gold standard of study design), the most useful way to present results is in terms of Absolute Risk Reduction ("ARR"). ARR compares the impact of treatment by comparing the outcomes of the treated group and the untreated group. In other words, if 20 out of 100 untreated individuals had a negative outcome, and 10 out of

100 treated individuals had a negative outcome, the ARR would be 10% (20 - 10 = 10). **According to a study published by the NIH, the ARR for the Pfizer Vaccine is a mere 0.7%, and the ARR for the Moderna Vaccine is only 1.1%.**

From the ARR, one can calculate the Number Needed to Vaccinate ("NNV"), which signifies the number of people that must be injected before even one person benefits from the vaccine. The NNV for the Pfizer Vaccine is 119, meaning that 119 people must be injected in order to observe the reduction of a COVID-19 case in one person. The reputed journal the *Lancet* reports data indicating that the NNV may be as high as 217.

There are several factors that reduce any purported benefit of the COVID-19 Vaccines. First, it is important to note that the Vaccines were only shown to reduce symptoms – not block transmission. For over a year now, these Defendants and state-level public health authorities have told the American public that SARS-CoV-2 can be spread by people who have none of the symptoms of COVID-19, therefore Americans must mask themselves, and submit to innumerable lockdowns and restrictions, even though they are not manifestly sick. If that is the case, and these officials were not lying to the public, and asymptomatic spread is real, then what is the benefit of a vaccine that merely reduces symptoms? There isn't any.

Secondly, it appears that these Defendants either did lie about asymptomatic spread, or were simply wrong about the science. The theory of asymptomatic transmission — used as the justification for the lockdown and masking of the healthy — was based *solely* upon mathematical modeling. This theory had no actual study participants, and no peer review. The authors made the unfounded assumption that asymptomatic persons were "75% as infectious" as symptomatic persons. But in the real world, healthy false positives turned out to be merely healthy, and were never shown to be "asymptomatic" carriers of anything. Studies have shown that PCR test-positive asymptomatic individuals do not induce clinical COVID-19 disease, not even in a family member with whom they share a home and extended proximity. An enormous study of nearly ten million people in Wuhan, China showed that asymptomatic individuals testing positive for COVID-19 **never** infected others. Since asymptomatic individuals do not spread COVID-19, they do not need to be vaccinated.

(4) § 360bbb–3(c)(2)(B): The Known and Potential Risks of the Vaccine Outweigh their Known and Potential Benefits

The DHHS Secretary can issue and maintain the Vaccine EUAs "**only if**" (emphasis added) the known and potential risks of each Vaccine are outweighed by its known and potential benefits.

The typical vaccine development process takes between 10 and 15 years, and consists of the following sequential stages: research and discovery (2 to 10 years), pre-clinical animal studies (1 to 5 years), clinical human trials in four phases (typically 5 years). Phase 1 of the clinical human trials consists of healthy individuals and is focused on safety. Phase 2 consists of additional safety and dose-ranging in healthy volunteers, with the addition of a control group. Phase 3 evaluates efficacy, safety and immune response in a larger volunteer group, and requires two sequential randomized controlled trials. Phase 4 is a larger scale investigation into longer-term safety. Vaccine developers must follow this process in order to be able to generate the data the FDA needs in order to assess the safety and effectiveness of a vaccine candidate.

This 10-15 year testing process has been abandoned for purposes of the Vaccines. The first human-to-human transmission of the SARS-CoV-2 virus was not confirmed until January 20, 2020, and less than a year later both mRNA Vaccines had EUAs and for the first time in history this novel mRNA technology was being injected into

millions of human beings. As of June 7, 2021, 138 million Americans, representing 42% of the population, have been fully vaccinated.

All of the stages of testing have been compressed in time, abbreviated in substance, and are overlapping, which dramatically increases the risks of the Vaccines. Plaintiffs' investigation indicates that Moderna and Pfizer designed their Vaccines in only two days. It appears that pharmaceutical companies did not independently verify the genome sequence that China released on January 11, 2020. It appears that the Vaccines were studied for only 56 days in macaques, and 28 days in mice, and then animal studies were halted. It appears that the pharmaceutical companies discarded their control groups receiving placebos, squandering the opportunity to learn about the rate of long-term complications, how long protection against the disease lasts and how well the Vaccines inhibit transmission. A number of studies were deemed unnecessary and not performed prior to administration in human subjects, including single dose toxicity, toxicokinetic, genotoxicity, carcinogenicity, prenatal and postnatal development, offspring, local tolerance, teratogenic and postnatal toxicity and fertility. The American public has not been properly informed of these dramatic departures from the standard testing process, and the risks they generate.

Plaintiff America's Frontline Doctors' ("AFLDS") medico-legal researchers have analyzed the accumulated COVID-19 Vaccine risk data, and report as follows:

Migration of the SARS-CoV-2 "Spike Protein" in the Body

The SARS-CoV-2 has a spike protein on its surface. The spike protein is what allows the virus to infect other bodies. It is clear that the spike protein is not a simple, passive structure. The spike protein is a "pathogenic protein" and a toxin that causes damage. The spike protein is itself biologically active, even without the virus. It is "fusogenic" and consequently binds more tightly to our cells, causing harm. If the purified spike protein is injected into the blood of research animals, it causes profound damage to their cardiovascular system, and crosses the blood-brain barrier to cause neurological damage. If the Vaccines were like traditional *bona fide* vaccines, and did not leave the immediate site of vaccination, typically the shoulder muscle, beyond the local draining lymph node, then the damage that the spike protein could cause might be limited.

However, the Vaccines were authorized without any studies demonstrating where the spike proteins traveled in the body following vaccination, how long they remain active and what effect they have. A group of international scientists has recently obtained the "biodistribution study" for the mRNA Vaccines from Japanese regulators. The study reveals that unlike traditional vaccines, this spike protein enters the bloodstream and circulates throughout the body over several days post-vaccination. It accumulates in a number of tissues, such as the spleen, bone marrow, liver, adrenal glands and ovaries. It fuses with receptors on our blood platelets, and also with cells lining our blood vessels. It can cause platelets to clump leading to clotting, bleeding and heart inflammation. It can also cross the blood-brain barrier and cause brain damage. It can be transferred to infants through breast milk. The VAERS system includes reports of infants suckling from vaccinated mothers experiencing bleeding disorders in the gastrointestinal tract.

Increased Risk of Death from Vaccines

The government operated VAERS database is intended to function as an "early warning" system for potential health risks caused by vaccines. It is broadcasting a red alert. Of the 262,000 total accumulated reports in VAERS, only 1772 are not related to COVID-19. The database indicates that the total reported vaccine deaths in the first quarter of 2021 represents a 12,000% to 25,000% increase in vaccine deaths, year-on-year. In ten years (2009-2019) there were 1529 vaccine deaths, whereas in the first quarter of 2021 there have been over 4,000. Further, 99% of all reported vaccine deaths in 2021 are caused by the COVID-19 Vaccines, only 1% being

caused by the numerous other vaccines reported in the system. It is estimated that VAERS only captures 1% to at best 10% of all vaccine adverse events.

Reproductive Health

The mRNA Vaccines induce our cells to manufacture (virus-free) “spike proteins.” The “spike proteins” are in the same family as the naturally occurring syncytin-1 and syncytin-2 reproductive proteins in sperm, ova and placenta. Antibodies raised against the spike protein might interact with the naturally occurring syncytin proteins, adversely affecting multiple steps in human reproduction. The manufacturers did not provide data on this subject despite knowing about the spike protein’s similarity to syncytin proteins for more than one year. There are now a very high number of pregnancy losses in VAERS. A study recently published in the New England Journal of Medicine, “Preliminary Findings of mRNA COVID-19 Vaccine Safety in Pregnant Persons,” exposes that pregnant women receiving Vaccines during their first or second trimesters suffer an 82% spontaneous abortion rate, killing 4 out of 5 unborn babies. There are worldwide reports of irregular vaginal bleeding without clear explanation. Scientists are concerned that the Vaccines pose a substantial risk to a woman’s reproductive system. This increased risk of sterility stems from an increased concentration of the spike proteins in various parts of the reproductive system after vaccination. Not enough is known to determine the risk of sterility, but it is beyond question that the risk is increased.

A leaked Pfizer document (excerpted below) exposes that Pfizer Vaccine nanoparticles accumulate in the ovaries at an extraordinarily high rate, in concentrations orders of magnitude higher than in other tissues. Billions of aggressive spike proteins are accumulating in very delicate ovarian tissues, the one place in the human body where females carry a finite number of fertile eggs.

Continued next page…

2.6.5.5B. PHARMACOKINETICS: ORGAN DISTRIBUTION CONTINUED **Test Article: [**

Sample	Total Lipid concentration (µg lipid equivalent/g [or mL]) (males and females combined)							%
	0.25 h	1 h	2 h	4 h	8 h	24 h	48 h	0.25 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
Pancreas	0.081	0.207	0.414	0.380	0.294	0.358	0.599	0.003
Pituitary gland	0.339	0.645	0.868	0.854	0.405	0.478	0.694	0.000
Prostate (males)	0.061	0.091	0.128	0.157	0.150	0.183	0.170	0.001
Salivary glands	0.084	0.193	0.255	0.220	0.135	0.170	0.264	0.003
Skin	0.013	0.208	0.159	0.145	0.119	0.157	0.253	--
Small intestine	0.030	0.221	0.476	0.879	1.28	1.30	1.47	0.024
Spinal cord	0.043	0.097	0.169	0.250	0.106	0.085	0.112	0.001
Spleen	0.334	2.47	7.73	10.3	22.1	20.1	23.4	0.013
Stomach	0.017	0.065	0.115	0.144	0.268	0.152	0.215	0.006
Testes (males)	0.031	0.042	0.079	0.129	0.146	0.304	0.320	0.007
Thymus	0.088	0.243	0.340	0.335	0.196	0.207	0.331	0.004
Thyroid	0.155	0.536	0.842	0.851	0.544	0.578	1.00	0.000
Uterus (females)	0.043	0.203	0.305	0.140	0.287	0.289	0.456	0.002
Whole blood	1.97	4.37	5.40	3.05	1.31	0.909	0.420	--
Plasma	3.97	8.13	8.90	6.50	2.36	1.78	0.805	--
Blood:Plasma ratio[a]	0.815	0.515	0.550	0.510	0.555	0.530	0.540	--

Each baby girl is born with the total number of eggs she will ever have in her entire life. Those eggs are stored in the ovaries, and one egg is released each month of a normal menstrual cycle. When there are no more eggs, a woman stops menstruating. The reproductive system is arguably the most delicate hormonal and organ balance of all our systems. The slightest deviation in any direction results in infertility. Even in 2021, doctors and scientists do not know all the variables that cause infertility.

There is evidence to support that the Vaccines could cause permanent autoimmune rejection of the placenta. Placental inflammation resulting in stillbirths mid-pregnancy (second trimester) is seen with COVID-19 and with other similar coronaviruses. There is a case report of a woman with a normally developing pregnancy who lost the otherwise healthy baby at five months during acute COVID-19. The mother's side of the placenta was very inflamed. This "infection of the maternal side of the placenta inducing acute or chronic placental insufficiency resulting in miscarriage or fetal growth restriction was observed in 40% of pregnant women with similar coronaviruses." The mRNA Vaccines may instigate a similar reaction as the SARS-CoV-2 virus. There is a component in the vaccine that could cause the same autoimmune rejection of the placenta, but indefinitely. Getting COVID-19 has been associated with a high risk of mid-pregnancy miscarriage because the placenta fails. The mRNA Vaccines may have precisely the same effect, however, not for just the few weeks of being sick, but forever. Repeated pregnancies would keep failing in mid-pregnancy.

On December 1, 2020, a former Pfizer Vice President and allergy and respiratory researcher, Dr. Michael Yeadon, filed an application with the European Medicines Agency, responsible for approving drugs in the European Union, seeking the immediate suspension of all SARS-CoV-2 Vaccines, citing *inter alia* the risk to pregnancies. As of April 26, 2021, the VAERS database contains over 3,000 reports of failed pregnancies associated with the Vaccines.

Vascular Disease

Salk Institute for Biological Studies researchers in collaboration with the University of San Diego, published in the journal *Circulation Research* that the spike proteins themselves

damage vascular cells, causing strokes and many other vascular problems. All of the Vaccines are causing clotting disorders (coagulopathy) in all ages. The spike proteins are known to cause clotting that the body cannot fix, such as brain thrombosis and thrombocytopenia.

None of these risks has been adequately studied in trials, or properly disclosed to healthcare professionals or Vaccine subjects.

Autoimmune Disease

The spike proteins are perceived to be foreign by the human immune system, initiating an immune response to fight them. While that is the intended therapeutic principle, it is also the case that any cell expressing spike proteins becomes a target for destruction by our own immune system. This is an autoimmune disorder and can affect virtually any organ in the body. It is likely that some proportion of spike protein will become permanently fused to long-lived human proteins and this will prime the body for prolonged autoimmune diseases. Autoimmune diseases can take years to show symptoms and many scientists are alarmed at giving young people such a trigger for possible autoimmune disease.

Neurological Damage

The brain is completely unique in structure and function, and therefore it requires an environment that is insulated against the rest of the body's functioning. The blood-brain-barrier exists so the brain can function without disruption from the rest of the body. This is a complex, multi-layered system, using several mechanisms that keep nearly all bodily functions away from the brain. Three such systems include: very tight junctions between the cells lining the blood vessels, very specific proteins that go between, and unique enzymes that alter substances that do go through the cells. Working together, the blood-brain-barrier prevents almost everything from getting in. Breaching it is generally incompatible with life.

Most unfortunately, the COVID-19 Vaccines — unlike any other vaccine ever deployed — are able to breach this barrier through various routes, including through the nerve structure in the nasal passages and through the blood vessel walls. The resulting damage begins in the arterial wall, extends to the supporting tissue outside the arteries in the brain, and from there to the actual brain nerve cells inside. The Vaccines are programmed to produce the S1 subunit of the spike protein in every cell in every Vaccine recipient, but it is this subunit that causes the brain damage and neurologic symptoms. Elderly persons are at increased risk for this brain damage.

COVID-19 patients typically have neurological symptoms including headache and loss of smell and taste, as well as brain fog, impaired consciousness, and stroke. Researchers have published a paper in the *Journal of Neurological Sciences* correlating the severity of the pulmonary distress in COVID-19 with viral spread to the brain stem, suggesting direct brain damage, not just a secondary cytokine effect. It has been shown recently

by Dr. William Banks, professor of Internal Medicine at University of Washington School of Medicine, that the S1 subunit of the spike protein — the part of the SARS-CoV-2 virus that produces the COVID-19 disease and is in the Vaccines — can cross the blood brain barrier. This is even more concerning, given the high number of ACE2 receptors in the brain (the ACE2 receptor is that portion of the cell that allows the spike protein to connect to human tissue). Mice injected with the S1 subunit of the spike protein developed direct damage to the perivascular tissue. In humans, viral spike protein was detected in the brain tissues of COVID-19 patients, but not in the brain tissues of the controls. Spike protein produces endothelial damage.

There are an excessive number of brain hemorrhages associated with COVID-19, and the mechanism suggests that it is the spike protein that is responsible. The federal government's VAERS database shows a dramatic increase in adverse event reporting of neurological damage following injection with the Vaccine.

Year	**Dementia** (reports following injection with Vaccine)	**Brain Bleeding** (reports following injection with Vaccine)
2000	4	7
2010	0	17
2015	0	17
2018	21	31
2019	11	17
2020	12 → (43)	4 → (11)
2021	17 → (251)	0 → (258)

While the full impact of these Vaccines crossing the blood-brain barrier is unknown, they clearly put vaccinated individuals at a substantially increased risk of hemorrhage, neurological damage, and brain damage as demonstrated by the increased instances of such reporting in the VAERS system.

Effect on the Young

The Vaccines are more deadly or harmful to the young than the virus, and that is excluding the unknown future effects on fertility, clotting, and autoimmune disease. Those under the age of 18 face statistically zero chance of death from SARS-CoV-2 according to data published by the CDC, but there are reports of heart inflammation — both myocarditis (inflammation of the heart muscle) and pericarditis (inflammation of the lining outside the heart) — in young men, and at least one documented fatal heart attack of a healthy 15-year old boy in Colorado two days after receiving the Pfizer Vaccine.8 The CDC has admitted that "[s]ince April 2021, increased cases of myocarditis and pericarditis have been reported in the United States after the mRNA COVID-19 vaccination (Pfizer-BioNTech and Mederna), particularly in adolescents and young adults."

The Vaccines induce the cells of the recipient to manufacture trillions of spike proteins with the pathology described above. Because immune responses in the young and healthy are more vigorous than those in the old, paradoxically, the vaccines may thereby induce, in the very people least in need of assistance, a very strong immune response, including those which can damage their own cells and tissues, including by stimulating blood coagulation.

See also infra Section II.B.

Chronic Disease

Healthy children whose birthright is decades of healthy life will instead face premature death or decades of chronic disease. We cannot say what percentage will be affected with antibody dependent enhancement, neurological disorders, autoimmune disease and reproductive problems, but it is a virtual certainty that this will occur.

Antibody Dependent Enhancement

Antibody Dependent Enhancement ("ADE") occurs when SARS-CoV-2 antibodies, created by a Vaccine, instead of protecting the vaccinated person, cause a more severe or lethal case of the COVID-19 disease when the person is later exposed to SARS-CoV-2 in the wild.9 The vaccine *amplifies* the infection rather than *preventing* damage. It may only be seen after months or years of use in populations around the world.

This paradoxical reaction has been seen in other vaccines and animal trials. One well-documented example is with the Dengue fever vaccine, which resulted in avoidable deaths. Dengue fever has caused 100-400 million infections, 500,000 hospitalizations, and a 2.5% fatality rate annually worldwide. It is a leading cause of death in children in Asian and Latin American countries. Despite over 50 years of active research, a Dengue vaccine still has not gained widespread approval in large part due to the phenomenon of ADE. Vaccine manufacturer Sanofi Pharmaceutical spent 20 years and nearly $2 billion to develop the Dengue vaccine and published their results in the *New England Journal of Medicine*, which was quickly endorsed by the World Health Organization. Vigilant scientists clearly warned about the danger from ADE, which the Philippines ignored when it administered the vaccine to hundreds of thousands of children in 2016. Later, when these children were exposed in the wild, many became severely ill and 600 children died. The former head of the Dengue department of the Research Institute for Tropical Medicine (RITM) was indicted in 2019 by the Phillipines Department of Justice for "reckless imprudence resulting [in] homicide," because he "facilitated, with undue haste," Dengvaxia's approval and its rollout among Philippine schoolchildren.

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ADE has been observed in the coronavirus setting. The original SARS-CoV-1 caused an epidemic in 2003. This virus is a coronavirus that is reported to be 78% similar to the currentSARS-CoV-2 virus that causes the disease COVID-19. Scientists attempted to create a vaccine. Of approximately 35 vaccine candidates, the best four were trialed in ferrets. The vaccines appeared to work in the ferrets. However, when those vaccinated ferrets were challenged bySARS-CoV-1 in the wild, they became very ill and died due to what we would term a sudden severe cytokine storm. The reputed journals *Science*, *Nature* and *Journal of Infectious Diseases* have all documented ADE risks in relation to the development of experimental COVID-19vaccines. The application filed by Dr. Yeadon with the European Medicines Agency on December 1, 2020 also mentioned the risk from ADE. ADE is discovered during long-term animal studies, to which the Vaccines have not been subjected.

Vaccine-Driven Disease Enhancement in the Previously Infected- *See infra* section II. C.

More Virulent Strains

Scientists are concerned that universal inoculation may create more virulent strains. This has been observed with Marek's Disease in chickens.11 A large number of chickens not at risk of death were vaccinated, and now all chickens must be vaccinated or they will die from a virus that was nonlethal prior to widespread vaccination. The current policy to pursue universal vaccination regardless of risk may exert the same evolutionary pressure toward more highly virulent strains.

Blood Supply

Presently, the vaccinated are permitted to donate their spike protein laden blood into the blood supply, which projects all of the risks discussed *supra* onto the general population of unvaccinated blood donees.

Scientists and healthcare professionals all over the world are sounding the alarm and frantically appealing to the FDA to halt the Vaccines. They have made innumerable public statements. Fifty-seven top scientists and doctors from Central and South America are calling for an immediate end to all Vaccine COVID-19 programs. Other physician-scientist groups have made similar calls, among them: Canadian Physicians, Israeli People's Committee, Frontline COVID-19 Critical Care Alliance, World Doctors Alliance, Doctors 4 Covid Ethics, and Plaintiff America's Frontline Doctors. These are healthcare professionals in the field who are seeing the catastrophic and deadly results of the rushed Vaccines, and reputed professors of science and medicine, including the physician with the greatest number of COVID-19 scientific citations worldwide. They accuse the government of deviating from long-standing policy to protect the public. In the past, government has halted vaccine trials based on a tiny fraction — far less than 1% — of the number of unexplained deaths already recorded. The scientists all agree that the spike protein (produced by the Vaccines) *causes disease even without the virus*, which has motivated them to lend their imprimatur to, and risk their reputation and standing on, these public objections.

(5) § 360bbb–3(c)(3): There Are Adequate, Approved and Available Alternatives to the Vaccines

The DHHS Secretary can issue and maintain the Vaccine EUAs "**only if**" (emphasis added) there is no adequate, approved and available alternative to the Vaccines.

There are numerous alternative safe and effective treatments for COVID-19. These alternatives are supported by over 300 studies, including randomized controlled studies. Tens of thousands of physicians have publicly attested, and many have testified under oath, as to the safety and efficacy of the alternatives. Globally and in the United States, treatments such as Ivermectin, Budesonide, Dexamethasone, convalescent plasma and monoclonal antibodies, Vitamin D, Zinc, Azithromycin, Hydroxychloroquine, Colchicine and Remdesivir are being used to great effect, and they are far safer than the COVID-19 Vaccines.12

Doctors from the Smith Center for Infectious Diseases and Urban Health and the Saint Barnabas Medical Center have published an *Observational Study on 255 Mechanically Ventilated COVID Patients at the Beginning of the USA Pandemic*, which states: "Causal modeling establishes that weight-adjusted HCQ [Hydroxychloroquine] and AZM [Azithromycin] therapy improves survival by over 100%."13

Observational studies in Delhi and Mexico City show dramatic reductions in COVID-19 case and death counts following the mass distribution of Ivermectin. These results align with those of a study in Argentina, in which 800 healthcare professionals received Ivermectin, while another 400 did not. Of the 800, not a single person contracted COVID-19, while more than half of the control group did contract it. Dr. Pierre Kory, a lung specialist who has treated more COVID-19 patients than most doctors, representing a group of some of the

most highly published physicians in the world, with over 2,000 peer reviewed publications among them, testified before the U.S. Senate in December 2020.14 He testified that based on 9 months of review of scientific data from 30 studies, Ivermectin obliterates transmission of the SARS-CoV-2 virus and is a powerful prophylactic (if you take it, you will not contract COVID-19). Four large randomized controlled trials totaling over 1500 patients demonstrate that Ivermectin is safe and effective as a prophylaxis. In early outpatient treatment, three randomized controlled trials and multiple observational studies show that Ivermectin reduces the need for hospitalization and death in statistically significant numbers. In inpatient treatment, four randomized controlled trials show that Ivermectin prevents death in a statistically significant, large magnitude. Ivermectin won the Nobel Prize in Medicine in 2015 for its impacts on global health.15

Inexplicably, the Defendants never formed or assigned a task force to research and review existing alternatives for preventing and treating COVID-19. Instead, the Defendants and others set about censoring both concerns about the Vaccines, and information about safe and effective alternatives.

(6) § 360bbb–3(e)(1)(A)(i) and (ii): Healthcare Professionals and Vaccine Candidates are Not Adequately Informed

Once an EUA has been issued, § 360bbb–3(e) mandates that the DHHS Secretary "shall [ ] establish" conditions "designed to ensure" that both healthcare professionals and Vaccine candidates receive certain minimum required information that is necessary in order to make voluntary, informed consent possible. The required disclosures that the DHHS Secretary are designed to ensure include inter alia (i) that the Vaccines are only authorized for emergency use and not FDA approved, (ii) the significant known and potential risks of the Vaccines, (iii) available alternatives to the Vaccines, (iv) the option to accept or refuse the Vaccines.

The Vaccines are Not Approved by the FDA, but Merely Authorized for Emergency Use

Defendants have failed to educate the American public that the FDA has not actually "approved" the Vaccines, and that the DHHS Secretary has *not* in fact determined that the Vaccines are "safe and effective," and on the contrary has merely determined, in accordance with the proverbial "weasel language" of the EUA statute, that "**it is reasonable to believe**" that the Vaccines "**may be**" effective and that the benefits outweigh the risks. Instead of being so educated, the public is barraged with unqualified "safe and effective" messaging from all levels of federal and state government, the private sector and the media. They hear from no higher authority than the President himself that: "The bottom line is this: I promise you they are safe. They are safe. And even more importantly, they're extremely effective. If you're vaccinated, you are protected."

The public are also unaware of the serious financial conflicts-of-interest that burden Dr. Fauci, the National Institute of Allergies and Infectious Diseases, and the Vaccines and Related Biological Products Advisory Committee which advises and consults Defendants with respect to the Vaccine EUAs, as outlined in the Complaint (ECF 10, ¶¶ 250-256). Without the information

regarding conflicts-of interest, the public cannot assess for themselves the reliability and objectivity of the analysis underpinning the EUAs.

The Significant Known and Potential Risks of the Vaccines

Perhaps the first step in understanding the potential risks of the Vaccines is to understand exactly what they are, and what they are not. The CDC defines a "vaccine" as: "A product that stimulates a person's immune system to produce immunity to a specific disease, protecting the person from that disease. Vaccines are usually administered through needle injections, but can also be administered by mouth or sprayed into the

nose."16 The CDC defines "immunity" as: "Protection from an infectious disease. If you are immune to a disease, you can be exposed to it without becoming infected."17

However, the "Pfizer-BioNTech COVID-19 Vaccine" and the "Moderna COVID-19 Vaccine" do not meet the CDC's own definitions. They do not stimulate the body to produce immunity from a disease. They are a synthetic fragment of nucleic acid embedded in a fat carrier that is introduced into human cells, not for the purpose of inducing immunity from infection with the SARS-CoV-2 virus, and not to block further transmission of the virus, but in order to lessen the symptoms of COVID-19. No published, peer-reviewed studies prove that the "Pfizer-BioNTech COVID-19 Vaccine" and the "Moderna COVID-19 Vaccine" confer immunity or stop transmission.

Further, the "Pfizer-BioNTech COVID-19 Vaccine" and the "Moderna COVID-19 Vaccine" are not "vaccines" within the common, lay understanding of the public. Since vaccines were first discovered in 1796 by Dr. Edward Jenner, who used cowpox to inoculate humans against smallpox, and called the process "vaccination" (from the Latin term *vaca* for cow), the public has had an entrenched understanding that a vaccine is a microorganism, either alive but weakened, or dead, that is introduced into the human body in order to trigger the production of antibodies that confer immunity from the targeted disease, and also prevent its transmission to others. The public are accustomed to these traditional vaccines and understand them.

The public are fundamentally uninformed about the gene therapy technology behind the "Pfizer-BioNTech COVID-19 Vaccine" and the "Moderna COVID-19 Vaccine." Referring to the "mRNA technology" in its Vaccine, Moderna admits the "novel and unprecedented nature of this new class of medicines" in its Securities and Exchange Commission filings.18 Further, it admits that the FDA classes its Vaccine as a form of "gene therapy." No dead or attenuated virus is used in the "Pfizer-BioNTech COVID-19 Vaccine" and the "Moderna COVID-19 Vaccine." Rather, instructions, via a piece of lab-created genetic code (the mRNA) are injected into your body that tell your body how to make a certain "spike protein" that is purportedly useful in attacking the SARS-CoV-2 virus.

By referring to the "Pfizer-BioNTech COVID-19 Vaccine" and the "Moderna COVID-19 Vaccine" as "vaccines," and by allowing others to do the same, the Defendants knowingly seduce and mislead the public, short-circuit independent, critical evaluation and decision-making by the consumers of these products, and vitiate their informed consent to this novel technology which is being deployed in the unsuspecting human population for the first time in history.

Meanwhile, the federal government is orchestrating a nationwide media campaign funded with $1 billion — not to ensure that the Defendants meet their statutory disclosure obligations, but solely to promote the purported benefits of the Vaccines. Simultaneously, the Associated Press, Agence France Press, British Broadcasting Corporation, CBC/Radio-Canada, European Broadcasting Union (EBU), Facebook, Financial Times, First Draft, Google/YouTube, The Hindu Times, Microsoft, Reuters, Reuters Institute for the Study of Journalism, Twitter, The Washington Post and The New York Times all participate in the "Trusted News Initiative" which has agreed to not allow any news critical of the Vaccines.

Individual physicians are being censored on social media platforms (e.g., Twitter, Facebook, Instagram, TikTok), the modern day "public square." Plaintiff AFLDS has recorded innumerable instances of social media deleting scientific content posted by AFLDS members that runs counter to the prevailing Vaccine narrative, and then banning them from the platform altogether as users. Facebook has blocked the streaming of entire events at which AFLDS Founder Dr. Simone Gold has been an invited guest, prior to her uttering a word. Other doctors have been banned for posting or tweeting screenshots of government database VAERS.

The censorship also extends to medical journals. In an unprecedented move, the four founding topic editors for the *Frontiers in Pharmacology* journal all resigned together due to their collective inability to publish peer reviewed scientific data on various drugs for prophylaxis and treatment of COVID-19.

Dr. Philippe Douste-Blazy, a cardiology physician, former France Health Minister, 2017 candidate for Director of the WHO and former Under-Secretary-General of the United Nations, described the censorship in chilling detail:

The Lancet boss said "Now we are not going to be able to, basically, if this continues, publish any more clinical research data, because the pharmaceutical companies are so financially powerful today and are able to use such methodologies, as to have us accept papers which are apparently, methodologically perfect but in reality, which manage to conclude what they want to conclude." … one of the greatest subjects never anyone could have believed … I have been doing research for 20 years in my life. I never thought the boss of The Lancet could say that. And the boss of the New England Journal of Medicine too. He even said it was "criminal" — the word was used by him. That is, if you will, when there is an outbreak like the COVID-19, in reality, there are people … us, we see "mortality" when you are a doctor or yourself, you see "suffering." And there are people who see "dollars" — that's it.

In many instances, highly publicized attacks on early treatment alternatives seem to be done in bad faith. For example, one study on Hydroxychloroquine overdosed study participants by administering a multiple of the standard prescribed dose, and then reported the resulting deaths as though they were not a result of the overdose, but from the medication itself administered in the proper dosages. The twenty-seven physician-scientist authors of the study were civilly indicted and criminally investigated, and still the Journal of the American Medical Association has not retracted the article.19

The Available Alternatives to the Vaccines

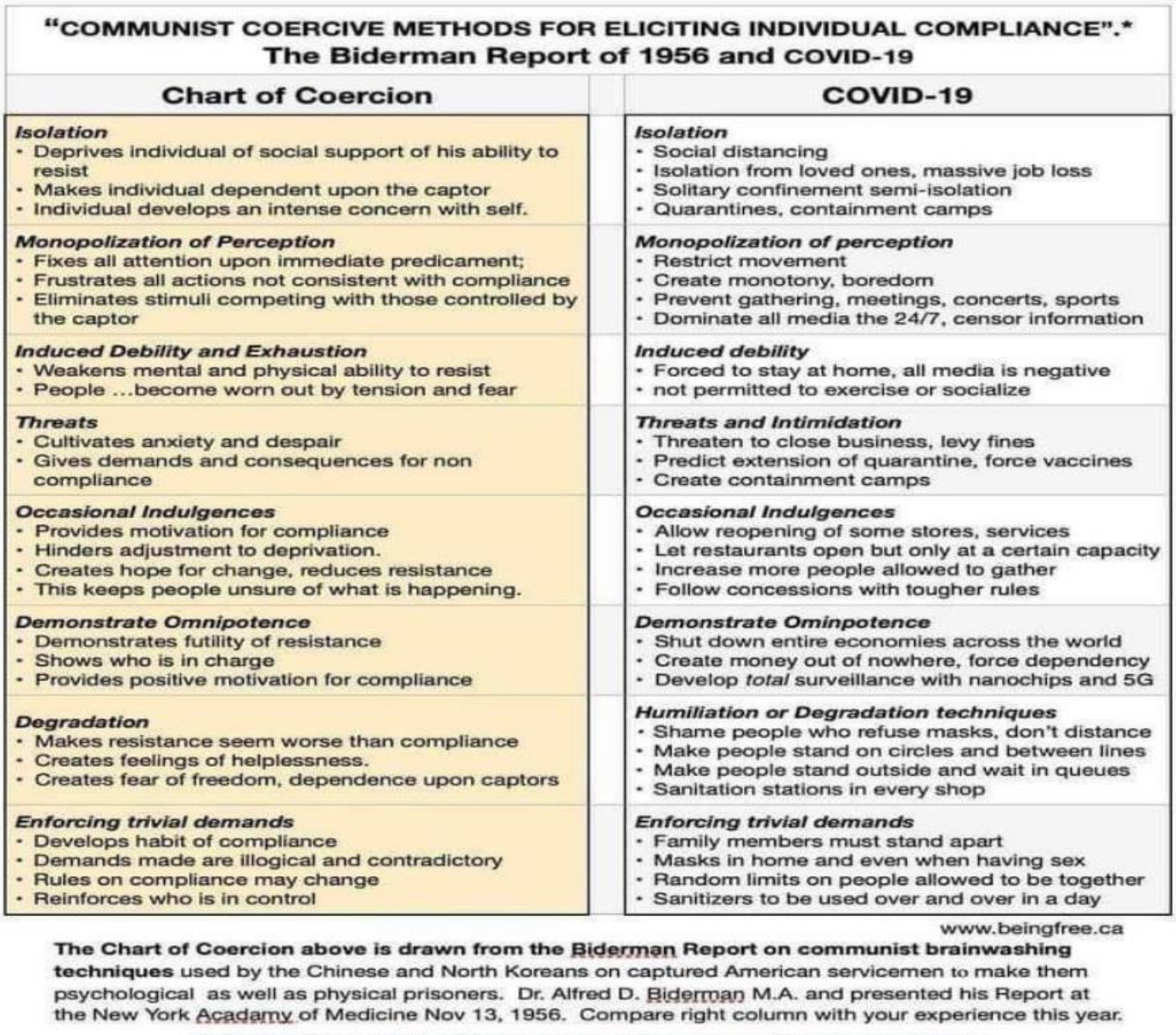
Information regarding available alternatives to the Vaccines has been suppressed and censored equally with information regarding the risks of the Vaccines, as aforesaid.

The Option to Accept or Refuse the Vaccines

The idea of using fear to manipulate the public is not new, and is a strategy frequently deployed in public health. In June 2020, three American public health professionals, concerned about the psychological effects of the continued use of fear-based appeals to the public in order to motivate compliance with extreme COVID-19 countermeasures, authored a piece for the journal Health Education and Behavior calling for an end to the fear-mongering. In doing so, they acknowledged that fear has become an accepted public health strategy, and that it is being deployed aggressively in the United States in response to COVID-19:

"… behavior change can result by increasing people's perceived severity and perceived susceptibility of a health issue through heightened risk appraisal coupled by raising their self-efficacy and response-efficacy about a behavioral solution. In this model, fear is used as the trigger to increase perceived susceptibility and severity."

In 1956, Dr. Alfred Biderman, a research social psychologist employed by the U.S. Air Force, published his study on techniques employed by communist captors to induce individual compliance from Air Force prisoners of war during the Korean War. The study was at the time and to some extent remains the core source for capture resistance training for the armed forces. The chart below compares the techniques used by North Korean communists with the fear-based messaging and COVID-19 countermeasures to which the American population has been subjected over the last year.



"COMMUNIST COERCIVE METHODS FOR ELICITING INDIVIDUAL COMPLIANCE".*
The Biderman Report of 1956 and COVID-19

Chart of Coercion	COVID-19
Isolation • Deprives individual of social support of his ability to resist • Makes individual dependent upon the captor • Individual develops an intense concern with self.	***Isolation*** • Social distancing • Isolation from loved ones, massive job loss • Solitary confinement semi-isolation • Quarantines, containment camps
Monopolization of Perception • Fixes all attention upon immediate predicament; • Frustrates all actions not consistent with compliance • Eliminates stimuli competing with those controlled by the captor	***Monopolization of perception*** • Restrict movement • Create monotony, boredom • Prevent gathering, meetings, concerts, sports • Dominate all media the 24/7, censor information
Induced Debility and Exhaustion • Weakens mental and physical ability to resist • People …become worn out by tension and fear	***Induced debility*** • Forced to stay at home, all media is negative • not permitted to exercise or socialize
Threats • Cultivates anxiety and despair • Gives demands and consequences for non compliance	***Threats and Intimidation*** • Threaten to close business, levy fines • Predict extension of quarantine, force vaccines • Create containment camps
Occasional Indulgences • Provides motivation for compliance • Hinders adjustment to deprivation. • Creates hope for change, reduces resistance • This keeps people unsure of what is happening.	***Occasional Indulgences*** • Allow reopening of some stores, services • Let restaurants open but only at a certain capacity • Increase more people allowed to gather • Follow concessions with tougher rules
Demonstrate Omnipotence • Demonstrates futility of resistance • Shows who is in charge • Provides positive motivation for compliance	***Demonstrate Ominpotence*** • Shut down entire economies across the world • Create money out of nowhere, force dependency • Develop *total* surveillance with nanochips and 5G
Degradation • Makes resistance seem worse than compliance • Creates feelings of helplessness. • Creates fear of freedom, dependence upon captors	***Humiliation or Degradation techniques*** • Shame people who refuse masks, don't distance • Make people stand on circles and between lines • Make people stand outside and wait in queues • Sanitation stations in every shop
Enforcing trivial demands • Develops habit of compliance • Demands made are illogical and contradictory • Rules on compliance may change • Reinforces who is in control	***Enforcing trivial demands*** • Family members must stand apart • Masks in home and even when having sex • Random limits on people allowed to be together • Sanitizers to be used over and over in a day

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The Chart of Coercion above is drawn from the Biderman Report on communist brainwashing techniques used by the Chinese and North Koreans on captured American servicemen to make them psychological as well as physical prisoners. Dr. Alfred D. Biderman M.A. and presented his Report at the New York Academy of Medicine Nov 13, 1956. Compare right column with your experience this year.

After a year of sustained psychological manipulation, the population is now weakened, frightened, desperate for a return of their freedoms, prosperity and normal lives, and especially vulnerable to pressure to take the Vaccine. The lockdowns and shutdowns, the myriad rules and regulations, the confusing and self-contradictory controls, the enforced docility, and the consequent demoralization, anxiety and helplessness are typical of authoritarian and totalitarian conditions. This degree of systemic and purposeful coercion means that Americans cannot give truly free and voluntary informed consent to the Vaccines.

At the same time, the population is being subjected to an aggressive, coordinated media campaign promoting the Vaccines funded by the federal government with $1 billion. The media campaign is reinforced by a system of coercive rewards and penalties designed to induce vaccination. The federal government is offering a range of its own incentives, including free childcare. The Ohio Governor rewarded those Ohio residents accepting the Vaccines by allowing them to enter into the "Vaxamillion" lottery with a total $5 million prize and the chance to win a fully funded college education, while barring entry for residents who decline the Vaccines. In New York, metro stations offer free passes to those receiving the Vaccine in the station. West Virginia is running a lottery exclusively for the vaccinated with free custom guns, trucks and lifetime hunting and fishing licenses, a free college education, and cash payments of $1.5 million and $600,000 as the prizes. Previously, the state offered a $100 savings bond for each injection with a Vaccine. New Mexican residents accepting the

Vaccines will be entered into weekly drawings to take home a $250,000 prize, and those fully vaccinated by early August could win the grand prize of $5 million. In Oregon, the vaccinated can win $1 million, or one of 36 separate $10,000 prizes through the state's "Take Your Shot" campaign. Other state and local governments are partnering with fast food chains to offer free pizza, ice cream, hamburgers and other foods to the vaccinated. Many people are desperate following the last year of economic destruction and deprivation of basic freedoms, and they are especially vulnerable to this coercion.

The penalties take many forms, among them:

• Using guilt and shame to make unvaccinated children and adults feel badly about themselves for refusing the Vaccines.

• Threatening the unvaccinated with false fears and anxieties about COVID-19, especially children who are at no risk statistically.

• Removing the rights of those who are unvaccinated, including: o Being prohibited from working

o Being prohibited from attending school or college

o Being limited in the ability to travel in buses, trains and planes

o Being prohibited from traveling outside the United States

o Being excluded from public and private events, such as performing arts venues.

Most recently, the President has announced an aggressive campaign to visit the homes of the unvaccinated, not for the purpose of ensuring that they have all of the information they might need in order to make fully informed, voluntary decisions about the Vaccines (the information required by § 360bbb–3(e)(1)(A)(i) and (ii)), but instead for the purpose of pressuring them to be injected with the Vaccine so that the Administration can reach its goal of having 70% of the American population vaccinated. He said: "Now we need to go to community by community, neighborhood by neighborhood, and oftentimes, door to door — literally knocking on doors — to get help to the remaining people protected from the virus."20 The White House press secretary referred to the door-knockers who would enter our communities to pressure us to accept the Vaccines using the language of war, as "strike forces." Then, after Dr. Fauci stated his opinion in mainstream media news outlets that "at the local level . . . there should be more mandates, there really should be", the press secretary announced that the Biden Administration would support state and local Vaccine mandates.[21]

A study recently published in the International Journal of Clinical Practice, "Informed Consent Disclosure to Vaccine Trial Subjects of Risk ofCOVID-19 Vaccines Worsening Clinical Disease,"[22]concludes:

> *COVID-19 vaccines designed to elicit neutralizing antibodies may sensitise vaccine recipients to more severe disease than if they were not vaccinated. Vaccines for SARS, MERS and RSV have never been approved, and the data generated in the development and testing of these vaccines suggest a serious mechanistic concern: that vaccines designed empirically using the traditional approach (consisting of the unmodified or minimally modified coronavirus viral spike to elicit neutralising antibodies), be they composed of protein, viral vector, DNA or RNA and irrespective of delivery method, may worsen COVID-19 disease via antibody-dependent enhancement(ADE).* ***This risk is sufficiently obscured in clinical trial protocols and consent forms for ongoingCOVID-19 vaccine trials that adequate patient comprehension of this risk is unlikely to occur, obviating truly informed consent by subjects in these trials.***

(emphasis added).

Plaintiffs' expert Dr. Lee Merritt is a fully licensed, board certified surgeon, and has been actively engaged in medical practice for over 35 years. As Chief of Staff, Chief of Surgery and Chief of Credentialing at a regional medical center, she participated in hospital administration and education with respect to *inter alia* informed consent. She states: "I have read the Complaint and Motion for Preliminary Injunction in the above captioned matter, specifically the allegations related to informed consent. I agree with the informed consent allegations contained in the Complaint and Motion for Preliminary Injunction" (*see* Declaration of Dr. Lee Merritt at Exhibit A). Dr. Merritt has provided an example of some of the language that she would recommend using for the purpose of obtaining voluntary, informed consent to the Vaccines.

The Injunction goes on to cover the VAERS and other reporting systems and monitoring of adverse events, immunity in people that have had SARS-CoV-2 infection or recovered from COVID-19, the reasons why children do not need to be vaccinated, whistleblower testimony about the deaths tally from the vaccines being 45,000 and then all of the laws and court decisions that have laid the groundwork for precedence with this injunction.

References listed in the sections I have presented.

1 Emergency Use Authorization ("EUA") issued December 11, 2020. *See* https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine.

2 EUA issued December 18, 2020. *See* https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/moderna-covid-19-vaccine.

3 EUA issued February 27, 2021. *See* https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/janssen-covid-19-vaccine.

4 For the sake of clarity of reference, Plaintiffs are using the names given to the Pfizer and Moderna EUA medical products by their manufacturers and the Defendants. However, Plaintiffs reject the highly misleading use of the term "vaccine" to describe the Pfizer and Moderna EUA medical products, since they are not vaccines within the settled meaning of the term and instead are more precisely described as a form of genetic manipulation.

5 https://www.oralhealthgroup.com/features/the-problems-with-the-covid-19-test-a-necessary-understanding/ (last visited July 15, 2021).

6 https://1027kearneymo.com/kpgz-news/2020/11/9/covid-tests-may-inflate-numbers-by-picking-up-dead-virus (last visited July 15, 2021).

7 https://www.statnews.com/2021/01/23/asymptomatic-infection-blunder-covid-19-spin-out-of-control/ (last visited July 15, 2021).

8 https://archive.is/mEBcV (last visited July 15, 2021).

9 https://www.nature.com/articles/s41564-020-00789-5 (last visited July 15, 2021).

10 https://trialsitenews.com/philippine-dengue-vaccine-criminal-indictments-includes-president-of-sanofi-pasteur-their-fda (last visited July 15, 2021).

11 https://en.wikipedia.org/wiki/Marek%27s_disease (last visited July 15, 2021).

12 *Numerous studies can be reviewed here: https://c19early.com (last visited June 7, 2021).*

13 https://www.medrxiv.org/content/10.1101/2021.05.28.21258012v1 (last visited July 15, 2021).

14 https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwji38elkuPxAhWeAp0JHZhzAeMQFnoECAIQAA&url=https%3A%2F%2Fwww.hsgac.senate.gov%2Fdownload%2Fkory12-08-2020&usg=AOvVaw3z2a7PpDLWgyfSrp3miF1y (last visited July 15, 2021).

15 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4692067/ (last visited July 15, 2021).

16 *See* https://www.cdc.gov/vaccines/vac-gen/imz-basics.htm (last visited July 9, 2021).

17 *Id.*

18 *See* www.sec.gov/Archives/edgar/data/1682852/000168285220000017/mrna-20200630.htm (last visited July 6, 2021).

19 https://www.medrxiv.org/content/medrxiv/early/2020/04/16/2020.04.07.20056424.full.pdf (last visited July 15, 2021).

20 See "Biden admin launching door-to-door push to vaccinate Americans, sparks major backlash," https://www.foxnews.com/media/biden-admin-door-to-door-coronavirus-vaccines (last visited July 15, 2021).

21*See* "Biden will back local vaccine mandates," https://thehill.com/changing-america/well-being/prevention-cures/562622-biden-will-back-local-vaccine-mandates (last visited July 15, 2021).

22*See*https://onlinelibrary.wiley.com/doi/epdf/10.1111/ijcp.13795 (last visited July 17, 2021).

A great explanation of what we may be beginning to see and what many scientists have been warning about regarding the failure of the vaccines and possible devastation to come

I recently ran across an excellent article titled **Is a Coronavirus Vaccine a Ticking Time Bomb?** that really articulates the problem that may be beginning to happen according to some the top scientists and vaccine experts. And I pray this is not the case. If what we may be beginning to see happening with mutating strains of the virus, the vaccine failing, an increase in serious COVID-19 illness and deaths in some vaccinated individuals, is related to this phenomenon, we may be in big trouble, especially those that have been vaccinated. This article was written in August of 2020, almost exactly a year ago. This is the problem that has been predicted by Geert Vanden Bossche, Dr. Michael Yeadon, and many others. The phenomenon I am referring to is the problem of Antibody Dependent Enhancement (ADE). I hope that this article written by Dr. Doug Corrigan, a PhD in biochemistry and molecular biology which really hit the nail on the head will help you understand the game of Russian Roulette that we are playing with the population of the world. And one thing that I didn't completely understand at first, but is a critical point, is that the resulting ADE and illness a person may suffer as a result, may not show up for many weeks or months after they have been vaccinated.

So, I decided to publish the entire article here in my newsletter. I feel that it is definitely worth the four pages it occupies. You can see the link to Dr. Corrigan's web site at the end. He has written some very interesting articles that you'll find there as well.

The article starting on the next page…

Will a vaccine to SARS-CoV-2 actually make the problem worse? Although not a certainty, all of the current data says that this prospect is a real possibility that needs to be paid careful attention to. If you stay with me, I'll explain why.

First, let's set aside the debate surrounding the topic of whether vaccines work and the negative health consequences due to the components of the vaccine. No matter where you stand on the vaccine issue, I'm not asking anyone to capitulate on this point. I'm just asking that this issue be set aside, because in this instance this argument is completely irrelevant. Even without bringing any other issue into the vaccine debate, a coronavirus vaccine is a highly dangerous undertaking due to a peculiar trojan horse mechanism known as Antibody Dependent Enhancement (ADE). Regardless of someone's conviction about vaccines, this point needs to be acknowledged. In the remaining portion of this article, I'm going to explain how ADE works and the future perils it may bring.

For a vaccine to work, our immune system needs to be stimulated to produce a neutralizing antibody, as opposed to a non-neutralizing antibody. A neutralizing antibody is one that can recognize and bind to some region ('epitope') of the virus, and that subsequently results in the virus either not entering or replicating in your cells.

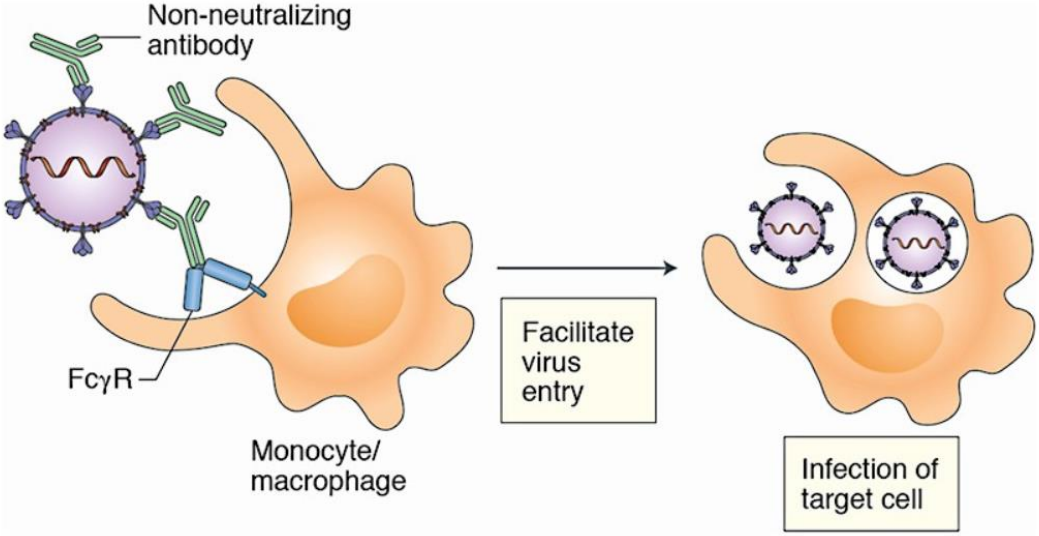
A non-neutralizing antibody is one that can bind to the virus, but for some reason, the antibody fails to neutralize the infectivity of the virus. This can occur, for example, if the antibody doesn't bind tightly enough to the virus, or the percentage of the surface area of the virus covered by the antibody is too low, or the concentration of the antibody is not high enough. Basically, there is some type of generic binding of the antibody to the virus, but it fails to neutralize the virus.

In some viruses, if a person harbors a non-neutralizing antibody to the virus, a subsequent infection by the virus can cause that person to elicit a more severe reaction to the virus due to the presence of the non-neutralizing antibody. This is not true for all viruses, only particular ones. This is called Antibody Dependent Enhancement (ADE), and is a common problem with Dengue Virus, Ebola Virus, HIV, RSV, and the family of coronaviruses. In fact, this problem of ADE is a major reason why many previous vaccine trials for other coronaviruses failed. Major safety concerns were observed in animal models. If ADE occurs in an individual, their response to the virus can be worse than their response if they had never developed an antibody in the first place.

An antibody can be rendered a non-neutralizing antibody simply because it doesn't bind to the right portion of the virus to neutralize it, or the antibody binds too weakly to the virus. This can also occur if a neutralizing antibody's concentration falls over time and is now no longer of sufficient concentration to cause neutralization of the virus. In addition, a neutralizing antibody can subsequently transition to non-neutralizing antibody when encountering a different strain of the virus.

What does ADE entail? The exact mechanism of ADE in SARS is not known, but the leading theory is described as follows: In certain viruses, the binding of a non-neutralizing antibody to the virus can direct the virus to enter and infect your immune cells. This occurs through a receptor called FcγRII. FcγRII is expressed on the

outside of many tissues of our body, and in particular, in monocyte derived macrophages, which are a type of white blood cell. In other words, the presence of the non-neutralizing antibody now directs the virus to infect cells of your immune system, and these viruses are then able to replicate in these cells and wreak havoc on your immune response. One end of the antibody grabs onto the virus, and the other end of the antibody grabs onto an immune cell. Essentially, the non-neutralizing antibody enables the virus to hitch a ride to infect immune cells. You can see this in this picture.



This can cause a hyperinflammatory response, a cytokine storm, and a generally dysregulation of the immune system that allows the virus to cause more damage to our lungs and other organs of our body. In addition, new cell types throughout our body are now susceptible to viral infection due to the additional viral entry pathway facilitated by the FcγRII receptor, which is expressed on many different cell types.

What this means is that you can be given a vaccine, which causes your immune system to produce an antibody to the vaccine, and then when your body is actually challenged with the real pathogen, the infection is much worse than if you had not been vaccinated.

Again, this is not seen in all viruses, or even in all strains of a given virus, and there is a great deal that scientists don't understand about the complete set of factors that dictate when and if ADE may occur. It's quite likely that genetic factors as well as the health status of the individual may play a role on modulating this response. That being said, there are many studies (in the reference section below) that demonstrate that ADE is a persistent problem with coronaviruses in general, and in particular, with SARS-related viruses. Less is known, of course, with respect to SARS-CoV-2, but the genetic and structural similarities between the SARS-CoV-2 and the other coronaviruses strongly suggests that this risk is real.

ADE has proven to be a serious challenge with coronavirus vaccines, and this is the primary reason many have failed in early in-vitro or animal trials. For example, rhesus macaques who were vaccinated with the Spike protein of the SARS-CoV virus demonstrated severe acute lung injury when challenged with SARS-CoV, while

monkeys who were not vaccinated did not. Similarly, mice who were immunized with one of four different SARS-CoV vaccines showed histopathological changes in the lungs with eosinophil infiltration after being challenged with SARS-CoV virus. This did not occur in the controls that had not been vaccinated. A similar problem occurred in the development of a vaccine for FIPV, which is a feline coronavirus.

For a vaccine to work, vaccine developers will need to find a way to circumvent the ADE problem. This will require a very novel solution, and it may not be achievable, or at the very least, predictable. In addition, the vaccine must not induce ADE in subsequent strains of SARS-CoV-2 that emerge over time, or to other endemic coronaviruses that circulate every year and cause the common cold.

A major trigger for ADE is viral mutation. Changes to the amino acid sequence of the Spike Protein (which is the protein on the virus that facilitates entry into our cells via the ACE2 receptor) can cause antigenic drift. What this means is that an antibody that was once neutralizing can become a non-neutralizing antibody because the antigen has slightly changed. Therefore, mutations in the Spike protein that naturally occur with coronaviruses could presumably result in ADE. Since these future strains are not predictable, it is impossible to predict if ADE will become a problem at a future date.

This inherent unpredictability problem is highlighted in the following scenario: A coronavirus vaccine may not be dangerous initially. If the initial testing looks positive, mass vaccination efforts would presumably be administered to a large portion of the population. In the first year or two, it may appear that there is no real safety issue, and over time, a greater percentage of the world population will be vaccinated due to this perceived "safety". During this interim period, the virus is busy mutating. Eventually, the antibodies that vaccinated individuals have floating around in their bloodstream are now rendered non-neutralizing because they fail to bind to the virus with the same affinity due to the structural change resulting from the mutation. Declining concentrations of the antibody over time would also contribute to this shift towards non-neutralization. When these previously vaccinate people are infected with this different strain of SARS-CoV-2, they could experience a much more severe reaction to the virus.

Ironically, in this scenario, this vaccine made the virus more pathogenic rather than less pathogenic. This is not something that vaccine producers would be able predict or test for with any level of real confidence at the outset, and it would only become evident at a later time.

If and when this does occur, who will be liable?

Does this vaccine industry know about this problem? The answer is yes, they do.

Quoting a Nature Biotechnology news article published on June 5th, 2020: ""It's important to talk about it [ADE]," says Gregory Glenn, president of R&D at Novavax, which launched its COVID-19 vaccine trial in May. But "we can't be overly cautious. People are dying. So we need to be aggressive here.""

And from the same article:

"ADE "is a genuine concern," says virologist Kevin Gilligan, a senior consultant with Biologics Consulting, who advises thorough safety studies. "Because if the gun is jumped, and a vaccine is widely distributed that is disease enhancing, that would be worse than actually not doing any vaccination at all."" The vaccine industry is aware of this problem. The degree to which they are taking it seriously, is another question.

While many vaccine developers are aware of the problem, some of them are approaching the problem with more Laissez-faire attitude. They see this problem as "theoretical," and not guaranteed, with the idea that animal trials should rule out the potential of ADE in humans.

As a side note, it is not ethical to conduct "challenge" studies in humans. However, challenge studies are conducted in animals. In other words, a clinical trial for a vaccine does not include administering the vaccine to a person, and then exposing this person to the virus post-vaccination to monitor their reaction. In clinical trials, humans are only given the vaccine, they are not "challenged" with the virus afterward. In animal studies, they do conduct a challenge test to observe how the animals respond to being infected with the actual virus after being vaccinated.

Will conducting animal studies solve the issue and remove the risk?

Not at all.

Anne De Groot, CEO of EpiVax argues that testing for vaccine safety in primates does not guarantee safety in humans, mainly because primates express different major histocompatibility complex (MHC) molecules, which alters epitope presentation and the immune response. Animals and humans are similar, but they are also very different. In addition, as pointed out above, the development of different viral strains in subsequent years could present a major problem not noticeable during the initial safety trials in either humans or animals.

What about unvaccinated people who are naturally infected with the virus and develop antibodies? Could these people experience ADE to a future strain of SARS-CoV-2?

The ADE response is actually much more complicated than the picture I outlined above. There are other competing and non-competing factors in our immune system that contribute to the ADE response, many of which are not fully understood. Part of that equation is a variety of different types of T-cells that modulate this response, and these T-Cells respond to other portions (epitopes) of the virus. In a vaccine, our body is normally presented with a small part of the virus (like the Spike protein), or a modified (attenuated or dead) virus which is more benign. A vaccine does not expose the entirety of our immune system to the actual virus.

These types of vaccines will only elicit antibodies that recognize the portion of the virus which is present in the vaccine. The other portions of the virus are not represented in the antibody pool. In this scenario, it is much more likely that the vaccine-induced antibodies can be rendered as non-neutralizing antibodies, because the entire virus is not coated in antibodies, only the portion that was used to develop the vaccine.

In a real infection, our immune system is exposed to every nook and cranny of the entire virus, and as such, our immune system develops a panacea of antibodies that recognize different portions of the virus and, therefore, coat more of the virus and neutralize it. In addition, our immune system develops T-Cell responses

to hundreds of different peptide epitopes across the virus; whereas in the vaccine the plethora of these T-Cell responses are absent. Researchers are already aware that the T-Cell response plays a cooperative role in either the development of, or absence of, the ADE response.

Based on these differences and the skewed immunological response which is inherent with vaccines, I believe that the risk of ADE is an order of magnitude greater in a vaccine-primed immune system rather than a virus-primed immune system. This will certainly become more apparent as COVID-19 progresses over the years, but the burden of proof rests on the shoulders of the vaccine industry to demonstrate that ADE will not rear its ugly head in the near term or the far term. Once a vaccine is administered and people develop antibodies to some misrepresentation of the virus, it cannot be reversed. Again, this is a problem that could manifest itself at a later date.

Although this article focused on the problem of ADE, it is not the only pathway or mechanism that could present a problem for people being infected after vaccination. Another pathway is governed by Th2 immunopathology, in which a defective T-cell response initiates an allergic inflammation reaction. A second pathway is based on the development of faulty antibodies that form immune complexes, which then activate the complement system a consequently damage the airways. These pathways are also potential risks for SARS-CoV-2.

Right now, the fatality rate of the virus is estimated to be approximately 0.26%, and this number seems to be dropping as the virus is naturally attenuating itself through the population. It would be a great shame to vaccinate the entire population against a virus with this low of a fatality rate, especially considering the considerable risk presented by ADE. I believe this risk of developing ADE in a vaccinated individual will be much greater than 0.26%, and, therefore, the vaccine stands to make the problem worse, not better. It would be the biggest blunder of the century to see the fatality rate of this virus increase in the years to come because of our sloppy, haphazard, rushed efforts to develop a vaccine with such a low threshold of safety testing and the prospect of ADE lurking in the shadows. I would hope (and this is a big hope), that this vaccine WILL NOT BE MANDATORY.

Hopefully, you now know a little more about the topic of Antibody Dependent Enhancement, and the real, unpredictable dangers of a coronavirus vaccine. In the end, your health should be your decision, not some bureaucrat's that doesn't know the first thing about molecular biology.

End of article- References for his article can be found after the article on his web site

https://sciencewithdrdoug.com/2020/08/01/is-a-coronavirus-vaccine-a-ticking-time-bomb/

Reputable scientific journal published study expressing concerns about Antibody Dependent Enhancement

On the heels of the previous article, a study was published in ***Nature Microbiology*** in October 2020 titled, **Antibody-dependent enhancement and SARS-CoV-2 vaccines and therapies.** That study covers many of the same concerns.

From the introduction

Antibody-based drugs and vaccines against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) are being expedited through preclinical and clinical development. Data from the study of SARS-Co-V and other respiratory viruses suggest that anti-SARS-CoV-2 antibodies could exacerbate COVID-19 through antibody-dependent enhancement (ADE). Previous respiratory syncytial virus and dengue virus vaccine studies revealed human clinical safety risks related to ADE, resulting in failed vaccine trials. Here, we describe key ADE mechanisms and discuss mitigation strategies for SARS-CoV-2 vaccines and therapies in development.

Risk of ADE for SARS-CoV-2 vaccines

Evidence for vaccine-induced ADE in animal models of SARS-CoV is conflicting, and raises potential safety concerns. Liu et al. found that while macaques immunized with a modified vaccinia Ankara viral vector expressing the SARS-CoV S protein had reduced viral replication after challenge, anti-S IgG also enhanced pulmonary infiltration of inflammatory macrophages and resulted in more severe lung injury compared to unvaccinated animals. They further showed that the presence of anti-S IgG prior to viral clearance skewed the wound-healing response of macrophages into a pro-inflammatory response. In another study, Wang et al. immunized macaques with four B-cell peptide epitopes of the SARS-CoV S protein and demonstrated that while three peptides elicited antibodies that protected macaques from viral challenge, one of the peptide vaccines induced antibodies that enhanced infection in vitro and resulted in more severe lung pathology in vivo.

Conclusion

ADE has been observed in SARS, MERS and other human respiratory virus infections including RSV and measles, which suggests a real risk of ADE for SARS-CoV-2 vaccines and antibody-based interventions. However, clinical data has not yet fully established a role for ADE in human COVID-19 pathology. Steps to reduce the risks of ADE from immunotherapies include the induction or delivery of high doses of potent neutralizing antibodies, rather than lower concentrations of non-neutralizing antibodies that would be more likely to cause ADE. Going forwards, it will be crucial to evaluate animal and clinical datasets for signs of ADE, and to balance ADE-related safety risks against intervention efficacy if clinical ADE is observed. Ongoing animal and human clinical studies will provide important insights into the mechanisms of ADE in COVID-19. Such evidence is sorely needed to ensure product safety in the large-scale medical interventions that are likely required to reduce the global burden of COVID-19.

End of excerpts

https://www.nature.com/articles/s41564-020-00789-5

My comments: one thing of great concern regarding ADE with these vaccines is that they are beginning to show that the neutralizing antibody levels drop rapidly one recent study showing that happens within 10 weeks after vaccination. If you lose the neutralizing antibodies and all you have left are the binding (non-neutralizing) antibodies the risk of ADE goes up substantially when that person is later challenged with the wild virus.

This next story demonstrates that concern.

Scientists finding the neutralizing antibodies drop quickly after vaccination and "breakthrough" cases are epidemic

A July 27th, 2021 article from the ***Guardian*** titled **UK scientists back Covid boosters as study finds post-jab falls in antibodies**, provides insights into the waning of the important neutralizing antibodies shortly after vaccination.

From the article

The UCL Virus Watch study found that antibodies generated by two doses of the Oxford/AstraZeneca and Pfizer/BioNTech vaccines started to wane as early as six weeks after the second shot, in some cases falling more than 50% over 10 weeks.

The UCL team analysed blood from 605 vaccinated people mostly in their 50s and 60s. They found that antibody levels varied widely between patients, but a double dose of Pfizer/BioNTech tended to produce far more antibodies against the coronavirus than two shots of the Oxford/AstraZeneca vaccine.

Three to six weeks after full vaccination with Pfizer, antibody levels typically stood at about 7,500 units per millilitre (ml), but more than halved to 3,320 units per ml after 10 weeks. For AstraZeneca, antibody levels peaked at about 1,200 units per ml and typically fell to 190 units per ml after 10 weeks. Since publishing the results in a letter to the Lancet, the researchers have seen the same trend in a further 4,500 participants in the study.

"We know levels of antibodies start high and drop substantially," said Prof Rob Aldridge, an infectious disease epidemiologist at University College London. "We're concerned that if they carry on dropping at the rate we've seen, the protective effects of the vaccines will start to drop too, and the big question is, when is that going to happen?"

End of excerpts

https://www.theguardian.com/world/2021/jul/22/uk-scientists-back-covid-boosters-as-study-finds-post-jab-falls-in-antibodies

My comment: While this is true that antibody levels drop after natural infection and after vaccines, as I have reported in other issues of my newsletter, the antibody levels do not seem to drop this rapidly after natural

infection and they remain at decent levels at least 8 months after the infection. And, other published research shows that after natural infection from COVID-19, there is a strong population of resident memory cells in the bone marrow that are ready to activate and kick out robust levels of antibodies when future exposure to the virus occurs. I just haven't seen evidence that vaccines produce memory cells to a significant degree or that are as robust or durable as seen after natural infection.

Another concerning article

Another article preview in ***Nature,*** published online and titled **Reduced sensitivity of SARS-CoV-2 variant Delta to antibody neutralization**, raises concerns about the Delta Variant being resistant to neutralizing antibodies from the vaccines, thus its ability to "escape" the vaccine's protection.

The abstract

The SARS-CoV-2 B.1.617 lineage was identified in October 2020 in India[1-5]. It has since then become dominant in some indian regions and UK and further spread to many countries[6]. The lineage includes three main subtypes (B1.617.1, B.1.617.2 and B.1.617.3), harbouring diverse Spike mutations in the N-terminal domain (NTD) and the receptor binding domain (RBD) which may increase their immune evasion potential. B.1.617.2, also termed variant Delta, is believed to spread faster than other variants. Here, we isolated an infectious Delta strain from a traveller returning from India. We examined its sensitivity to monoclonal antibodies (mAbs) and to antibodies present in sera from COVID-19 convalescent individuals or vaccine recipients, in comparison to other viral strains. Variant Delta was resistant to neutralization by some anti-NTD and anti-RBD mAbs including Bamlanivimab, which were impaired in binding to the Spike. Sera from convalescent patients collected up to 12 months post symptoms were 4 fold less potent against variant Delta, relative to variant Alpha (B.1.1.7). Sera from individuals having received one dose of Pfizer or AstraZeneca vaccines barely inhibited variant Delta. Administration of two doses generated a neutralizing response in 95% of individuals, with titers 3 to 5 fold lower against Delta than Alpha. Thus, variant Delta spread is associated with an escape to antibodies targeting non-RBD and RBD Spike epitopes.

https://pubmed.ncbi.nlm.nih.gov/34237773/

Another…

The ***Times*** of Israel reports that the vaccine quickly wanes after 4 to 5 months. The article is titled, **HMO: Early vaccinees are twice as likely to catch COVID as later recipients**

From the article…
People vaccinated before late February are twice as likely to catch the coronavirus than other inoculated Israelis, according to new research.

“We looked at tens of thousands of people tested in the month of June, alongside data on how long had passed since their second shot, and found that those vaccinated early were more likely to test positive,” Dr. Yotam Shenhar, who headed the research, told The Times of Israel.

“This definitely reinforces the argument for giving a third vaccine dose to the elderly.”

The report, published by the healthcare provider Leumit, comes on the heels of other Israeli studies that suggest a decreasing vaccine effectiveness, partly as a result of the Delta variant and partly because of the passage of time.

Data released by the Health Ministry on Thursday suggested that people vaccinated in January were said to have just 16% protection against infection now, while in those vaccinated in April the effectiveness was at 75%.

“Now we see vaccination effectiveness drops, so it seems we definitely need to think about a third vaccine,” he said. “We have started already by giving the immunocompromised, but in my assessment we need to consider giving third shots to everyone over 70 or 80. We shouldn’t wait long; we need to make a decision fast.”

In his study, the apparent waning effect in immunity was felt across all ages. For all age groups, early vaccinators were 1.95 times more likely to be confirmed coronavirus positive. Among those aged 60-plus, early vaccinators are twice as likely to get infected. For those aged 40-59 early vaccinators are 2.1 times more vulnerable, and among under 39s they are 1.6 more likely to catch the coronavirus.

“In a previous analysis we showed that as time passes since the vaccine, the level of antibodies drops at a rate of about 40% per month. This new study builds a clearer picture of the effect seen in the months after vaccination,” said Shenhar.

Israel has seen a dramatic rise in recent COVID-19 infections, with the daily caseload rising from several dozen to over 1,400 in recent days.

End of excerpts

https://www.timesofisrael.com/hmo-those-who-inoculated-early-twice-as-likely-to-catch-covid-as-later-adopters/

One more bombshell report. This time from the CDC…

A CDC, yes CDC report shows 74% of people infected in a Massachusetts outbreak we're fully vaccinated

This July 30th ***CNBC*** article titled, **CDC study shows 74% of people infected in Massachusetts Covid outbreak were fully vaccinated**, is another of the explosive stories we are seeing all over media this past week about

the fact that breakthrough infections are commonplace and not rare as we have been told to believe ad nauseum. Apparently that dam is breaking and now a flood of stories are coming out. BUT, even though they can no longer claim that infections are "rare" if you've been vaccinated, or that you can't transmit to others, of course they're still putting a spin on these latest "revelations". And the spin is that at least if you're vaccinated your illness will not be as severe, will not land you in the hospital, and make you much less likely to die. Well, we have already seen from reporting earlier in this newsletter that that is absolutely not the case. But trust me that they will hang on to that narrative as long as they possibly can in order to continue to push the vaccines. Which honestly is the exact opposite thing of what we should be doing as discussed earlier in this newsletter according to many of the scientists and vaccine experts in the world. This will just continue to push the evolutionary mutations in the virus and could eventually create a monster that even natural immunity may be significantly challenged by. It would be like not recognizing that indiscriminately pushing antibiotics on everybody that has a sniffle will eventually create superbugs that no antibiotic will be able to defeat. Oh wait, the medical profession has been doing that for decades and antibiotic resistant infections now kill well over 100,000 people a year in the U.S. Have we not learned anything from prior mistakes?

From the article
About three-fourths of people infected in a Massachusetts Covid-19 outbreak were fully vaccinated against the coronavirus with four of them ending up in the hospital, according to new data published Friday by the Centers for Disease Control and Prevention.

The new data, published in the U.S. agency's Morbidity and Mortality Weekly Report, also found that fully vaccinated people who get infected carry as much of the virus in their nose as unvaccinated people, and could spread it to other individuals.

"This finding is concerning and was a pivotal discovery leading to CDC's updated mask recommendation," CDC Director Dr. Rochelle Walensky said in a statement. "The masking recommendation was updated to ensure the vaccinated public would not unknowingly transmit virus to others, including their unvaccinated or immunocompromised loved ones." **My comment:** As if masks will make a difference. That notion has been dispelled by dozens of studies over the years including in 2020, many of which I have on my website (https://wellnessdoc.com). Yet, they continue to promote an unscientific, disproven and harmful policy like the zealots they are.

Article continued…
On Tuesday, the CDC reversed course on its prior guidance and recommended fully vaccinated Americans who live in areas with high Covid infection rates resume wearing face masks indoors. The guidelines cover about two-thirds of the U.S. population, according to a CNBC analysis.

End of excerpts

https://www.cnbc.com/2021/07/30/cdc-study-shows-74percent-of-people-infected-in-massachusetts-covid-outbreak-were-fully-vaccinated.html

One more from the CDC…

The Dirty little secret that vaccinated people can get infected or spread the virus is finally out of the bag

To build on all the other examples I have in this newsletter regarding the previously perpetrated misinformation campaign comes a new story as reported by ***NBC News*** in an article online July 30th, 2020 titled, **CDC warns in internal document that 'war has changed' with the coronavirus.**

From the article
The Centers for Disease Control and Prevention has issued a stern warning about the delta variant of the coronavirus: "Acknowledge the war has changed." Now, it says even vaccinated people are able to readily spread the virus.

That is part of the message from a recent internal presentation prepared by the CDC detailing findings, some of which are considered preliminary, on the dangers posed by the delta variant, which has already led to a spike in cases in the United States. The document, obtained Friday by NBC News and first published by The Washington Post, explains the scientific background behind the agency's change in mask guidance earlier this week.

It concludes that the delta variant is "highly contagious, likely to be more severe" and that "breakthrough infections may be as transmissible as unvaccinated cases."

Researchers have been focusing on viral load — a term for just how much of the virus is present in infected peoples' bodies — which can affect transmissibility and severity. Infections with the delta variant lead to higher levels of virus in the body, even in breakthrough cases in fully vaccinated individuals, the document said. Virus levels can be as high in breakthrough cases as in unvaccinated people, even if vaccinated people don't get nearly as sick. **My comment:** *This myth over lower severity is dispelled by many other stories in this issue.*

What's more, these higher levels also persist for longer than was seen with previous strains, meaning an infected person is likely contagious for longer.

End of excerpts

https://www.nbcnews.com/science/science-news/cdc-warns-internal-document-war-has-changed-coronavirus-n1275478

Once again, this really proves that we are playing with fire by continuing to push these ineffective vaccines.

A report from the UK dispels the narrative that disease is always less severe in the vaccinated, as it is reported that 87% of deaths are in the fully vaccinated

The July 29th article in ***The Daily Expose*** titled, **EXCLUSIVE – Covid-19 deaths are rising and official data shows 87% of the people who have died were Vaccinated**, shows how data is often reported in such a way as to hide the real impact of the true numbers. It also shows that the further we go down the road since the vaccinations have started, a very disturbing trend is becoming apparent. Serious illness and deaths in the fully vaccinated appeared to be rising overtime. This could be a foreshadowing of what the many experts we have reported on over the months preceding have been warning about, and that is Antibody Dependent Enhancement (ADE) in vaccinated individuals. This is not unexpected as this phenomenon is one of the reasons why previous attempts to make coronavirus vaccines Have never made it past the animal trials. Unfortunately, due to the warp speed efforts of pushing this vaccine on the public as quickly as possible the proper animal trials were never done. That would have required vaccinating the animals and then waiting until the immunity begins to wane before exposing them to the wild virus again. Had they done that, they may very well have found that a high percentage of those animals not only got sick but died. This could have saved countless lives that now stand to be lost since millions of humans have replaced that portion of the clinical trials.

From the article

Public Heath Scotland (PHS) have released a weekly report on Covid-19 statistics covering data on testing, vaccinations, hospitalisations and deaths. We've been studying the reports by the week and recently told you how the report released on the 23rd June 2021 announced that 5,522 people had died within 28 days of having a Covid-19 vaccine in Scotland.

A few weeks ago we noticed that Public Health Scotland were being very clever with the way they were presenting the data, in what seems to be an attempt to hide a shocking statistic in regards to Covid-19 deaths and the Covid-19 vaccine. Unfortunately for PHS, they weren't quite clever enough, as their latest report has allowed us to uncover the shocking statistic that they were attempting to hide.

Public Health Scotland have been presenting data on cases, hospitalisations, and deaths by vaccination status. However, we noticed that they were particularly clever in the way they were presenting the data on deaths.

The data on both cases and hospitalisations has been presented with a total for each week within the last 4 weeks prior to the date of the report.

For instance, table 15 of their 28th July report on the number of alleged Covid-19 positive cases is presented as follows –

See the next page…

Overall results of COVID-19 cases and hospitalisations, and deaths by vaccination status

COVID-19 cases by vaccination status

Table 15: Number of COVID-19 positive cases individuals by week and vaccination status, 26 June 2021 to 23 July 2021

	No. of COVID-19 cases / No. of people eligible for COVID-19 vaccination or vaccinated (%)		
Week	Unvaccinated	1 Dose	2 Doses
26 June 2021 - 02 July 2021	14,457 / 1,436,957 (1.006%)	4,082 / 908,273 (0.449%)	4,360 / 2,553,943 (0.171%)
03 July 2021 - 09 July 2021	11,128 / 1,303,773 (0.854%)	3,601 / 933,904 (0.386%)	4,386 / 2,661,496 (0.165%)
10 July 2021 - 16 July 2021	7,554 / 1,185,784 (0.637%)	3,180 / 970,834 (0.328%)	3,716 / 2,742,555 (0.135%)
17 July 2021 - 23 July 2021	4,937 / 1,072,563 (0.460%)	2,373 / 973,507 (0.244%)	3,023 / 2,853,103 (0.106%)

Vaccination status is determined as at the date of PCR specimen date according to the definitions described above. The data displayed within the greyed-out section (3 days) are considered preliminary and are subject to change as more data is updated.

The above clearly shows that the majority of positive cases of Covid-19 between 26th June and 23rd July have been people who weren't vaccinated, accounting for 57% of all cases. However, in the most recent week, between 17th July and 23rd July we can see that the tables have turned and those who've had the Covid-19 vaccine account for 52% of positive cases.

Table 16 of PHS 28th July report is also presented in the same fashion, showing weekly totals within the past four weeks on the number of Covid-19 related hospital admissions –

Table 16: Number of COVID-19 related acute hospital admissions by week and vaccination status, 26 June 2021 to 23 July 2021

	No. of COVID-19 related acute hospitalisations / No. of people eligible for COVID-19 vaccination or vaccinated (%)		
Week	Unvaccinated	1 Dose	2 Doses
26 June 2021 - 02 July 2021	163 / 1,436,957 (0.011%)	42 / 908,273 (0.005%)	139 / 2,553,943 (0.005%)
03 July 2021 - 09 July 2021	266 / 1,303,773 (0.020%)	43 / 933,904 (0.005%)	228 / 2,661,496 (0.009%)
10 July 2021 - 16 July 2021	238 / 1,185,784 (0.020%)	46 / 970,834 (0.005%)	229 / 2,742,555 (0.008%)
17 July 2021 - 23 July 2021	197 / 1,072,563 (0.018%)	37 / 973,507 (0.004%)	167 / 2,853,103 (0.006%)

Vaccination status is determined as at the date of positive PCR test according to the definitions described above. The data displayed within the greyed-out section (1 week) are considered preliminary and are subject to change as more data is updated.

The above shows a slightly different story though to what we have seen in terms of confirmed cases. That's because the majority of hospital admissions have been people who have been vaccinated, accounting for 50.8% of all admissions. What's interesting about this is the number of admissions against the number of alleged positive cases.

From the 26th June to the 23rd July 2021, PHS claim that 38,067 positive cases of Covid-19 were confirmed in the unvaccinated population. However, within the same time frame just 15,485 positive cases of Covid-19 were confirmed in the fully vaccinated population.

However, of the unvaccinated population, 863 people have been hospitalised in the same time frame. Whereas of the fully vaccinated population, 763 people have been hospitalised in the same time frame.

This means that just 2.3% of confirmed Covid-19 cases in the unvaccinated population have resulted in hospitalisation. Whereas 5% of confirmed Covid-19 cases in the fully vaccinated population have resulted in hospitalisation. There is a slight flaw to this analysis in respect of there will be a lag between a confirmed case and hospitalisation, but even so this clearly shows that the jabs are not quite doing what they claim to do "on the tin".

The Covid-19 vaccines were only allegedly proven to reduce the risk of hospitalisation and death, however the methods used to prove this are highly questionable. Therefore to measure the effectiveness of the vaccines in the real world we shouldn't be looking at how many people have been hospitalised or died due to Covid-19 against the number of people vaccinated or not vaccinated. We should be looking at how many people have been hospitalised or died due to Covid-19 against the number of people allegedly infected with Covid-19 by their vaccination status.

Using that measure against the above data we can clearly see the fully vaccinated have got a problem, because it looks like if they are infected with Covid-19 they are much more likely to be hospitalised than if they were not vaccinated.

But we're afraid the data shows that being hospitalised is the least of their worries, even if Public Health Scotland have tried their hardest to conceal it.

Tracking data from December 29th, the onset of the vaccination program- This notation and the bolding below are mine to make it easier to see the category differences better.

- As of the **8th July**, 2,962 deaths were in the **unvaccinated** population. As of the **15th July**, 2,967 deaths were in the **unvaccinated** population. This is **an increase of 5.**

- As of the **8th July**, 257 deaths were people who'd had just **one dose** of a Covid-19 vaccine, however they may have had two doses due to PHS adding them to the one dose figures if their second dose was less than 14 days prior to their death. As of the **15th July**, 262 people who'd had just one dose of a Covid-19 vaccine had died of Covid-19. This is **an increase of 5.**

- As of the **8th July**, 64 deaths were in the **fully vaccinated population**. As of the **15th July**, 92 deaths were in the fully **vaccinated population**. This is **an increase of 28**.

This means that people who've been vaccinated against Covid-19 account for 87% of the deaths in the third wave of deaths in Scotland that have just begun. The fully vaccinated account for 74% of the deaths that have only just begun to occur again, those who'd had a single dose account for 13% of the deaths, and the

unvaccinated account for just 13% of the deaths. This is despite the fact the fully vaccinated account for just 23% of the cases seen in the previous four weeks.

By unpicking the data that Public Health Scotland have cleverly attempted to hide we have proven that you are more likely to be hospitalised and more likely to die if you are infected with Covid-19 after being vaccinated.

Antibody-dependent enhancement occurs when the antibodies generated during an immune response recognise and bind to a pathogen, but they are unable to prevent infection. Instead, these antibodies act as a "Trojan horse," allowing the pathogen to get into cells and exacerbate the immune response.
We were warned this is what the Covid-19 vaccines would cause based on the evidence produced in previous decades, the data we've just uncovered shows that the public should have heeded those warnings.

End of excerpts

https://dailyexpose.co.uk/2021/07/29/87-percent-covid-deaths-are-vaccinated-people/

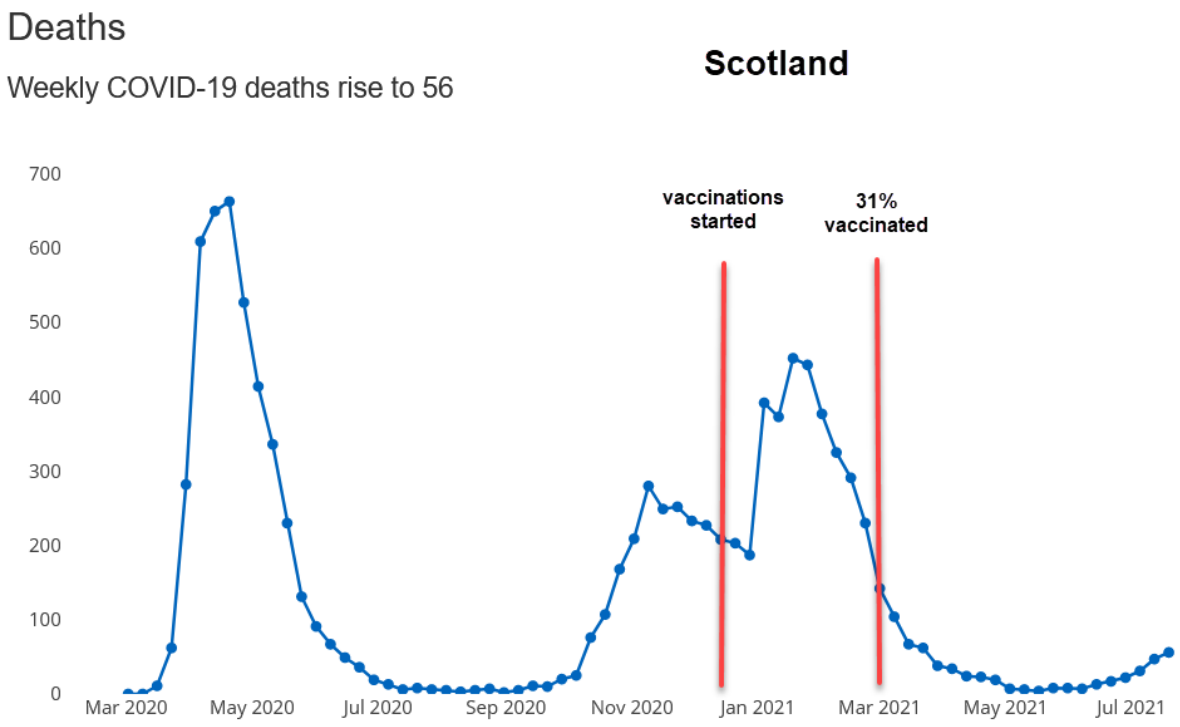
This is an example of how statistics can be deceptive.

Table 17: Number of confirmed COVID-19 related deaths by vaccination status at time of the most recent PCR positive specimen date, 29 December 2020 to 08 July 2021

Age group	Unvaccinated	1 Dose	2 Doses	Total
< 40	21	1	0	**22**
40-49	55	1	1	**57**
50-59	184	5	1	**190**
60-69	412	13	5	**430**
70-79	765	43	26	**834**
80+	1,525	194	31	**1,750**
Total	**2,962**	**257**	**64**	**3,283**

Vaccination status is determined as at the most recent PCR positive specimen date according to the definitions described above.

Looking at this chart, on face value it would appear that the unvaccinated represent a far higher percentage of deaths due to COVID-19 than the vaccinated. But that chart accounts for all COVID deaths since December 29th when only 1.9% of the population was vaccinated. Therefore 98% were unvaccinated. Thus nearly 100% of deaths accumulating during that time period were all in unvaccinated people. By January 27th only 9% had been vaccinated (91% unvaxxed) and by March 3rd, only 31% had been vaccinated (69% unvaxxed). In addition, as you will see from the graph below, there was a wave of deaths from COVID in January and February like many other places in the world because of the seasonality of this virus. With such a low percentage of the population being vaccinated at that point it would make sense that the vast majority of deaths would be in the unvaccinated regardless of the "protection" the vaccine may or may not provide.



So back to the table above this graph. It's no surprise that the majority of deaths are in the unvaccinated because of what I just discussed. What is concerning is the trend over the last 30 days. And this seems to be the trend in many countries including the United States. This is something we're going to have to keep a close eye on in the coming weeks and months. And in the meantime, as many health experts not tied with pharma or the government are recommending, I believe we should halt the vaccine program and start a serious debate and unbiased assessment about the risks of continuing to vaccinate masses of people in the middle of a pandemic with a vaccine that does not stop infection or transmission. Once again as I have said hundreds of times, if the vaccine will not prevent infection or transmission how in the world will it ever help us get to herd immunity? This is an especially daunting question considering the vaccines also appear to be weakening a person's innate immune system and overriding the body's nonspecific antibodies which help protect us from a variety of pathogenic viruses we are exposed to.

Don’t take my word for it, I urge you to watch and share the segment where Del Bigtree shows important segments of the interview with Geert Vanden Bossche discussing these very same concerns. You can see that here at the 46-minute mark to the 60 minute mark… https://thehighwire.com/watch/

One last comment about that graph above. In a previous newsletter I showed approximately 30 countries that had a spike in deaths immediately following the institution of their mass vaccination programs. If you look at when this program started and that spike of deaths during January and early February, it looks suspiciously like all of the other countries.

Mixed messaging abounds from the CDC, leading Tucker Carlson to coin a new acronym for CDC

And here's an example…

The absurdity that the CDC and media continue to push the pandemic of the unvaccinated narrative and then this happens….

Dr. Rochelle Wolensky, Director of the CDC in an interview on New Day CNN July 28th, 2021

"I do want to sort of comment, that in some fully vaccinated venues, if they are unmasked and if there are a few people that are transmitting there as a fully vaccinated person, it is possible to pick up disease in those settings we've seen that in some of our outbreaks investigations this summer which is why overall it's so very critical to just get the huge amount of disease in some of these areas down."

You can see this video during the ***Jaxon Report*** on the ***Highwire,*** Episode 226 titled **Ahead of the Curve**.
See that here: https://thehighwire.com/watch/

One expert thinks the vaccines were doomed to fail from the beginning and boosters are not the answer

In a July 14th article posted on his website titled **Not Covid-19 vaccine-mediated but naturally acquired immunity enables herd immunity**, Dr. Geert Vanden Bossche made a case for the superiority of natural immunity and why the vaccines as developed and used during the pandemic were doomed to fail.

He stated the following:

Overall conclusion: From the very beginning of the mass vaccination program, it should have been clear that because of the intrinsic limitations of S-based Covid-19 vaccines and their deployment in mass vaccination campaigns in the midst of a pandemic, herd immunity was simply the last thing this mass vaccination program

could possibly achieve and that moving this program forward would fulfill all the conditions for driving S-directed viral immune escape to eventually result in full resistance of Sars-CoV-2 to the Covid-19 vaccines. Boosting vaccinal Abs with 2nd generation vaccines is not going to solve the issue of immune escape, even if the immunization with 'updated' vaccines would be repeated by 6-month intervals. This is because 2nd generation vaccines will primarily recall S-specific Abs elicited by the first generation vaccines (due to 'antigenic sin') and not be effective against recombinations of Sars-CoV-2 variants, which are highly likely to occur as a result of co-infection, especially in the most vulnerable (see previous critical opinion article: 'Why is the ongoing mass vaccination experiment driving a rapid evolutionary response of SARS-CoV-2?').

https://www.geertvandenbossche.org/post/not-covid-19-vaccine-mediated-but-naturally-acquired-immunity-enables-herd-immunity

Pfizer makes record profits thanks to the boost from its COVID-19 vaccine

Imagine what will happen now as the duration of the vaccine is waning, and boosters will be recommended every 6 months or so.

Mothers pass antibodies produced in response to the COVID-19 vaccines to their babies through breastmilk

Since the incident I reported on in the last topic relating to the truncated mRNA in the batches of the Pfizer vaccine is fresh in your mind, I thought I would follow with this next story.

The authors of this report are excited about the results because think that it is a good idea for mothers to pass antibodies to the engineered spike protein on to their infants through the breastmilk, because they believe that this will help to protect their infants from SARS-CoV-2. At the end of this topic, I will share with you a concern I have in the form of a hypothesis that could play out as a long-term risk for the child.

The research letter was published in the ***Journal of the American Medical Association*** May 18th, 2021. It was titled **Specific antibodies in breast milk after COVID-19 vaccination of breastfeeding women**.

From the article

Results |Eighty-four women completed the study, providing 504 breast milk samples. Women were a mean (SD) age of 34 (4) years and infants 10.32 (7.3) months (Table).

Mean levels of anti–SARS-CoV-2-specific IgA antibodies in the breast milk increased rapidly and were significantly elevated at 2 weeks after the first vaccine (2.05 ratio; $P < .001$), when 61.8% of samples tested positive, increasing to 86.1% at week 4 (1 week after the second vaccine). Mean levels remained elevated for the duration of follow-up, and at week six, 65.7% of samples tested positive. Anti–SARSCoV-2-specific IgG antibodies remained low for the first 3 weeks, with an increase at week 4 (20.5 U/mL; $P = .004$), when 91.7% of samples tested positive, increasing to 97% at weeks 5 and 6 (Figure).

No mother or infant experienced any serious adverse event during the study period. Forty-seven women (55.9%) reported a vaccine-related adverse event after the first vaccine dose **and 52 (61.9%) after the second vaccine dose,** with local pain being the most common complaint (Table). **Four infants developed fever during the study period 7, 12, 15, and 20 days after maternal vaccination. All had symptoms of upper respiratory tract infection including cough and congestion, which resolved without treatment except for 1 infant who was admitted for neonatal fever evaluation due to his age and was treated with antibiotics pending culture results.**

Table. Maternal and Infant Characteristics

	No. (%)
Study participants, No.	84
Maternal features	
Maternal age, mean (SD), y	34 (4)
No. of children, mean (SD)	2.36 (0.98)
Chronic diseases	22 (26.2)
Gestational diabetes	3 (3.6)
First vaccine adverse effects	47 (55.9)
Local pain	40 (47.6)
Fatigue	8 (9.5)
Fever	0
Other	12 (14.3)
Second vaccine adverse effects	52 (61.9)
Local pain	34 (40.5)
Fatigue	28 (33.3)
Fever	10 (11.9)
Other	22 (26.2)
Infant related features	
Vaginal delivery mode	78 (92.9)
Infant age at time of first maternal vaccine, mean (SD), mo	10.32 (7.31)
Birth week, mean (SD)	39.01 (1.95)
Birth weight, mean (SD), g	3175.27 (502.33)
Exclusive breastfeeding	35 (41.6)

End of excerpts

https://pubmed.ncbi.nlm.nih.gov/33843975/

My comments:
Sixty-two percent of the women suffered adverse events from the second dose of the vaccine. Twenty-two were listed as “other” side effects. I looked for a supplemental table that would show all of the adverse events so that I could see what other kinds of side effects the women were getting. We were told that none of them had serious side effects, but then why don't they publish all of the side effects? This is suspect.

Also, one of the four infants that developed upper respiratory infections was hospital sized and started on antibiotics pending a culture. I thought it strange that they didn't publish the results of that culture. If those lab results came back with that infant having COVID-19, that have a devastating impact on the outcome of the study. I would think if the culture would have come back with something other than that, they would have made that known to prevent this kind of speculation. This is also suspect. In addition, if you look at the bottom of the table only 35 of the 84 women were exclusively breastfeeding. With four children developing upper respiratory infections, it would be very interesting to know whether the children that developed these infections were part of the group of babies that were exclusively breastfed or not.

One last observation. The conclusion that none of the infants had suffered adverse reactions to he these antibodies is premature. And here is where my hypothetical comes in. The report did not reveal whether a long-term follow-up study is to be continued with these infants, but because of the experimental nature of this biological that their mother had taken it would certainly be a great idea. We know from the report I shared about the denaturing of the synthetic messenger RNA resulting in truncated (shortened) pieces of the spike protein in the Pfizer vaccines that was discovered during the computer hacking incident of the ***European Medicines Agency*** covered in this issue. A HUGE concern with that is the bits and pieces that are injected into the body will also be copied by the ribosomes of the cells and the body will spit out billions of those copies. If those random Yeah amino acid sequences happen to match one or more of your body's own proteins, it could be setting you up for a variety of autoimmune diseases.

Informed consent is the hallmark of ethical responsibility for all medical procedures and medications. Yet, for vaccines it has always been sorely lacking.

In a March 2021 article published in ***Perspective- Infectious Diseases*** titled **Informed consent disclosure two vaccine trial subjects of risk of COVID-19 vaccines worsening clinical disease**, authors are critical of the lack of patient informed consent revolving around COVID-19 vaccines the risk of causing Antibody Dependent Enhancement (ADE), or what is sometimes called Pathogenic Priming. The section I have pasted here goes through a nice history of why many top scientists and medical experts have been terrified about the prospect of this developing in some people. In fact, as I have reported in previous issues of this newsletter, there have been thousands of reports world-wide of incidents of previously uninfected people developing severe COVID-19, with many dying after they have had their shots. These have been roundly dismissed as unfortunate coincidences.

From the article-

Results of the study: COVID-19 vaccines designed to elicit neutralizing antibodies may sensitise vaccine recipients to more severe disease than if they were not vaccinated. Vaccines for SARS, MERS and RSV have never been approved, and the data generated in the development and testing of these vaccines suggest a serious mechanistic concern: that vaccines designed empirically using the traditional approach (consisting of the unmodified or minimally modified coronavirus viral spike to elicit neutralising antibodies), be they composed of protein, viral vector, DNA or RNA and irrespective of delivery method, may worsen COVID-19 disease via antibody-dependent enhancement (ADE). This risk is sufficiently obscured in clinical trial protocols and consent forms for ongoing COVID-19 vaccine trials that adequate patient comprehension of this risk is unlikely to occur, obviating truly informed consent by subjects in these trials.

Conclusions drawn from the study and clinical implications: The specific and significant COVID-19 risk of ADE should have been and should be prominently and independently disclosed to research subjects currently in vaccine trials, as well as those being recruited for the trials and future patients after vaccine approval, in order to meet the medical ethics standard of patient comprehension for informed consent.

Vaccine-elicited enhancement of disease was also observed with the SARS and MERS viruses and with feline coronavirus, which are closely related to SARS-CoV-2, the causative pathogen of COVID-19 disease. The immune mechanisms of this enhancement have invariably involved antibodies, from direct antibody-dependent enhancement, to immune complex formation by antibodies, albeit accompanied by various coordinated cellular responses, such as Th2 T-cell skewing.2-7 Notably, both neutralizing and non-neutralising antibodies have been implicated. A recent study revealed IgG-mediated acute lung injury in vivo in macaques infected with SARS that correlated with a vaccine-elicited, neutralizing antibody response.8 Inflammation and tissue damage in the lung in this animal model recapitulated the inflammation and tissue damage in the lungs of SARS-infected patients who succumbed to the disease. The time course was also similar, with the worst damage occurring in delayed fashion in synchrony with ramping up of the immune response. Remarkably, neutralising antibodies controlled the virus in the animal, but then would precipitate a severe, tissue damaging, inflammatory response in the lung. This is a similar profile to immune complex-mediated disease seen with RSV vaccines in the past, wherein vaccinees succumbed to fatal enhanced RSV disease because of the formation of antibody-virus immune complexes that precipitated harmful, inflammatory immune responses. It is also similar to the clinical course of COVID-19 patients, in whom severe COVID-19 disease is associated with the development of anti-SARSCoV- 2 serum antibodies,[9] with titres correlating directly with the severity of disease.[10] Conversely, subjects who recover quickly may have low or no anti-SARS-CoV-2 serum antibodies.[11]

End of excerpts

https://pubmed.ncbi.nlm.nih.gov/33113270/

Once again, we see the strategy to erase the placebo group

There was a May 18th, 2021 feature article in the ***British Medical Journal*** by Peter Doshi, senior editor titled **COVID-19 vaccines: in the rush for regulatory approval do we need more data?** One of these significant points the article makes is as I have predicted earlier, vaccine makers are allowing people that were in the control group, meaning those not getting the vaccines (instead the placebo) to now get the vaccines. This practice essentially erases the placebo group making it impossible to follow up with their health months and

years down the road. This would be critical in order to compare the kinds of illnesses they develop to the groups that received the vaccines. This is a sleight of hand that vaccine manufacturers have done with virtually every other vaccine they have developed. It is a way of hiding adverse changes in health outcomes down the road in those receiving the vaccines.

From the article

The BMJ asked Moderna, Pfizer, and Janssen (Johnson and Johnson) what proportion of trial participants were now formally unblinded, and how many originally allocated to placebo have now received a vaccine. Pfizer declined to say, but Moderna announced that "as of April 13, all placebo participants have been offered the Moderna covid-19 vaccine and 98% of those have received the vaccine."2 In other words, the trial is unblinded, and the placebo group no longer exists.

Janssen told *The BMJ*: "Wedo not have specific figures on how many of our study participants have received a vaccine at this time." But the company confirmed it was implementing an amended protocol across all countries to unblind all participants in its two phase III trials, the earlier of which passed the median of two month follow-up mark in January.

How the FDA will weigh the loss of blinding and placebo-controlled follow-up is unclear, but just months ago the agency said these trial properties were vital.

End of excerpts

https://www.bmj.com/content/bmj/373/bmj.n1244.full.pdf

My comment: How can the FDA which considered these protocols "vital" allow these for-profit companies to get away with this and still consider full approval? If these companies did not behave in the best interest of investigators to track long term safety and therefore put the public at risk, how can they be rewarded for bad behavior? Is this just another example of the good old boys club protecting the interests of their buddies?

Update from India, the original home of the Delta Variant

Interestingly, the percentages of the Indian population with COVID antibodies is high.

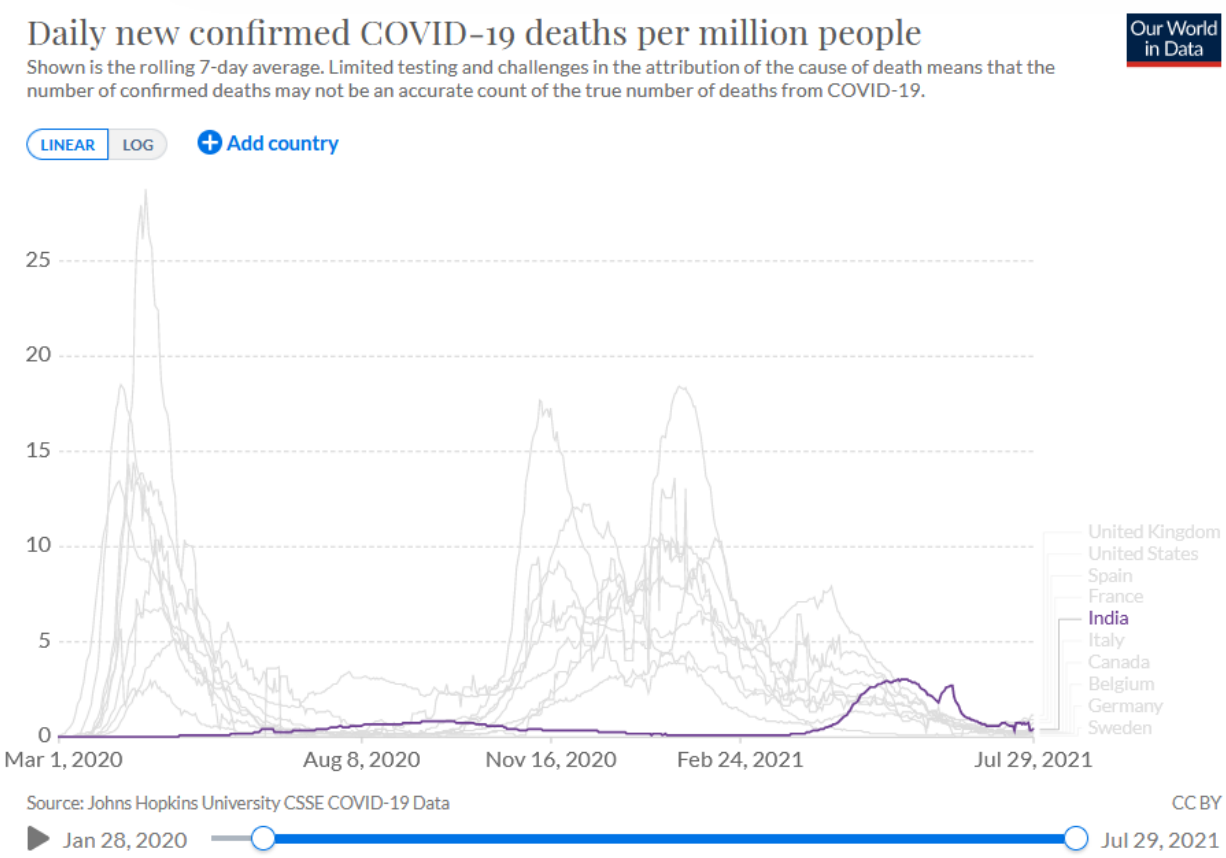
Two-thirds of Indians have coronavirus antibodies, survey shows

July 20, 2021 (Reuters) - Two-thirds of India's population have antibodies against the coronavirus, according to data released on Tuesday from a survey of 29,000 people across the nation conducted in June and July.

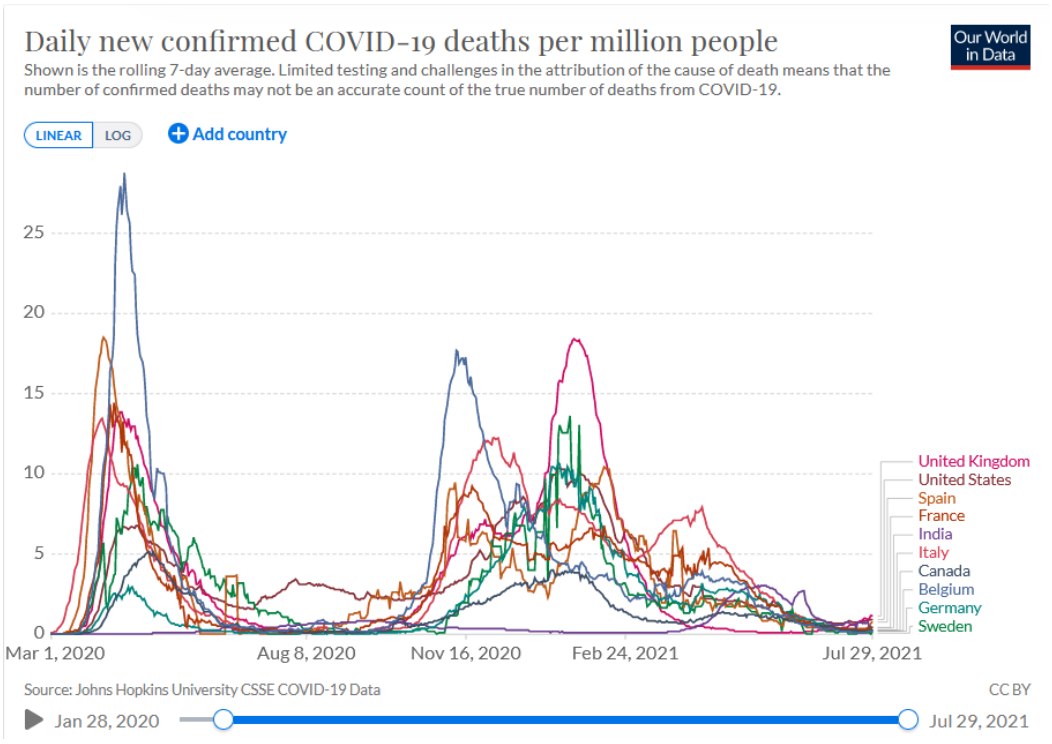
The fourth national blood serum survey which tests for antibodies, known as a sero survey, included 8,691 children aged 6-17 years for the first time. Half of them were seropositive.

The survey showed 67.6% of adults were seropositive, while more than 62% of adults were unvaccinated. As of July, just over 8% of eligible adult Indians had received two vaccine doses.
The study also surveyed 7,252 healthcare workers and found 85% had antibodies, with one in 10 unvaccinated.

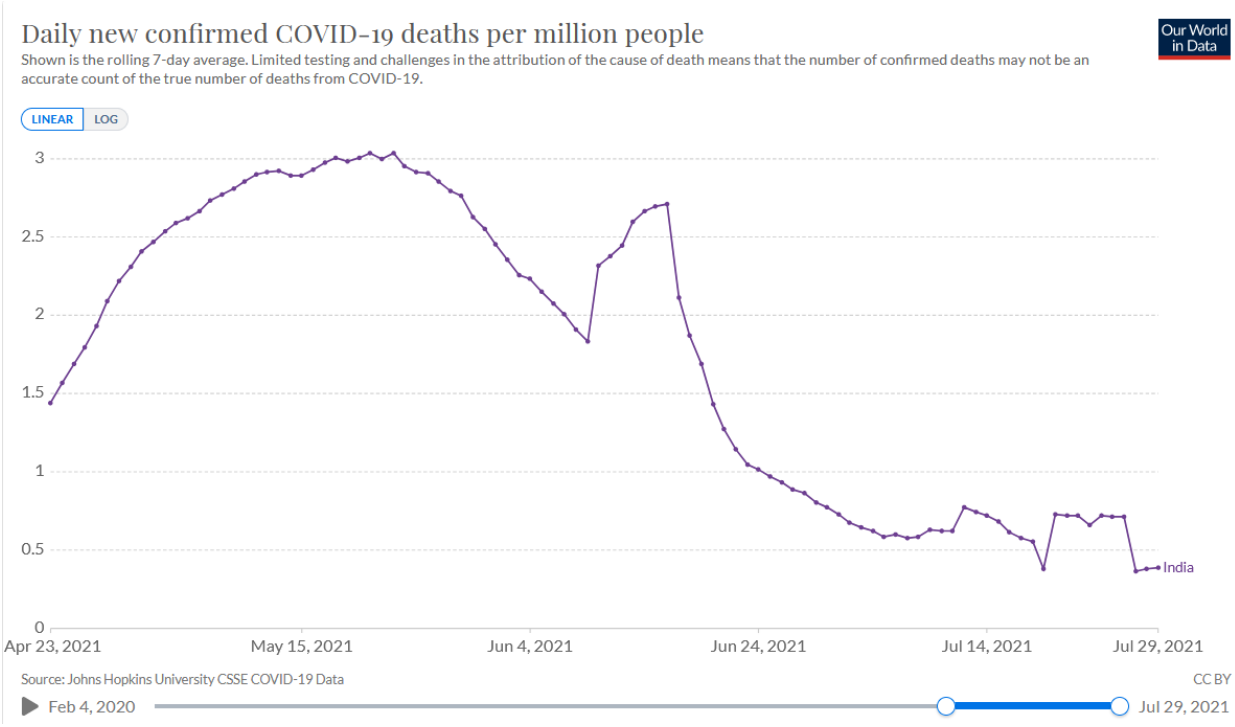
https://www.reuters.com/world/india/india-govt-survey-shows-two-thirds-have-coronavirus-antibodies-2021-07-20/



How does that compare to the U.S. and some European countries?



Expanding the Indian graph, focusing on April 23rd to July 29th shows the dramatic decrease in deaths.



As can be seen, although Delta is contagious and deadly to some people, the pandemic seems to have waned there even though only 7% of the country's population have been vaccinated as of July 30th, 2021. And keep in mind as reported earlier in this story, it is estimated that two thirds of India's population have had the SARS-CoV-2 infection and are now immune.

"A Pandemic of the Unvaccinated"- What is the TRUTH?

The latest reports that 99% of all COVID-19 deaths are in unvaccinated people in the U.S. is an absurd lie. And that's not the only lie we have been told. There is an abundance of them. Here are just some of them and the proof as to their fallacy.

1. **The vaccines are failing-** The U.S. would have to be an anomaly compared to other nations. Israel the country with the highest vaccination rates in the world reports that people that were vaccinated in January have already lost a good portion of their protection according to ***Pfizer Chief Scientific Officer*** Mikael Dolsten. "The Pfizer vaccine is highly active against the Delta variant," Dolsten said in an interview, according to *Reuters*. But after six months, he said, "there likely is the risk of reinfection as antibodies, as predicted, wane."

   In addition, England reports that **43% of their hospitalizations and deaths are in fully vaccinated people** as this table clearly shows. The report from ***Public Health England*** is titled**, SARS-CoV-2 variants of concern and variants under investigation in England** and was published June 25th, 2021.

See the table on the next page…

SARS-CoV-2 variants of concern and variants under investigation

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001359/Variants_of_Concern_VOC_Technical_Briefing_16.pdf

Table 4. Attendance to emergency care and deaths by vaccination status among Delta confirmed cases (sequencing and genotyping) in England, 1 February 2021 to 14 June 2021.

	Total	Cases with specimen date in past 28 days*	Unlinked	Unvaccinated	<21 days post dose 1	≥21 days post dose 1	≥14 days post dose 2
Delta cases since 1 Feb 2021 ¥	60,624	53,177	7,461	35,521	4,094	9,461	4,087
Cases with an A&E visit§ (excluding cases with the same specimen and attendance dates)‡	1,555	NA	14	1,038	116	285	102
Cases with an A&E visit§ (including cases with the same specimen and attendance dates)	2,176	NA	24	1,446	155	378	173
Cases where presentation to A&E resulted in overnight inpatient admission§ (excluding cases with the same specimen and admission dates)‡	488	NA	7	324	30	87	40
Cases where presentation to A&E resulted in overnight inpatient admission§ (including cases with the same specimen and admission dates)	806	NA	10	527	50	135	84
Deaths^	73	NA	2	34	1	10	26 43%

Data sources: Emergency care attendance and admissions from Emergency Care Dataset (ECDS), deaths from PHE daily death data series (deaths within 28 days)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001359/Variants_of_Concern_VOC_Technical_Briefing_16.pdf

And from Israel, the data on people testing positive for COVID is looking even worse for the vaccines.

Israel Confirmed Cases, July 4th – July 10th, Vaccinated* vs. Unvaccinated**

Age Group	Cases, Vaccinated	Cases, Unvaccinated	Percent of Cases Vaccinated	Percent of Population*** Vaccinated
20-29	217	61	78%	77%
30-39	248	84	75%	82%
40-49	356	54	87%	85%
50-59	237	26	90%	89%
60-69	227	14	94%	91%
70-79	143	12	92%	95%
80-89	42	6	88%	91%
קבוצת גיל	נדבקים מחוסנים	נדבקים לא מחוסנים	אחוז נדבקים מחוסנים	אחוז מחוסנים באוכלוסיה

ישראל, מקרי קורונה מאומתים, 4 ביולי עד 10 ביולי, מחוסנים לעומת לא מחוסנים

Source: Israel Ministry of Health Dashboard
https://datadashboard.health.gov.il/COVID-19/general
* *Vaccinated – 2 shots.*
** *Unvaccinated – No shots.*
*** *Excluding population with 1 shot.*

A July 29th, 2021 Tweet by a person that I have been following who is reporting on Israeli health data and someone that I have noticed is being followed by many credible and well known scientists, is reporting some shocking statistics. And thankfully he can interpret Hebrew.

Ran Israeli @RanIsraeli · Jul 29

New update from the Israeli MoH:
The number of deaths in July - Age 60+:
25 deaths=Fully vaxxed.
6 deaths=Not fully vaxxed.
The number of initially reported severe/critical patients - Age 60+ :
182=Fully vaxxed.
46=Not fully vaxxed.
govextra.gov.il/ministry-of-he...
drive.google.com/file/d/1n7ng6G...

How does that contrast to what we are hearing from our media and CDC?

As more proof that they are realizing the vaccines are failing, as ***Forbes*** reports, Pfizer has already petitioned the FDA to authorize a third dose for the fall to try to help keep vaccinated people protected. This is also happening in Israel, the U.K and other countries around the world. https://www.forbes.com/sites/jonathanponciano/2021/07/11/declining-vaccine-efficacy-particularly-among-older-individuals-prompting-pfizers-emergency-booster-request-former-fda-chief-says/

2. **The Delta variant may be more contagious than the original alpha version, but it is also less deadly-** This is the normal evolution of a virus. As they evolve, they become more contagious but less virulent (lethal). This is Virology 101. So, the media and the agencies promoting the vaccines focus on cases rather than the effects those cases are having on people in the way of hospitalizations and deaths.

These are the metrics that matter. If people are getting typical cold or flu symptoms, but never progress in severity to require medical care what is the big deal? They get it, get over it and develop natural immunity to it in the future. How exaggerated are their claims? I went to the CDC's own website showing rates of hospitalizations in the U.S. and found that the current rates for all ages are at the lowest since the beginning of the pandemic.

You can see the CDC graph for yourself here: https://gis.cdc.gov/grasp/COVIDNet/COVID19_3.html

You can see the data from the aforementioned report from ***Public Health England*** titled**, SARS-CoV-2 variants of concern and variants under investigation in England** on page 8 showing that the Delta is far less deadly than the Alpha (UK) virus and other variants.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001359/Variants_of_Concern_VOC_Technical_Briefing_16.pdf

Table 2. Number of confirmed (sequencing) and probable (genotyping) cases by variant as of 14 June 2021

Variant	Confirmed (sequencing) case number	Probable (genotyping) case number*	Total case number	Case Proportion*	Deaths	Case Fatality	Cases with 28 day follow up	Deaths among those with 28 day follow up	Case Fatality among those with 28 day follow up
Alpha	218,332	5,689	224,021	77.9%	4,259	1.9% (1.8 to 2.0%)	217,228	4,252	2.0% (1.9 to 2.0%)
Beta	871	55	926	0.3%	13	1.4% (0.7 to 2.4%)	858	13	1.5% (0.8 to 2.6%)
Delta	31,132	29,523	60,655	21.1%	73	0.1% (0.1 to 0.2%)	5,762	17	0.3% (0.2 to 0.5%)
Eta	441	0	441	0.2%	12	2.7% (1.4 to 4.7%)	428	12	2.8% (1.5 to 4.8%)
Gamma	170	42	212	0.1%	0	0.0% (0.0 to 1.7%)	155	0	0.0% (0.0 to 2.4%)
Kappa	422	0	422	0.1%	1	0.2% (0.0 to 1.3%)	404	1	0.2% (0.0 to 1.4%)
Theta	7	0	7	0.0%	0	0.0% (0.0 to 41.0%)	5	0	0.0% (0.0 to 52.2%)

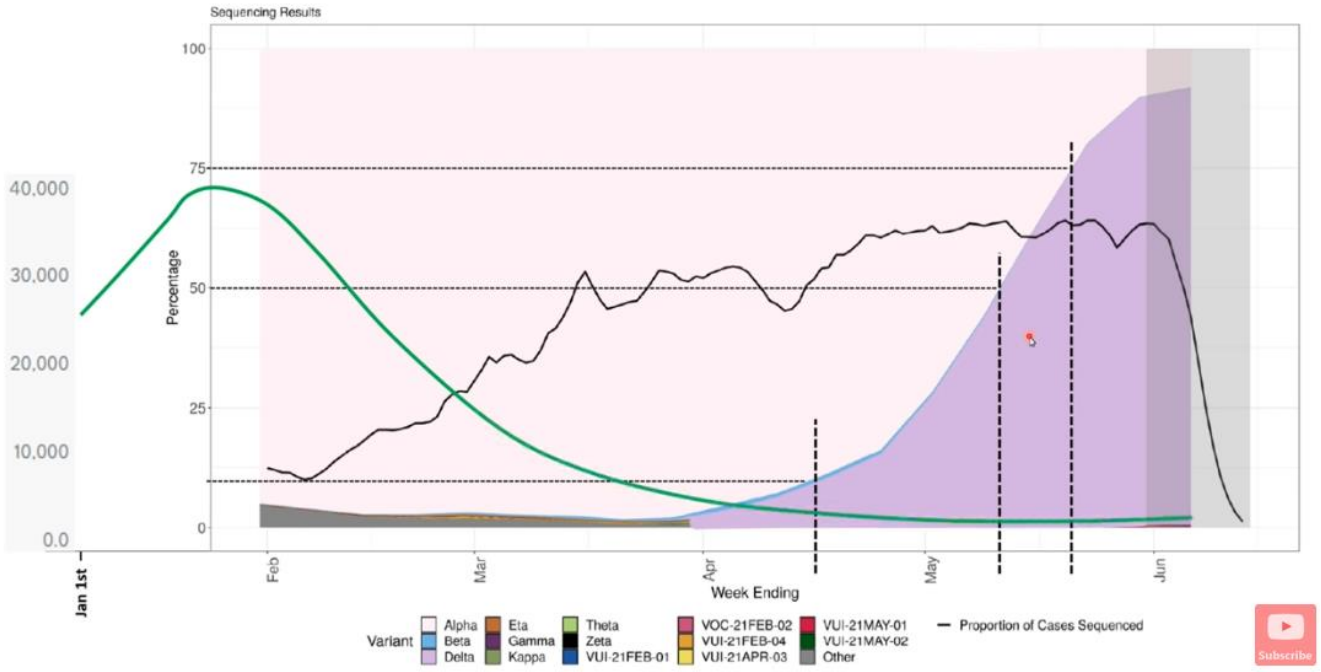
Compare the Delta (Indian) Variant statistics to the Alpha (UK), Beta (South African) or Eta Variants and you will see that it is far less lethal. But you would never know that by listening to the hysterical “misinformation media”.

Want more evidence of the disconnect with what we hear in the media in the U.S. and what they are experiencing elsewhere?

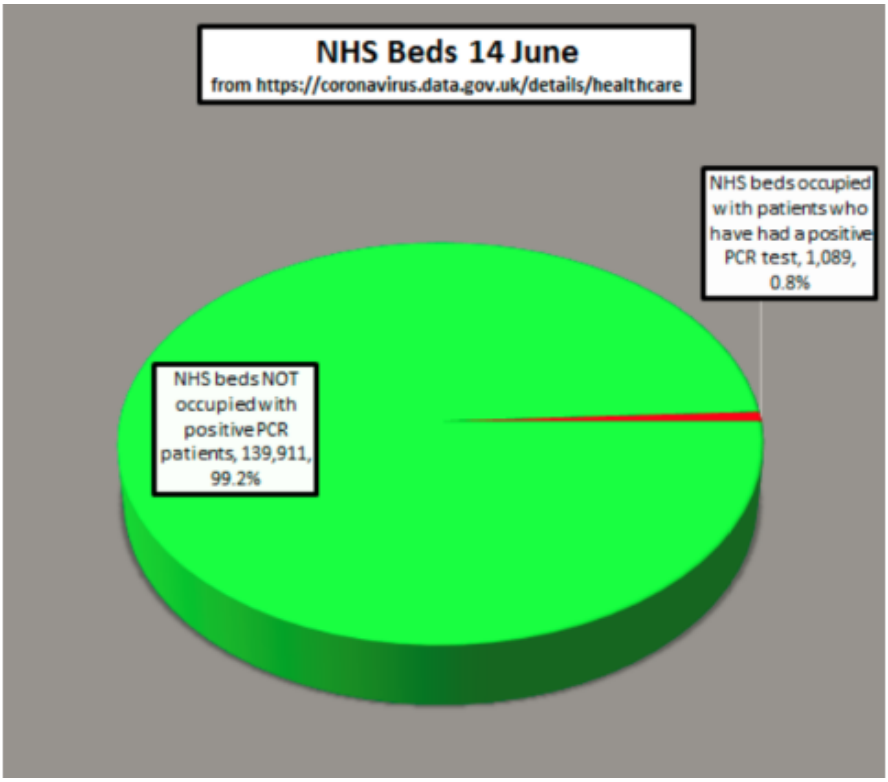
See next page…

A picture is worth a thousand words as they say…This graph shows the dominant Delta Variant in the UK as of a month ago at over 90% of cases. And the green line is representing the rate of hospitalizations over time superimposed on the graph.

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."



3. **Natural infection is far superior to the vaccines**- I have posted at least two dozen studies since May 2020 that show this to be true. Recently in Israel, the following report came from their national health data. The article in ***Israel National News*** titled, **Natural infection vs vaccination: Which gives more protection?** found that **nearly 40% of new COVID patients were vaccinated - compared to just 1% who had been infected previously.** https://www.israelnationalnews.com/News/News.aspx/309762

For more evidence on the lasting immunity after infection see my eBook covering that at https://www.wellnessdoc.com/ebooks-and-publications/

4. **They are playing with the numbers-** An article published in ***The Hill*** July 7th, 2021, titled **Top health expert says vaccinated people are spreading delta variant** reveals several things including what the subtitle says, **"The CDC currently does not require vaccinated individuals to undergo regular testing"**. From the article: Speaking to Insider, Christopher Murray, the director of the ***Institute for Health Metrics and Evaluation***, said that not testing vaccinated people — as the U.S. Centers for Disease Control and Prevention (CDC) recommends — may be overlooking some transmission.

   "We actually have states where hospitalizations are going up more than cases," Murray said, adding that "we're probably missing a bunch of transmission in vaccinated individuals." (bold emphasis mine) My comment: Dah! It's all making sense now. I was asking myself, why are the vaccines failing in other countries leading to high percentages of cases and people being admitted to hospitals, even dying from COVID being in vaccinated individuals, yet we are being told that 99% of people here in the U.S. being admitted to hospitals and dying are unvaccinated. Well, if you don't test the vaccinated when they come to the hospital, you would get very skewed numbers! So the next question is, why would they not test the vaccinated? The CDC knows that the vaccines don't protect against infection or transmission. So why in the world wouldn't they want to know what percent of vaccinated individuals are represented in cases, hospitalization numbers and deaths? Is it because it would reveal the false narrative that the vaccines are going to "help us get back to normal"? Is it because it would encourage vaccine hesitancy? Is it because it would expose the lies that have been told to the public ad nauseum about the vaccine's effectiveness? (See my article from my June newsletter on the Actual Risk Reduction (ARR) and Number Needed to Vaccinate (NNV) to benefit one person). Regardless of the reason, it shows either the corruption or the incompetency of the CDC. Neither bode well for encouraging the trust of the American people.

   https://thehill.com/changing-america/well-being/longevity/561994-top-health-expert-says-vaccinated-people-are-spreading

5. **Why the panic and the desperation? Who is left that "needs" to be vaccinated?**
   All we hear these days is that 50% of the population in unvaccinated. The shrill screams, sense of urgency and desperation is palpable.

   What is the truth? And is the remaining 50% of the population vulnerable to COVID-19 (the disease)? According to CDC estimates, the number of people that have had COVID is approximately 8X the number of known confirmed cases. https://academic.oup.com/cid/article/72/12/e1010/6000389

As of July 17, 2021, there have been 35 million PCR "**confirmed"** cases of COVID-19 in the U.S. Using the CDC's own data and their 8X estimate, that means that approximately 280 million Americans (84%) of the 335 million Americans have had the SARS-CoV-2 infection that will confer to them strong immunity from future infection. Even if that number were just 6X, that would be 210 million people (63%). And based on the 2 dozen or so studies that I have accumulated, that means that they will have a robust and lasting defense against future infection and developing COVID-19, the disease. An immunity that is proving to be much more lasting than the "vaccines". That is because the immune system builds a response to all of the viral proteins, not just the spike protein as with the vaccines. Therefore, when there are natural mutations, especially with the spike protein, the immune system trained from natural infection to recognize other sequences of the virus will still be effective. And reinfections are so rare after someone has had the infection, that there are less than a hundred documented and confirmed cases of over 190 million cases worldwide. Could it be that a large percentage of those 50% holdouts, are in people that have read the science and know that the risk of an experimental vaccine is not worth taking when they are already protected?

And to further the notion that people that have had the infection and recovered need the vaccines flies in the face of all the science that has reported on it thus far, the article from ***Israel National News*** I have included above is a good example of that point. In fact, many experts like Dr. Hooman Noorchashm MD an immunologist have pointed out that it is a **highly risky** practice to vaccinate those that have had it and recovered. https://www.newswars.com/doctors-issue-dire-warnings-about-covid-19-vaccine-dangers/

Getting the vaccines if you had COVID can be dangerous

Here is another reference to an article titled, Self-Reported Real-World Safety and Reactogenicity of COVID-19 Vaccines: A Vaccine Recipient Survey, that showed that people that have had the infection prior to vaccination had a 56% greater risk of more severe reactions leading to hospital care after the vaccines.

In conclusion

This extensive survey of over 2000 recipients of COVID-19 vaccines confirmed the findings of recent randomised controlled trials (RCTs) demonstrating that COVID-19 vaccines are generally safe with limited severe side effects. Moreover, it linked previous COVID-19 illnesses with an increased incidence of vaccination side effects. It also demonstrated that mRNA vaccines caused milder, less frequent systemic side effects but more local reactions *(than the adenovirus vector vaccines).* These findings will need to be validated in clinical studies, preferably randomized controlled trials including patients from multiple groups. (Emphasis mine)

https://pubmed.ncbi.nlm.nih.gov/33803014

In summary, other than a small percentage of adults that haven't had the infection or the vaccine, and those that have done their homework about vaccine risks and have a high vaccine risk awareness I.Q. (especially when considering fast-tracked, protocol short-cut experimental gene therapy shots), that only leaves the children. Yes the children, our future and our treasure. And pharma has their sights on

them, licking their chops with dollar signs in their eyes. I'll get to them shortly, but first let's consider another reason they are using the full-court-press.

So, once again why the desperation in the words and actions of public officials? I believe that there are many forces at work here, but I have a theory about one of them.

The Federal Government has spent tens of billions of dollars investing in the vaccines and the vaccine program. The product they have purchased has a shelf life. They just can't let their investment spoil on the shelf. In fact, one of the reasons that messenger RNA technology has been slow to come to market, is because messenger RNA degrades so rapidly as will be discussed in a ***British Medical Journal Investigation*** I will share with you now. This is one of the reasons they had the extreme cold protocols (-90 degrees F.) for shipping and storage of their products. As we know they have relaxed those policies which the rationale for has never been adequately explained. Regardless, this very likely means that the vaccines will have to be used much more rapidly. Not only that but as I reported in an earlier issue of this newsletter, it was discovered in the UK because of a hacking incident that uncovered emails discussing about an assessment of the quality of the messenger RNA in the vaccine lots and revealed that a significant percentage of messenger RNA proteins sequences did not match the protein sequences of the engineered spike protein as designed. They were truncated or just sections of the spike.

Here is that story as I reported it….

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

From the article:

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

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

EMA scientists tasked with ensuring manufacturing quality—the chemistry, manufacturing, and control aspects of Pfizer's submission to the EMA—worried about "truncated and modified mRNA species present in the finished product." Among the many files leaked to *The BMJ*, an email dated 23 November by a high ranking EMA official outlined a raft of issues. In short, commercial manufacturing was not producing vaccines to the specifications expected, and regulators were unsure of the

implications. EMA responded by filing two “major objections” with Pfizer, along with a host of other questions it wanted addressed.

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

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

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

AN IMPORTANT SECTION AT THE END OF THE ARTICLE:

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

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

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

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

End of excerpts

https://www.bmj.com/content/372/bmj.n627

And now to the kids. The icing on the cake for pharma.

6. **Risks to children-** What is the risk to children from the virus? And does it warrant experimenting on

them with an agent that has no long-term safety data on and a questionable risk benefit profile in the short-term?

As recently reported in a study using data through ***Public Health England (PHE)*** titled, **Deaths in Children and Young People in England following SARS-CoV-2 infection during the first pandemic year: a national study using linked mandatory child death reporting data**, the risk of death to healthy children is statistically zero. It used data from March 1st, 2020, through February 28th, 2021, a total of one year. They used detailed clinical data in the ***National Child Mortality Database (NCMD)***, a comprehensive and unique mandatory national dataset of deaths <18 years of age, to review the contribution of SARS-CoV-2 to death.

Out of over 12 million children under 18 years of age, it was estimated that there were 469,282 that were infected in that years' time. Of that there were only 25 deaths due to COVID-19. That is an Infection Fatality Rate (IFR) of just 0.005%. That is one child dying per 20,000 infected. If you factor out the children that had serious co-morbidities, **only 6 healthy children died and the IFR becomes 0.001% or 1 death in approximately 78,000 total infections.** When comparing those deaths to the entire population of children and young people under the age of 18 (12,023,568 children), it is **1 death for every 2 million children.** Now any death in a child is tragic and in a utopian world none would die. But the reality is that in the same one year that this study evaluated, 3,105 children under age 18 died from all causes in England.

https://www.medrxiv.org/content/10.1101/2021.07.07.21259779v1

Study finds that zero children without underlying health conditions have died from COVID in the U.S.

Recently a team led by Dr. Marty Makary is a medical expert and professor at the ***Johns Hopkins School of Medicine, Bloomberg School of Public Health***, and ***Carey Business School*** discovered that ZERO children died from COVID-19 in the U.S. that did not have any pre-existing health conditions.

Dr. Makary authored a July 19th ***Wall Street Journal*** article titled **The Flimsy Evidence Behind the CDC's Push to Vaccinate Children**, in which he wrote about their findings.

From the article

A tremendous number of government and private policies affecting kids are based on one number: 335. That is how many children under 18 have died with a Covid diagnosis code in their record, according to the Centers for Disease Control and Prevention. Yet the CDC, which has 21,000 employees, hasn't researched each death to find out whether Covid caused it or if it involved a pre-existing medical condition.

Without these data, the CDC Advisory Committee on Immunization Practices decided in May that the benefits of two-dose vaccination outweigh the risks for all kids 12 to 15. I've written hundreds of peer-reviewed medical studies, and I can think of no journal editor who would accept the claim that 335 deaths resulted from a virus without data to indicate if the virus was incidental or causal, and without an analysis of relevant risk factors such as obesity.

My research team at Johns Hopkins worked with the nonprofit FAIR Health to analyze approximately 48,000 children under 18 diagnosed with Covid in health-insurance data from April to August 2020. **Our report found a mortality rate of zero among children without a pre-existing medical condition such as leukemia.** If that trend holds, it has significant implications for healthy kids and whether they need two vaccine doses. The National Education Association has been debating whether to urge schools to require vaccination before returning to school in person. How can they or anyone debate the issue without the right data?

Meanwhile, we've already seen inflated Covid death numbers in the U.S. revised downward. Last month Alameda County, Calif., reduced its Covid death toll by 25% after state public-health officials insisted that deaths be attributed to Covid only if the virus was a direct or contributing factor.

Organizations and politicians who are eager to get every living American vaccinated are following the CDC without understanding the limitations of the methodology. CDC Director Rochelle Walensky claimed that vaccinating a million adolescent kids would prevent 200 hospitalizations and one death over four months. But the agency's Covid adolescent hospitalization report, like its death count, doesn't distinguish on the website whether a child is hospitalized *for* Covid or *with* Covid. The subsequent Morbidity and Mortality Weekly Report of that analysis revealed that 45.7% "were hospitalized for reasons that might not have been primarily related" to Covid-19.

End of excerpts

https://www.wsj.com/articles/cdc-covid-19-coronavirus-vaccine-side-effects-hospitalization-kids-11626706868

Risk comparison-

According to the ***National Safety Council***, the odds of dying in a car crash in 2019 (which is a one-year period) was 1 in 8,393. The odds of them dying in a car crash over the course of 1 year is nearly 10 times greater than the risk when comparing to the number of children that had the infection. When comparing to the entire population under age 18, the risk of dying in a car accident is 239 times greater (23,900%) than dying of COVID-19. My goodness folks, life is not without risk. If you are going to strap your child in a car and drive them around, you are putting them at far greater risk than the risk of them dying from COVID-19.
https://injuryfacts.nsc.org/all-injuries/preventable-death-overview/odds-of-dying/data-details/

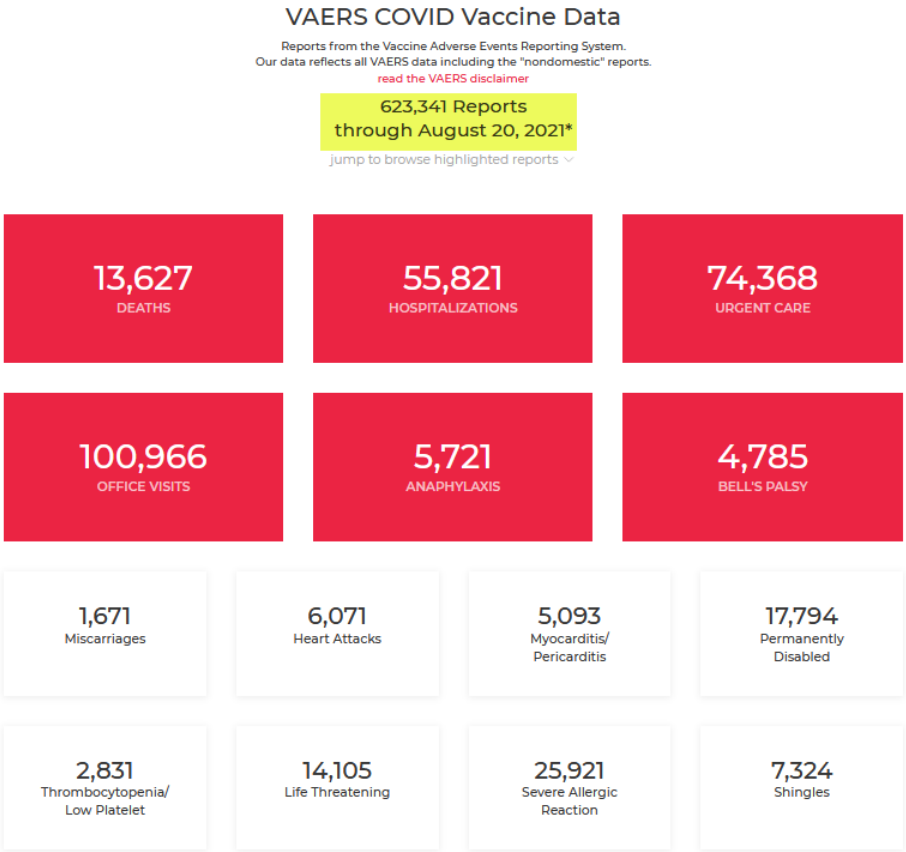
Not only that, but it has been proven time and time again that children are not vectors for spreading the virus, because we all know that one of the sales pitches is we need to vaccinate the children to protect grandma and grandpa. First of all, why don't we do a survey of all of the grandmas and grandpas in this country and ask them if they feel it is worth the risk to vaccinate their grandkids with this experimental shot to protect them from their grandkids. I would bet the results would fall heavily on the "leave 'em alone" side.

To consider vaccinating children, especially healthy children with these experimental products that are causing serious side effects in an alarming number of young people is horrific. I pray that the people in charge of making these decisions will leave their own competing financial and professional interests behind and do the right thing for our children.

September 1st, 2021 update

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

The death reports after COVID-19 vaccines have now exceeded the total number of deaths from ALL VACCINES COMBINED since the system was started 30 years ago!



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

Percentage of people reporting injuries and deaths after COVID-19 vaccines

As of August 20th, the estimates are that there were 168 million people fully vaccinated in the U.S. That is 168,000,000 or 51% of the population. As shown above, there have been nearly 623,000 injuries reported after the shots. Dividing the injuries into the number of people fully vaccinated, it works out to 1 injury every 270 people, or 0.37% of those getting the shots. Considering the 13,627 reported deaths to VAERS (if accurate), would mean that 1 person in every 12,328 people that are fully vaccinated die with suspicious enough circumstances for a doctor or close relative to believe that their death was as a result of the vaccine.

According to a search of VAERS records, a portion of those reported deaths are from people outside of the U.S. If this is true, it is puzzling why the CDC's reporting system would allow this, since this system is supposed to be specific for the U.S. But let's assume that is true. That reported number is 6,128 deaths as of August 20th, 2021. Using that conservative figure, that still means that there is 1 reported death for every 27,415 fully vaccinated people. Even using this most conservative number, if there were a drug on the market that was

killing one out of every 27,415 people that took it, it would be immediately pulled from the market! And if you don't think the VAERS figures are conservative, read this next section.

Key Point

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., 1,194,000 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 119,400 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

What about the European Union? What is the reported casualty count there?

The database (https://www.adrreports.eu/en/index.html), which covers the 27 countries of the ***European Union*** is similar to the U.S. ***VAERS*** Database. Also, like VAERS the reported deaths and injury are likely significantly understated (As has been previously reported, a 2010 study funded by the ***CDC*** and conducted by ***Harvard***, found that <1% of vaccine adverse reactions are reported to VAERS). And. as you read this consider that there are about 50 countries that are considered a part of Europe. So, these numbers may only reflect around half or slightly more of the total REPORTED injuries and deaths across Europe.

The title of an article published in ***GlobalResearch.org*** on August 3rd 2021, sums up the magnitude of the problem across the pond. The title of the article is **20,595 Dead 1.9 Million Injured (50% Serious) Reported in European Union's Database of Adverse Drug Reactions for COVID-19 Shots.** From the total of injuries recorded, half of them (968,870) are **serious** injuries.

https://www.globalresearch.ca/20595-dead-1-9-million-injured-50-serious-reported-european-union-database-adverse-drug-reactions-covid-19-shots/5751904

Relevant facts

- The current population of all of the countries in the E.U. combined is 447,794,691 (2020 Census data as reported by the World Bank). https://data.worldbank.org/indicator/SP.POP.TOTL?locations=EU
- According to ***Our World in Data***, the percentage of people fully vaccinated in countries of the ***European Union*** is 49% as of July 31st, 2021, (the date the data for injuries and deaths were updated). 49% of the total vaccinated population means that 219,419,399 people are considered fully vaccinated. https://ourworldindata.org/coronavirus

So, now let's do some simple math.

- For round numbers, there have been 1 million REPORTED **serious adverse reactions** to the vaccines in the E.U. as of July 31st, 2021. With 220 million people fully vaccinated, that means that **1 person in every 220 people are having a serious adverse reaction** to the vaccines. How can that be called "safe" as we keep hearing? Name any drug on the market. If it was causing a serious adverse reaction in 1 out of every 220 people taking it, it would be pulled from the market immediately and a full investigation would be launched to figure out what went wrong and who the responsible parties were!

- How about deaths? With 21,000 REPORTED **deaths**, that calculates to **1 death in every 10,449 people that are fully vaccinated**. Once again, if there were a drug on the market that was killing one out of every 10,449 people that took it, it would be immediately pulled from the market!

The scenario is most likely far worse

And remember these are just reported serious injuries and deaths. Just like our own ***VAERS*** system, the ***EudraVigilance*** system in the EU is most certainly also very underreported. And I know that this is purely speculation, but it's not out of the realm of possibility. Imagine **if the reported numbers were just 10% of the actual numbers. That would mean that there would be 1 serious vaccine injury in every 22 vaccinated persons and 1 death in every 1,045 vaccinated people!**

From the article

From the total of injuries recorded, half of them (968,870) are **serious** injuries.

*"**Seriousness** provides information on the suspected undesirable effect; it can be classified as 'serious' if it corresponds to a medical occurrence that results in **death**, is life-threatening, requires inpatient hospitalisation, results in another medically important condition, or prolongation of existing hospitalisation, results in persistent or significant disability or incapacity, or is a congenital anomaly/birth defect."*

Here is the summary data through July 31, 2021.

**I have broken out the 4 different vaccines total injuries from the article. In the article, the injuries and deaths from the vaccines are listed by category and type of injury.*

From the article: A *Health Impact News* subscriber in Europe ran the reports for each of the four COVID-19 shots we are including here. This subscriber has volunteered to do this, and it is a lot of work to tabulate each reaction with injuries and fatalities, since there is no place on the EudraVigilance system we have found that tabulates all the results. Since we have started publishing this, others from Europe have also calculated the numbers and confirmed the totals. **If you want to see that in detail, you can click on the link at the bottom of this section.*

- **Total reactions** for the experimental mRNA vaccine **Tozinameran** (code **BNT162b2**, **Comirnaty**) from **BioNTech/ Pfizer: 9,868 deaths** and **767,225** injuries to 31/07/2021

- **Total reactions** for the experimental mRNA vaccine **mRNA-1273 (CX-024414) from Moderna: 5,460**

deaths and **212,474 injuries** to 31/07/2021

- **Total reactions** for the experimental **vaccine AZD1222/VAXZEVRIA (CHADOX1 NCOV-19) from Oxford/ AstraZeneca**: **4,534 deaths** and **923,749 injuries** to 31/07/2021

- **Total reactions** for the experimental **COVID-19 vaccine JANSSEN (AD26.COV2.S) from Johnson & Johnson**: **733 deaths** and **57,159 injuries** to 31/07/2021

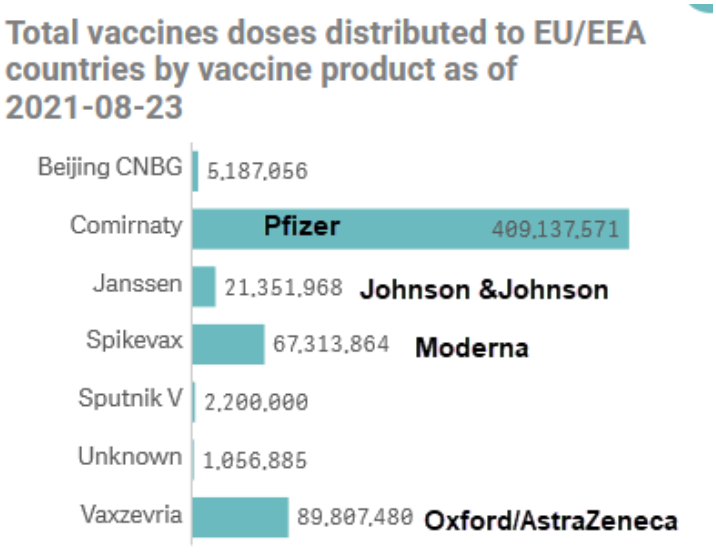
EudraVigilance - European database of suspected adverse drug reaction reports

EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

Last Update: Jul 31, 2021	Reported Cases	Fatalities	% fatalities to cases	All Multiple Symptoms	Serious injuries	% serious to ALL
Oxford/AstraZeneca	346 881	4 534	1,31%	923 749	496 693	53,77%
Pfizer-BioNTech	327 665	9 868	3,01%	767 225	336 609	43,87%
Moderna	84 587	5 460	6,45%	212 474	116 849	54,99%
Janssen	19 915	733	3,68%	57 159	18 719	32,75%
Total:	**779 048**	**20 595**	2,64%	**1 960 607**	**968 870**	49,42%

***Note (This is my comment):** The number of injuries and deaths reported for each vaccine most likely does not reflect the comparison of the different vaccines for risk of injury, because it may reflect the number of doses of those vaccines administered. The Pfizer (now called the Camirnaty shot), is by far the most used one (see the graph below). https://www.globalresearch.ca/20595-dead-1-9-million-injured-50-serious-reported-european-union-database-adverse-drug-reactions-covid-19-shots/5751904

There has been a simultaneous name change (rebranding) of all the top COVID-19 vaccines



All this, yet the FDA has now fully approved Pfizer's shot. Was that done aboveboard and what data did they rely on to make their determination?

The approval of the Pfizer vaccine may be the most scandalous thing the FDA has ever done (and that's saying a lot)

Let's get straight to the point…

1. The extent of the data the FDA relied on for their determination was only up to March 13th, 2021 and the Delta variant (vaccine resistant) wasn't established until months later. Therefore, the vaccine the FDA approved was for the original Wuhan strain, which is gone from the scene now. Therefore, the vaccine is largely ineffective against the present-day radically different virus.

2. By the March 13th data endpoint that the FDA relied on, there was only 6-months of data for a trial that isn't designed for completion until January 29th, 2023.

3. Only 7% of trial participants ever reached 6-months of "blinded" follow-up. Therefore, there is no safety or efficacy data available past 6-months (since March 13th).

4. The FDA skipped the usual step of referring the matter to either the ***Vaccines and Related Biological Products Advisory Committee (VRBPAC)*** or the ***Advisory Committee on Immunization Practices (ACIP)*** committees.

5. The FDA IGNORED the only vaccine safety monitoring system we have, which is the CDC's own ***Vaccine Adverse Event Reporting System (VAERS).***

Point 1 (con't)- That was before the Delta variant came on the scene here in the U.S. It was first identified sometime in March but didn't become the dominant variant until several weeks later. Why is that important? It is because the Delta variant has developed several mutations (*see below) of the spike protein which allow it to evade the vaccine induced immune response to the original Wuhan spike protein configuration.

According to the CDC, Delta and its subtypes display spike protein mutations T19R, (V70F), T95I, G142D, E156-, F157-, R158G, (A222V*), (W258L*), (K417N*), L452R, T478K, D614G, P681R, and D950N.

As you will see in this issue of my newsletter, the percentages of patients hospitalized and succumbing to COVID-19 is has shifted predominantly to fully vaccinated people in many of the most highly vaccinated countries in the world as the vaccine is failing. **There are two main reasons for that.**

Number one- the number of antibodies drop off quickly after vaccination. A ***University College London*** study found that antibodies generated by two doses of the Oxford/AstraZeneca and Pfizer/BioNTech vaccines started to wane **as early as six weeks after the second shot, in some cases falling more than 50% over 10 weeks.** https://www.theguardian.com/world/2021/jul/22/uk-scientists-back-covid-boosters-as-study-finds-post-jab-falls-in-antibodies

And it takes 2-weeks after the second shot for the body to reach maximum antibody protection. That means **within 4-weeks** after that point, the antibodies are already declining. And by 8-weeks after a person is considered fully protected, the "protection" has already diminished by 50%. Why wasn't that brought to the attention of the regulators when Pfizer applied for the ***Emergency Use Authorization (EUA)*** in December of 2020? The FDA had set a bar of 50% effectiveness to even approve a vaccine under EUA. There is a very good chance that this product would not have even met that bar in the first place if this evidence had been fully disclosed.

Number two- The previously mentioned issue of vaccine escape by the Delta variant. A Forbes article Julu 23rd (**a month <u>before</u> FDA approval**) reported that the ***Health Ministry of Israel*** had determined that the Pfizer vaccine's effectiveness had dropped to 39%. And we have just approved it? Don't the folks at the FDA read the data coming in from countries that are slightly ahead of us in the rollout of the vaccines and where the Delta variant became prevalent before it was here? Wouldn't that be a good way to predict what may occur here? I guess that would make too much logical and strategic sense and we can't have that now, can we? Or, could it be that the FDA rushed the approval knowing that if they waited any longer, the efficacy of the Pfizer vaccine would fall so drastically that it wouldn't even reach the minimum 50% effectiveness bar that they set last fall for the Emergency Use Authorization?

Regardless, the good news is natural immunity following infection with SARS-CoV-2 affords MUCH better and lasting protection than the vaccines. More about that later in this newsletter, as a brand-new study out of Israel proves that point.

Point 2- See Point 3

Point 3- With only six months of data and allowing the unblinding of the trial subjects before the end of the six-month period, that brings the data and validity of it into question. Not only that but as I've reported in previous issues against the FDA's original recommendations Pfizer was allowed to offer vaccines to the control group. This essentially wipes out or erases the placebo group making it impossible to follow them and track for long term adverse effects from the vaccine. This seems to be a concerted effort to undermine the ability to identify any safety signals or long-term adverse effects in the population. This in and of itself should disqualify the clinical trial altogether.

Point 4- This is an essential step which allows for public comment on the approval process. This would accommodate for not just lay people, but doctors and scientists to face the committee and comment regarding their concerns, giving them the chance to ask pointed and direct questions of the committee. This is part of the democratic process. But, as we have seen with so many things related to COVID-19, scientific debate and discussion has been censored and those that offer alternative scientific positions are cancelled. It is obvious that the powers-that-be considered this too risky, especially in light of the vaccine failures that are being seen all around the world and the astronomical numbers of adverse reactions and deaths being reported. Refer to Point 5.

Point 5- With well over 600,000 adverse events including 56,000 hospitalizations, 74,000 urgent care visits and over 13,000 deaths reported from the vaccines, how can this possibly be ignored?! That number of deaths is more than have been reported by all 70 vaccines combined over the last 30 years. As you will also see in this issue, there have been 2-million adverse injury reports from the vaccines in the 27 countries of the ***European Union***, with half of them considered serious. In addition to that, there have been over 20,000 deaths reported. An interesting note about that is, that the Pfizer vaccine represents the vast number of doses given to citizens of those countries. You just saw that a few pages ago.

Peter Doshi, Associate Editor of the ***British Medical Journal (BMJ)*** makes many of these points in an excellent Opinion Letter to the BMY dated August 23rd, 2021, and titled **<u>Does the FDA think these data justify the first full approval of a covid-19 vaccine?</u>**

https://blogs.bmj.com/bmj/2021/08/23/does-the-fda-think-these-data-justify-the-first-full-approval-of-a-covid-19-vaccine/

The official narrative we had been hearing of COVID-19 is now a disease of the unvaccinated, is falling apart as data coming in from around the world contradicts the CDC's claims

A new report from ***Public Health England*** dated August 15th, 2021, and titled, **SARS-CoV-2 variants of concern and variants under investigation in England Technical briefing 21**, reveals a disturbing trend, at least for vaccinated people over 50.

The following table is from pages 22 & 23. It covers the time period from February 1st, 2021 to August 15th, 2021.

SARS-CoV-2 variants of concern and variants under investigation

Table 5. Attendance to emergency care and deaths of sequenced and genotyped Delta cases in England by vaccination status (1 February 2021 to 15 August 2021)

Variant	Age group (years)**	Total	Cases with specimen date in past 28 days	Unlinked	<21 days post dose 1	≥21 days post dose 1	≥14 days post dose 2	Unvac-cinated
Delta cases	<50	337,834	106,718	35,397	25,965	57,688	40,544	178,240
	≥50	48,264	20,295	4,242	228	6,075	32,828	4,891
	All cases	386,735	127,091	40,273	26,194	63,763	73,372	183,133
Cases with an emergency care visit§ (exclusion‡)	<50	11,195	N/A	88	886	1,581	1,161	7,479
	≥50	2,952	N/A	18	19	372	1,803	740
	All cases	14,147	N/A	106	905	1,953	2,964	8,219
Cases with an emergency care visit§ (inclusion#)	<50	14,676	N/A	154	1,111	1,926	1,447	10,038
	≥50	5,098	N/A	36	43	574	2,956	1,489
	All cases	19,774	N/A	190	1,154	2,500	4,403	11,527

Cases where presentation to emergency care resulted in overnight inpatient admission§ ((exclusion‡)	<50	2,538	N/A	41	144	267	246	1,840
	≥50	1,593	N/A	11	13	149	990	430
	All cases	4,131	N/A	52	157	416	1,236	2,270
Cases where presentation to emergency care resulted in overnight inpatient admission§ (inclusion#)	<50	4,112	N/A	71	229	402	366	3,044
	≥50	3,173	N/A	28	31	287	1,838	989
	All cases	7,285	N/A	99	260	689	2,204	4,033
Deaths within 28 days of positive specimen date	<50	113	N/A	3	6	5	27	72
	≥50	1,076	N/A	13	8	85	652	318
	All cases	1,189	N/A	16	14	90	679	390

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1012644/Technical_Briefing_21.pdf

On the surface, this may look like the vaxxed have the advantage as they have fewer numbers of PCR positive cases. The greater concern is in the hospitalizations and deaths which is what I have been saying all along, as this is what stresses the capacity of the healthcare system.

Deaths

- The deaths in the vaxxed (679) out of 73,372 positive cases **(.93%)** represents 64% of total deaths.
- The deaths in the unvaxxed (390) out of 183,133 positive cases **(.21%)** is 36% of total deaths *(see highlighted numbers in the table above).*
- In the vaxxed group, that calculates to 1 death in every 108 cases.
- In the unvaxxed it works out to be 1 death in every 470 cases.

That ratio is approximately 4.4 times higher in the vaxxed than the unvaxxed.

Hospitalization

Check out the percentage of vaxxed vs. unvaxxed that presented to the E.R. **and resulted in overnight in-patient admission**.

For those under age 50, the rate is higher in the unvaxxed vs. vaxxed (1.7% vs. 0.5% of PCR cases).

The over 50-age group. In that cohort, there were 989 in the unvaxxed group and 1,838 in the vaxxed group. **That means that 2.5% of the vaxxed cases had to be admitted to the hospital for an overnight stay. This compares to just 0.54% in the unvaxxed cohort.**

This trend that we are seeing in highly vaccinated countries of the vaccinated becoming less and less protected and more and more sick as time goes on is very concerning, in this case especially with older individuals. This could be caused in part by the rapid decline of the antibodies conferred by the vaccines. But if that were the case, why would the unvaccinated older individuals, which have no vaccine caused SARS spike protein generated antibodies be doing so much better with regard to serious illness and deaths? This could point to an even more concerning issue for vaccinated individuals. It could be a signal for Antibody Dependent Enhancement (ADE) occurring in vaccinated individuals. As I reported nearly a year ago, ADE discovered in animal trials during attempts to develop coronavirus vaccines nearly 20 years ago affected the older animals at a rate nearly 10 times higher.

Children's Health Defense also reported on this phenomenon specifically with the Pfizer vaccine (and before the vaccines were authorized under the EUA)

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

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

Even as of June the trend of vaccinated getting reinfected, hospitalized and even dying is accelerating!

Now the even more concerning part for vaccinated people. I had the section below in my newsletter last month. It was from ***Public Health England's*** Technical Report document that was dated June 25th. The percentage of deaths in the vaccinated was 43% at that time. The range of dates covering that report was from February 1st, 2021, through June 14th, 2021. Now, as just reported a couple pages earlier, that has increased to 64%. And it's not just a 20% increase in the matter of 60 days. Recall that these statistics run from February 1st, 2021. That means that in the short span of the last 60 days, the increase in percentage of deaths in vaccinated individuals has been enough to skew the whole six months of reporting up 20%.

As it appears like the severity of disease is escalating in vaccinated people, could be the feared ***ADE, Antibody Dependent Enhancement***. Or that the vaccines are interfering with the non-specific antibodies and innate arm of the immune system, in essence undermining the body's first line of defenses. Both of these possibilities were predicted by many credible doctors and scientists.

From my July newsletter

"A Pandemic of the Unvaccinated"- What is the TRUTH?

The latest reports that 99% of all COVID-19 deaths are in unvaccinated people in the U.S. is an absurd lie. And that's not the only lie we have been told. There is an abundance of them. Here are just some of them and the proof as to their fallacy.

1. **The vaccines are failing-** The U.S. would have to be an anomaly compared to other nations. Israel the country with the highest vaccination rates in the world reports that people that were vaccinated in January have already lost a good portion of their protection according to ***Pfizer Chief Scientific Officer*** Mikael Dolsten. "The Pfizer vaccine is highly active against the Delta variant," Dolsten said in an interview, according to *Reuters*. But after six months, he said, "there likely is the risk of reinfection as antibodies, as predicted, wane."

   In addition to all of that, England reports that **43% of their hospitalizations and deaths are in fully vaccinated people** as this table clearly shows. The report from ***Public Health England*** is titled**, SARS-CoV-2 variants of concern and variants under investigation in England** and was published June 25th, 2021.

SARS-CoV-2 variants of concern and variants under investigation

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001359/Variants_of_Concern_VOC_Technical_Briefing_16.pdf

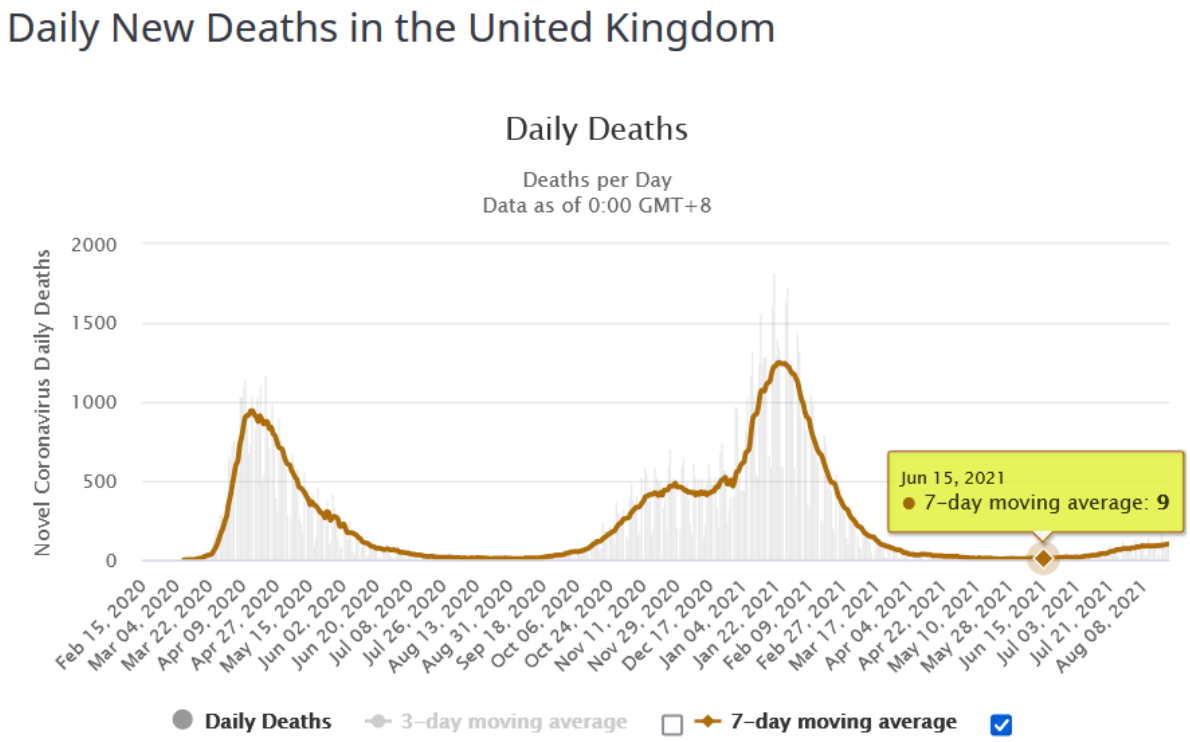
Table 4. Attendance to emergency care and deaths by vaccination status among Delta confirmed cases (sequencing and genotyping) in England, 1 February 2021 to 14 June 2021.

	Total	Cases with specimen date in past 28 days*	Unlinked	Unvaccinated	<21 days post dose 1	≥21 days post dose 1	≥14 days post dose 2
Delta cases since 1 Feb 2021 ¥	60,624	53,177	7,461	35,521	4,094	9,461	4,087
Cases with an A&E visit§ (excluding cases with the same specimen and attendance dates)‡	1,555	NA	14	1,038	116	285	102
Cases with an A&E visit§ (including cases with the same specimen and attendance dates)	2,176	NA	24	1,446	155	378	173
Cases where presentation to A&E resulted in overnight inpatient admission§ (excluding cases with the same specimen and admission dates)‡	488	NA	7	324	30	87	40
Cases where presentation to A&E resulted in overnight inpatient admission§ (including cases with the same specimen and admission dates)	806	NA	10	527	50	135	84
Deaths^	73	NA	2	34	1	10	26 43%

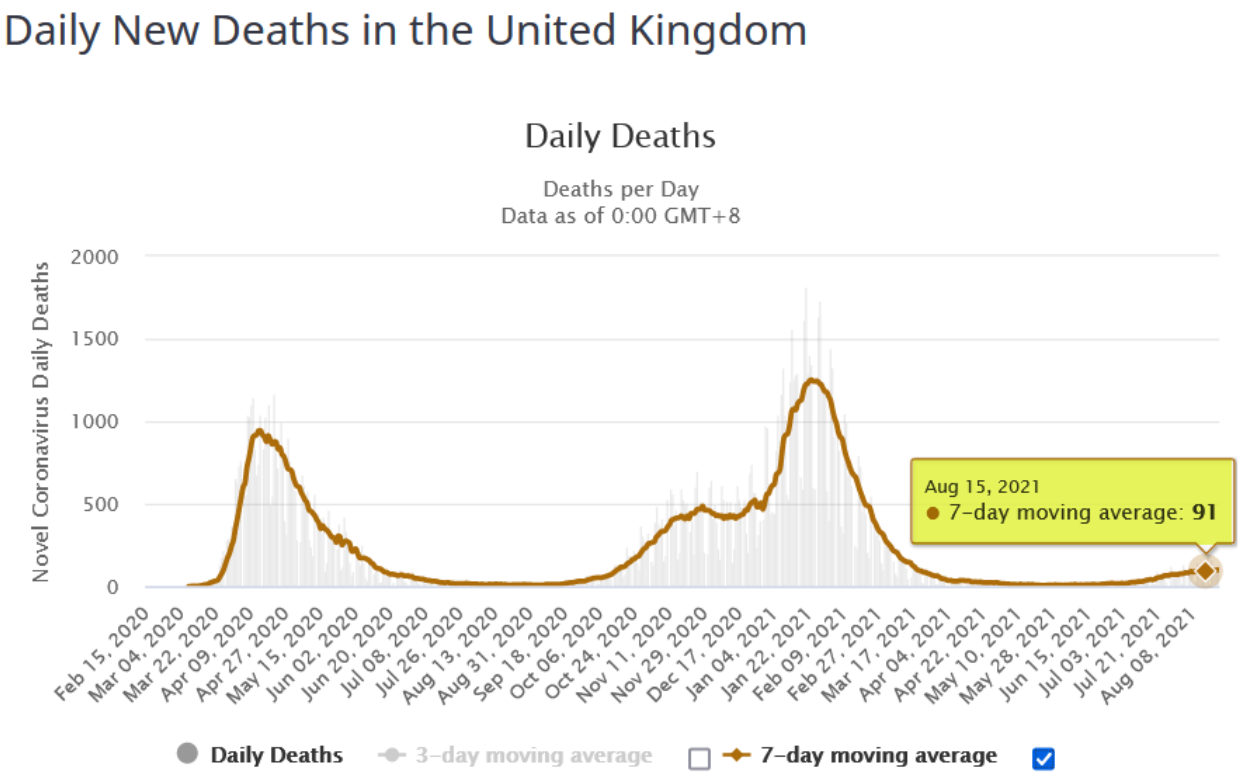
Data sources: Emergency care attendance and admissions from Emergency Care Dataset (ECDS), deaths from PHE daily death data series (deaths within 28 days)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001359/Variants_of_Concern_VOC_Technical_Briefing_16.pdf

This was the 7-day average of deaths at that time in the UK on June 14th



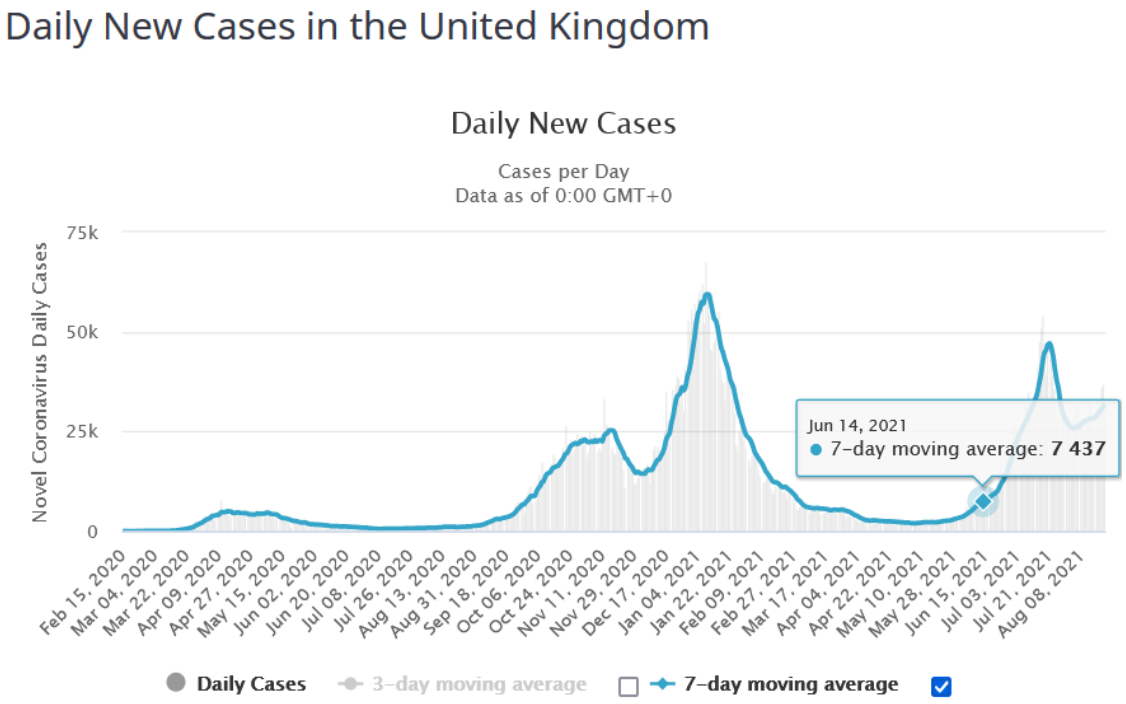
This was the 7-day average for deaths in the UK on August 15th, the date of the PHE report.



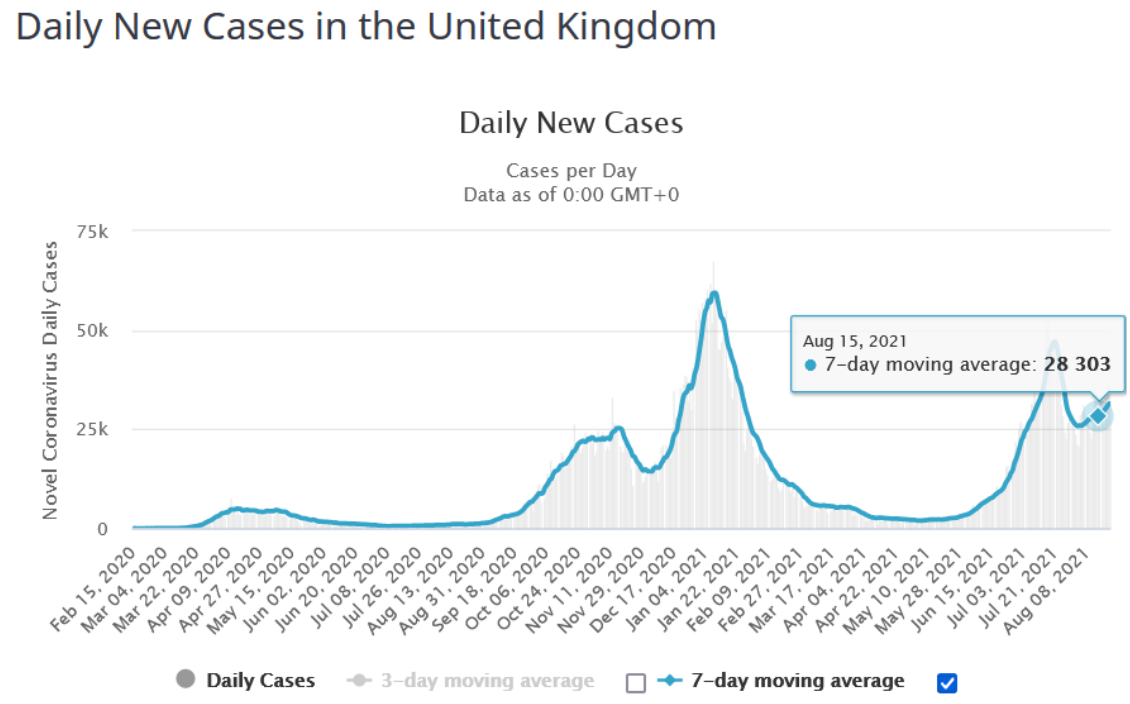
As you can see, the 7-day average for daily deaths is 10-fold higher as of August 15th (91) as compared to June 14th (9).

Case comparison for June 14th and August 15th

June 14th



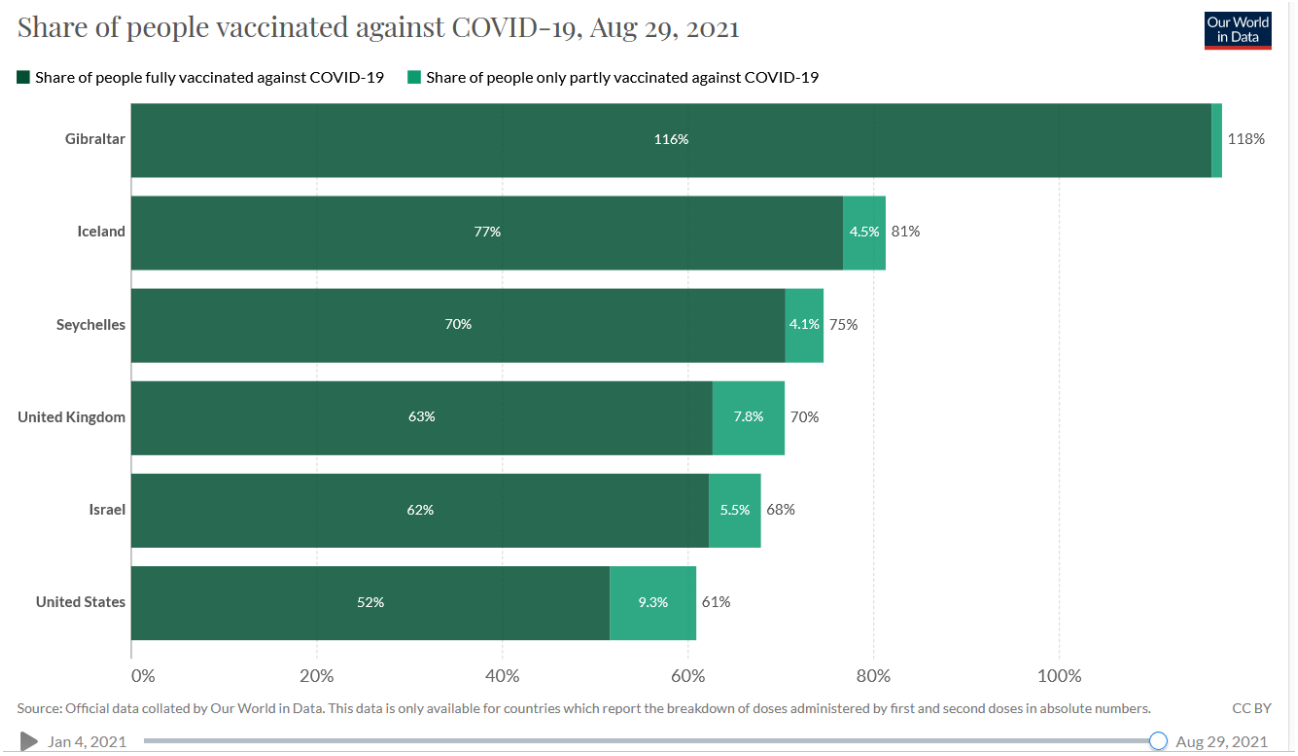
August 15th



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

In many countries, the mass vaccination programs have been associated with spikes in deaths immediately following the start and now deaths in fully vaccinated appear to be rising higher than in the unvaccinated

This is a graph showing some of the countries with the highest vaccination rates in the world



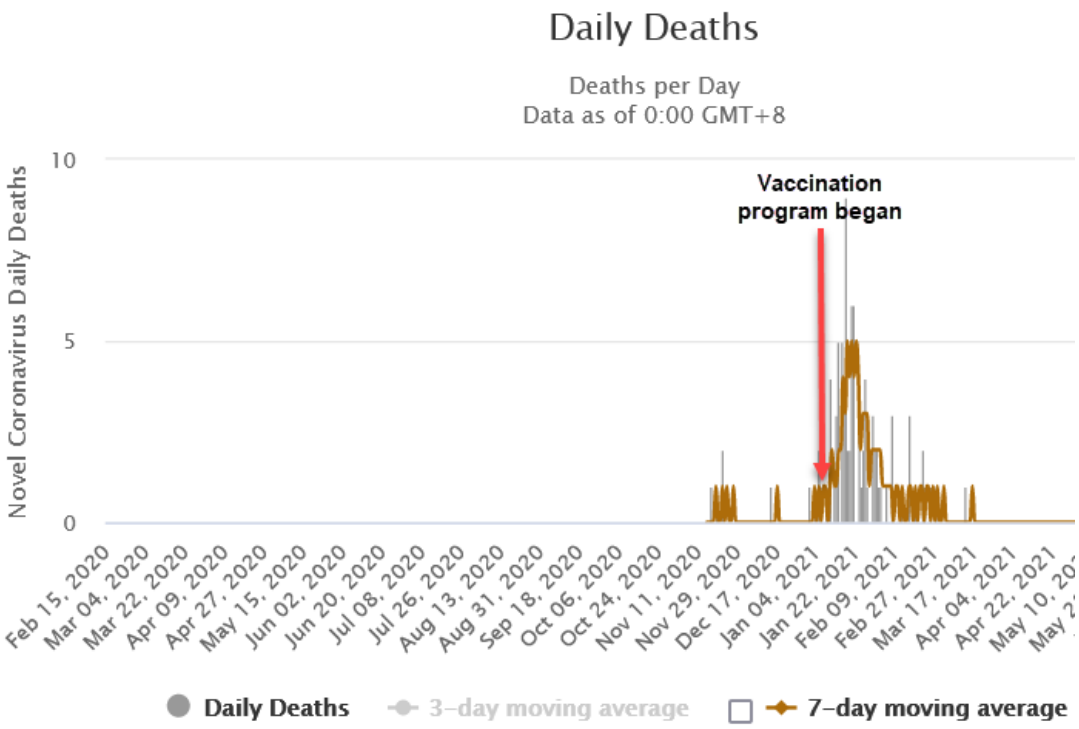
How Gibraltar has a 116% vaccination rate is a mystery to me. But that is what *Our World in Data* is reporting. Regardless, let's starts there.

Gibraltar

In an article by Lance D. Johnson and published on Dr Eddy Bettermann MD's website titled, **Elderly population suddenly dying off for unexplained reasons, and it's no longer coded as covid-19**, the sudden deaths in the elderly of Gibraltar immediately after the vaccination program began is called the "worst loss of life there in over 100 years". *(Gibraltar has a population of 33,680).*

From the article

Around the world, medical authorities are seeing a spike in elderly deaths, after covid-19 vaccination. Gibraltar, a nation located at the southern tip of Spain is suffering from an unexplained surge in elderly deaths. In the second week of January, a subset of the elderly population suddenly started to die off *(see the graph below)*. The new wave of unexplained elderly deaths is occurring at nearly three times the magnitude of covid-19 deaths that were recorded during 2020.



My comment: If you have been reading my newsletters, you would have seen other reports from dozens of countries around the world showing spikes in deaths related to "COVID" shortly after the mass vaccine rollouts.

Continued from the article

The new, unexplained surge in elderly deaths is occurring approximately forty times faster when compared to the overall timeline of covid-19 deaths that occurred since a pandemic was first declared. This surge in elderly deaths occurred after 5,847 doses of experimental mRNA injections were administered to the citizens of Gibraltar. In just one week, 17 percent of the country's population had been inoculated with the first dose of Pfizer's mRNA experiment.

Before the vaccine experiment began, the covid-19 related death toll accounted for ten people. After the vaccine rollout, the total number of deaths had skyrocketed to forty-five people. In the first eight days of the vaccination program, thirty-five seniors suddenly passed away.

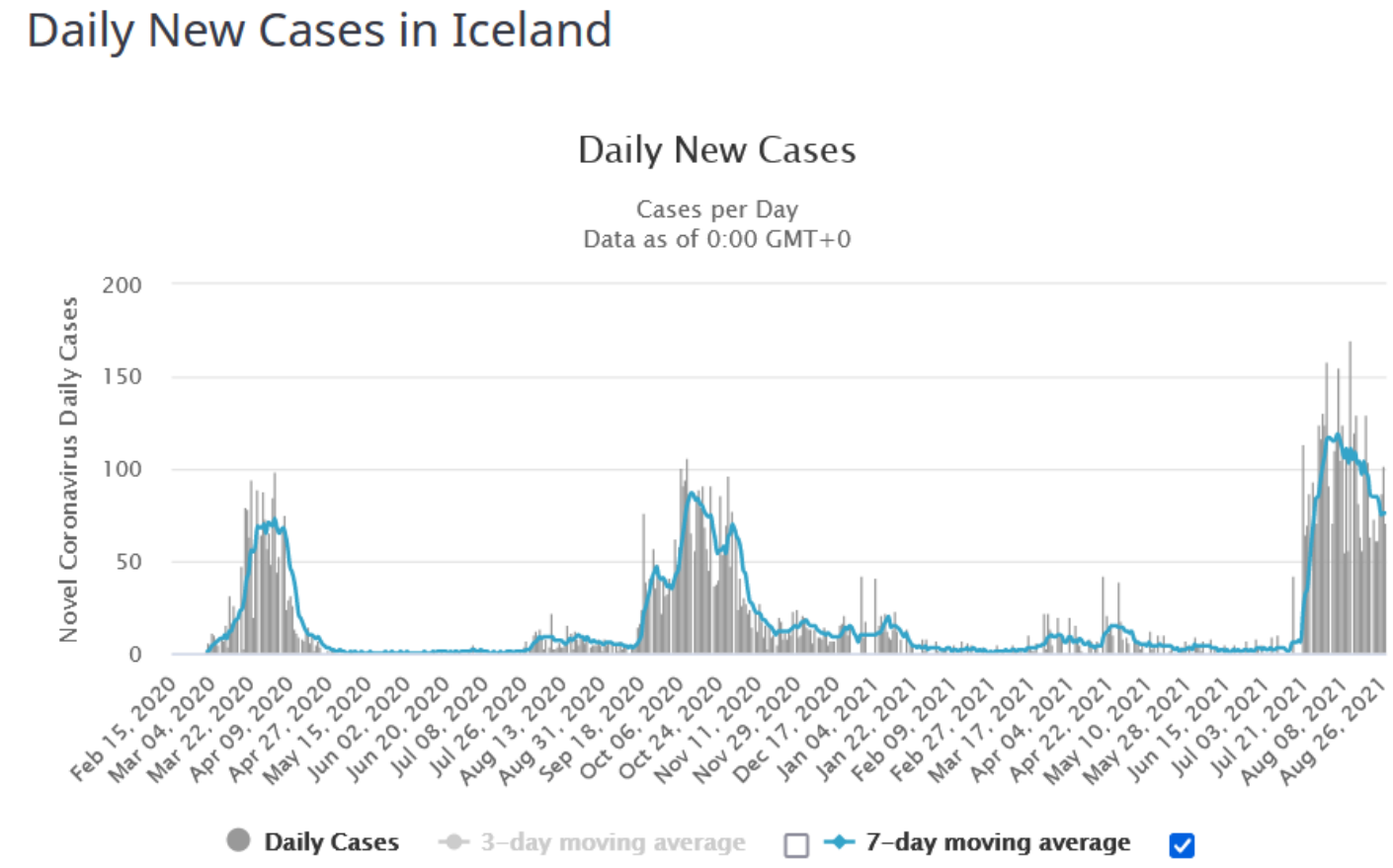
After the first week of vaccination, Chief Minister Fabian Picardo said, "This is now the worst loss of life of Gibraltarians in over 100 years. Even in war, we have never lost so many in such a short time."

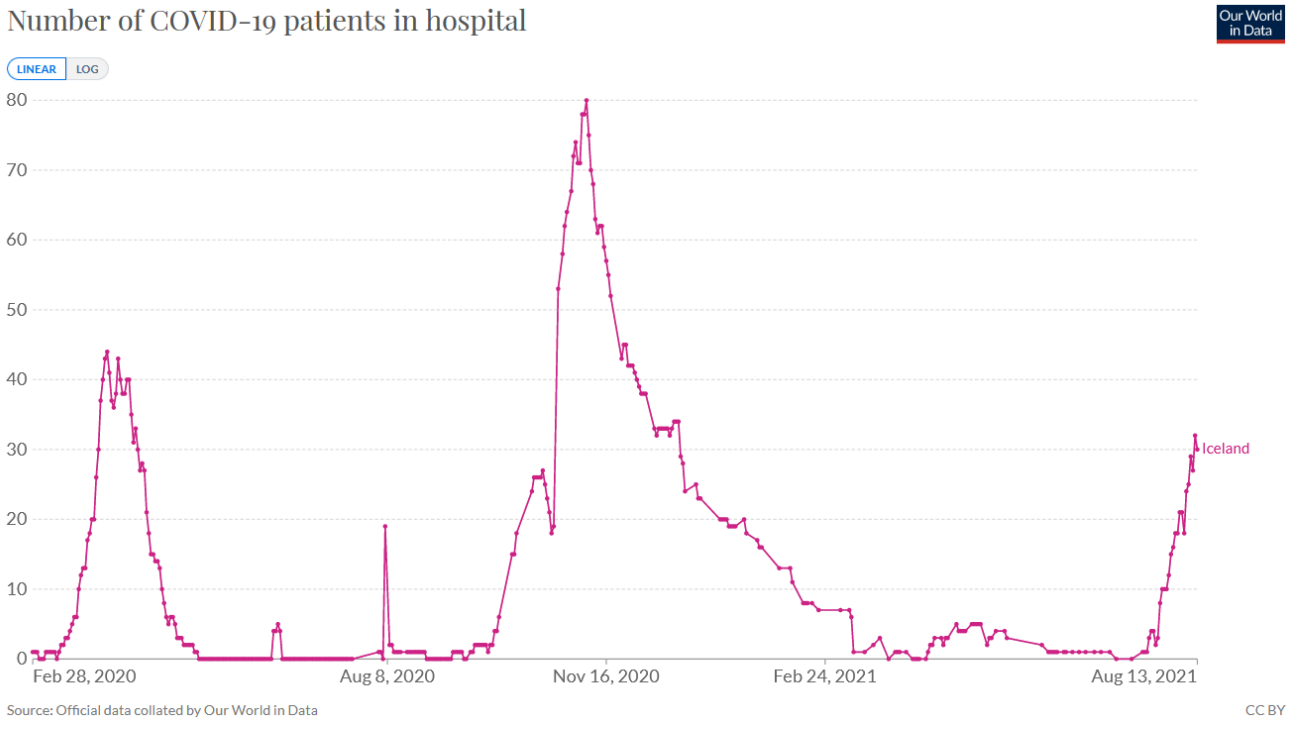
Vaccine-induced deaths to be blamed on new "covid-variant"

In 2020, medical examiners would have easily labeled these sudden deaths as covid-19, but now these deaths are somehow unexplained, with no definitive cause. Before the covid-19 vaccines were unleashed, seniors died of covid-19. Now seniors are dying of natural causes again, right after being vaccinated. It won't be long before a surge in elderly deaths around the world is blamed on a new variant of SARS-CoV-2, with medical authorities calling for new vaccines, more doses, and mRNA updates. Isn't it suspicious that a deadly covid-variant became headline news suddenly after the vaccine rollout? https://dreddymd.com/2021/02/18/elderly-population-suddenly-dying-off-for-unexplained-reasons-and-its-no-longer-coded-as-covid-19/

Iceland

Iceland is second on our list with 77% of the population fully vaccinated. Iceland is a small country both is size and from a population perspective. The population of Iceland is 344,000. At 75% of their population fully vaccinated, they rank among the highest in the world. So what do their cases and hospitalizations look like currently.

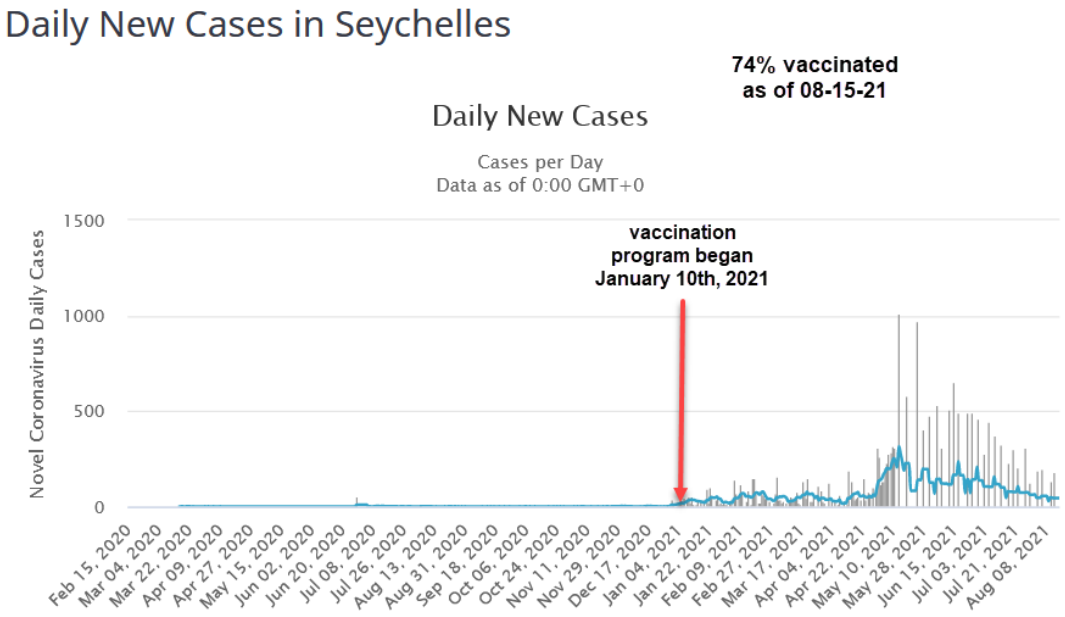




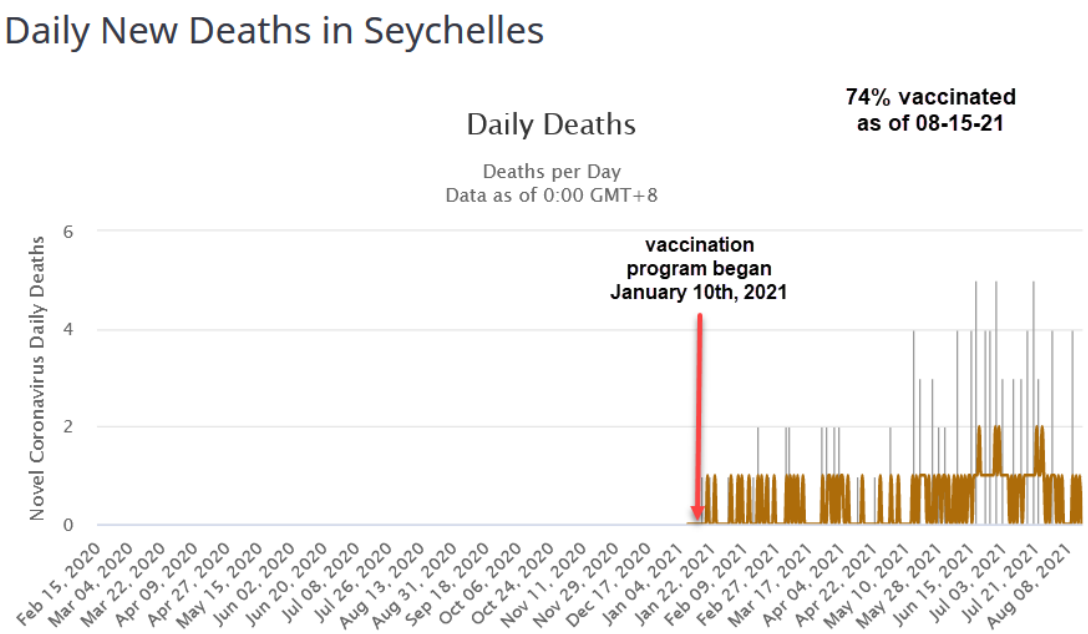
Seychelles

Seychelles is third on our list with 70% of the population of 98,000 fully vaccinated. Seychelles is a small island nation in the Indian Ocean. According to Wikipedia, Seychelles launched its mass vaccination campaign on 10 January, initially with 50.000 doses of Sinopharm's BBIBP-CorV vaccine donated by the United Arab Emirates. The UAE has since donated 20.000 more doses of a different vaccine to Seychelles.

Check out this graph that shows what happened then…



That marginal increase in cases is somewhat interesting but look at what happened to the COVID death rates!



Bear in mind that Seychelles is a very small nation, so these numbers of people are not large. But the changepoint is unmistakable as they appeared to have been doing just fine with next to zero cases and deaths up to that point.

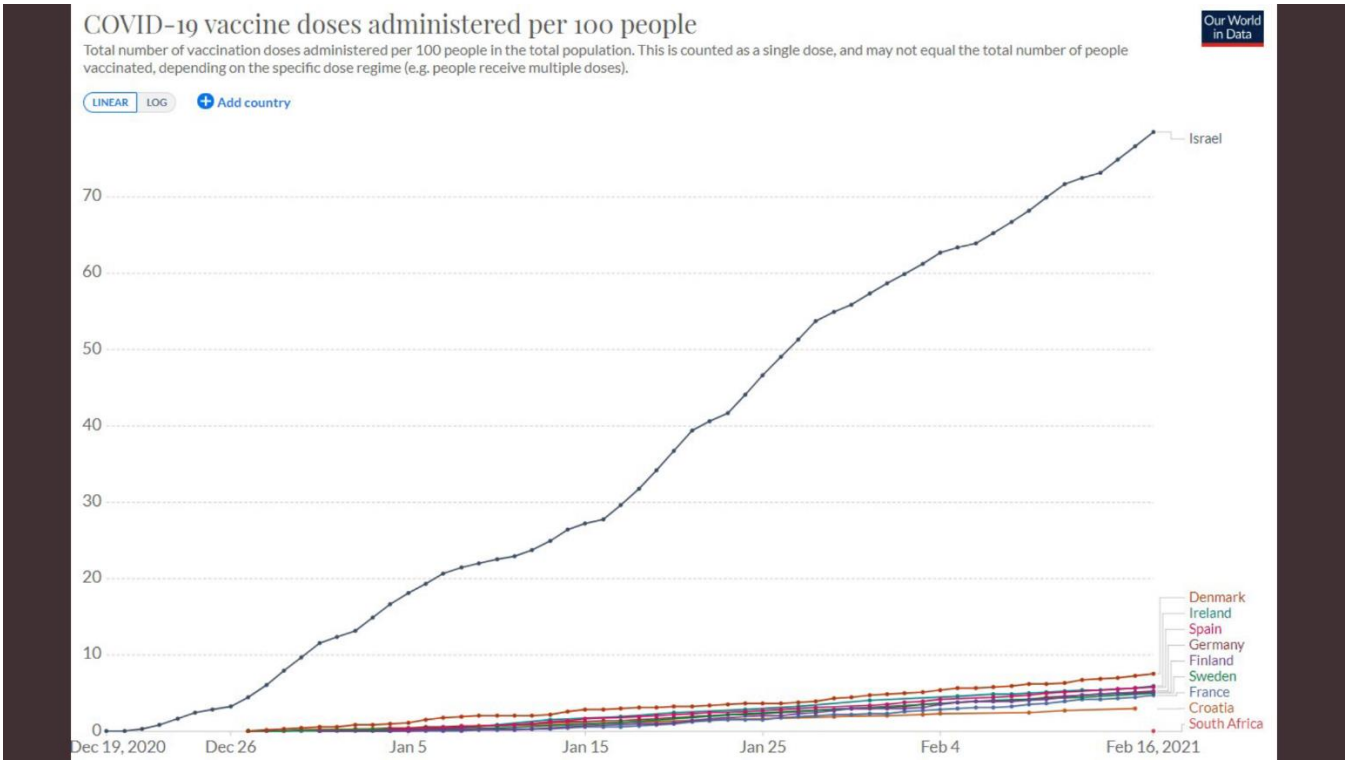
The United Kingdom

I have already covered the U.K. earlier in this issue. As you read there, the script has also flipped with the percentage of those being hospitalized and dying from COVID-19 is increasingly shifting to the vaccinated, especially in those over 50-years of age.

Israel

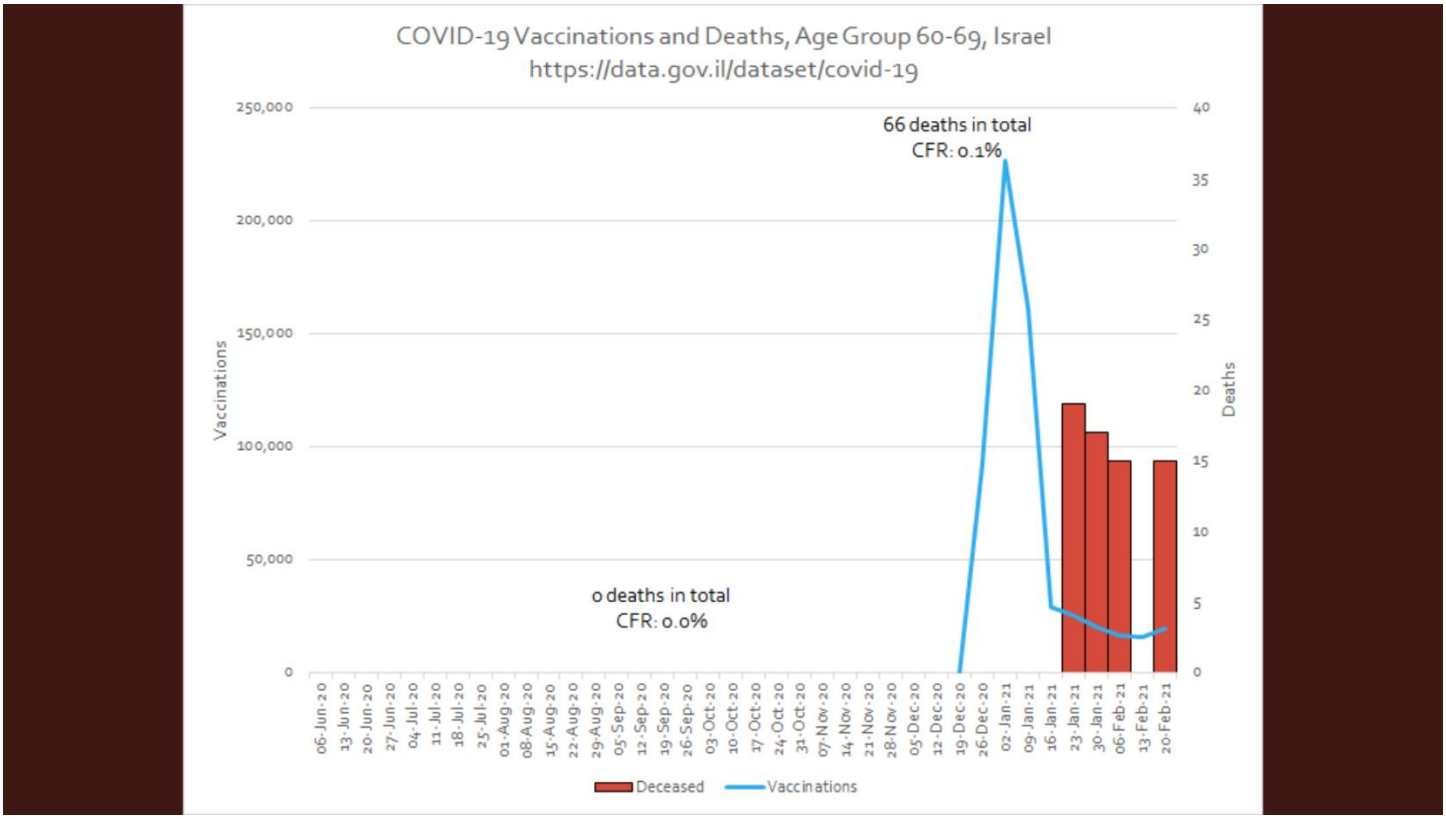
Let's look first at what happened in Israel after the rollout of their mass vaccination program.

As you can see from this next graph, as of mid-February, Israel had the highest rate of COVID-19 vaccine distribution in the world by far. But as you will see in the subsequent graphs, it seemed to correlate with a large increase in deaths in their elderly after they got the vaccines!

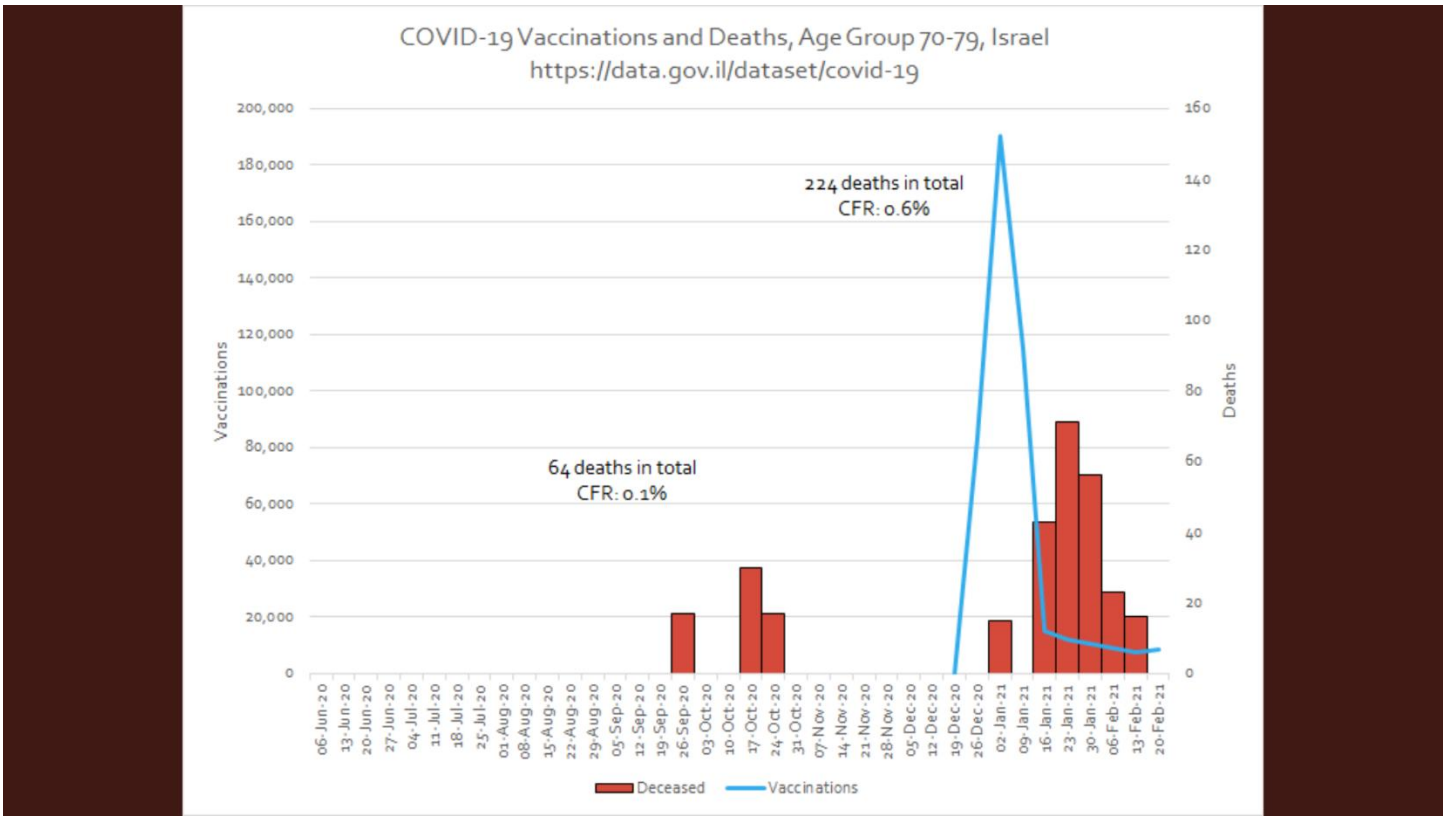


See the next page…

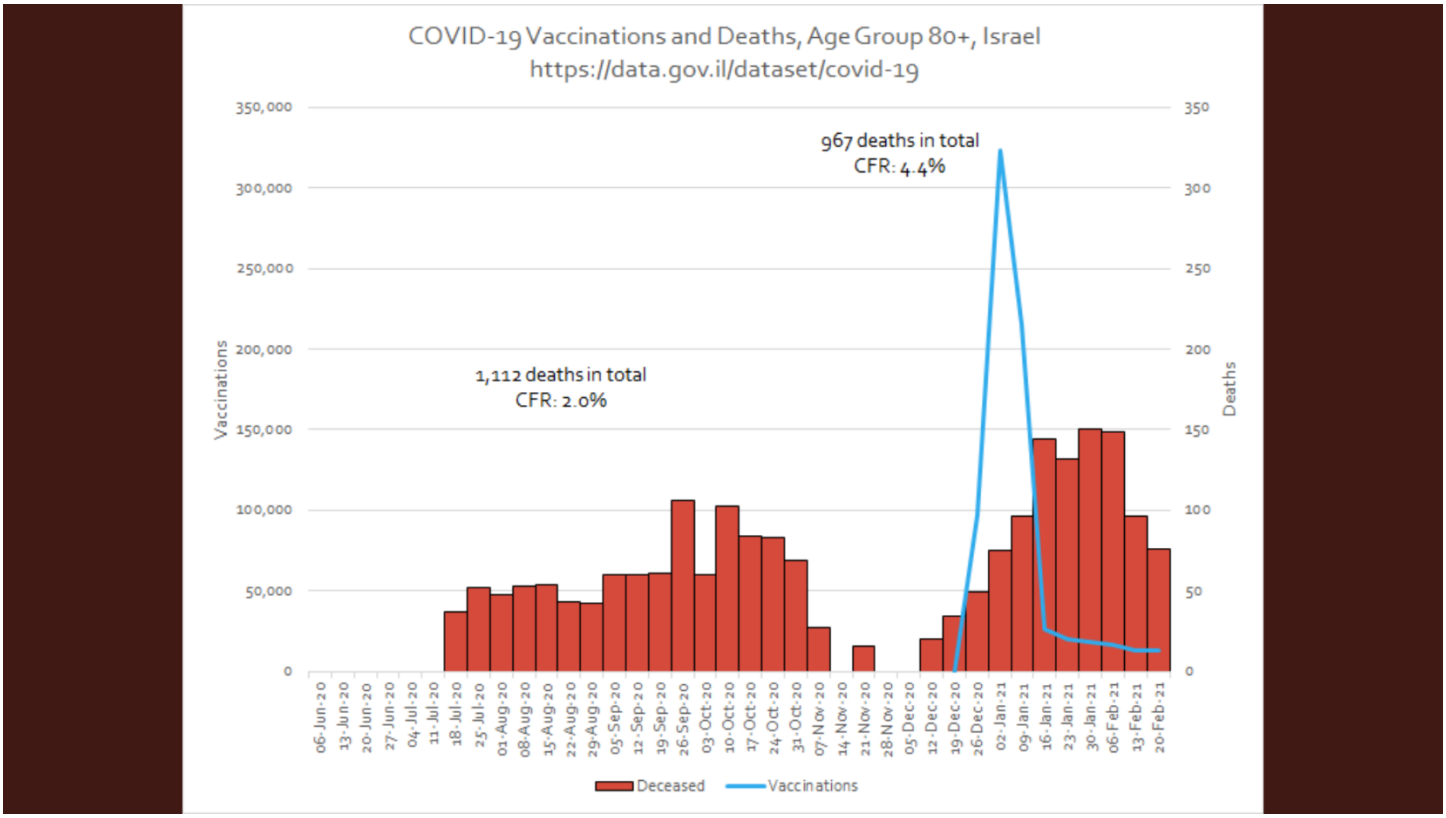
Deaths in the 60- to 69-year-old age group- Vaccination campaign is the blue line



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



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



The big question is, does the large increase in deaths relate to various side effects from the vaccines that aren't tolerated by the frail and elderly, or is it the Antibody Dependent Enhancement (AKA Pathogenic Priming) scenario that so many of the world's health experts were warning about as described earlier in this paper. Either way, if you extrapolate these findings on a much larger scale in a country like the United States who are lagging far behind Israel in vaccination coverage, it should send up major red flags that would call for further investigation before we see potentially catastrophic results here with our elderly population.

So, how is Israel doing now?

As an example, and this ***Forbes*** article was dated July 23rd, yet the title of the article could not be used if it were written 4 weeks later, because as you will see, the percentage of those hospitalized and dying of COVID-19 are fully vaccinated.

Title: <u>Pfizer Shot Just 39% Effective Against Delta Infection, But Largely Prevents Severe Illness, Israel Study Suggests</u>.

From the article

Recent data from Israel's health ministry suggests Pfizer's Covid-19 vaccine is far less effective at preventing infection and symptomatic illness with the Delta variant than with previous strains of coronavirus, a finding that conflicts with other research indicating high levels of protection against the contagious variant as countries around the world struggle to contain new waves of infection.

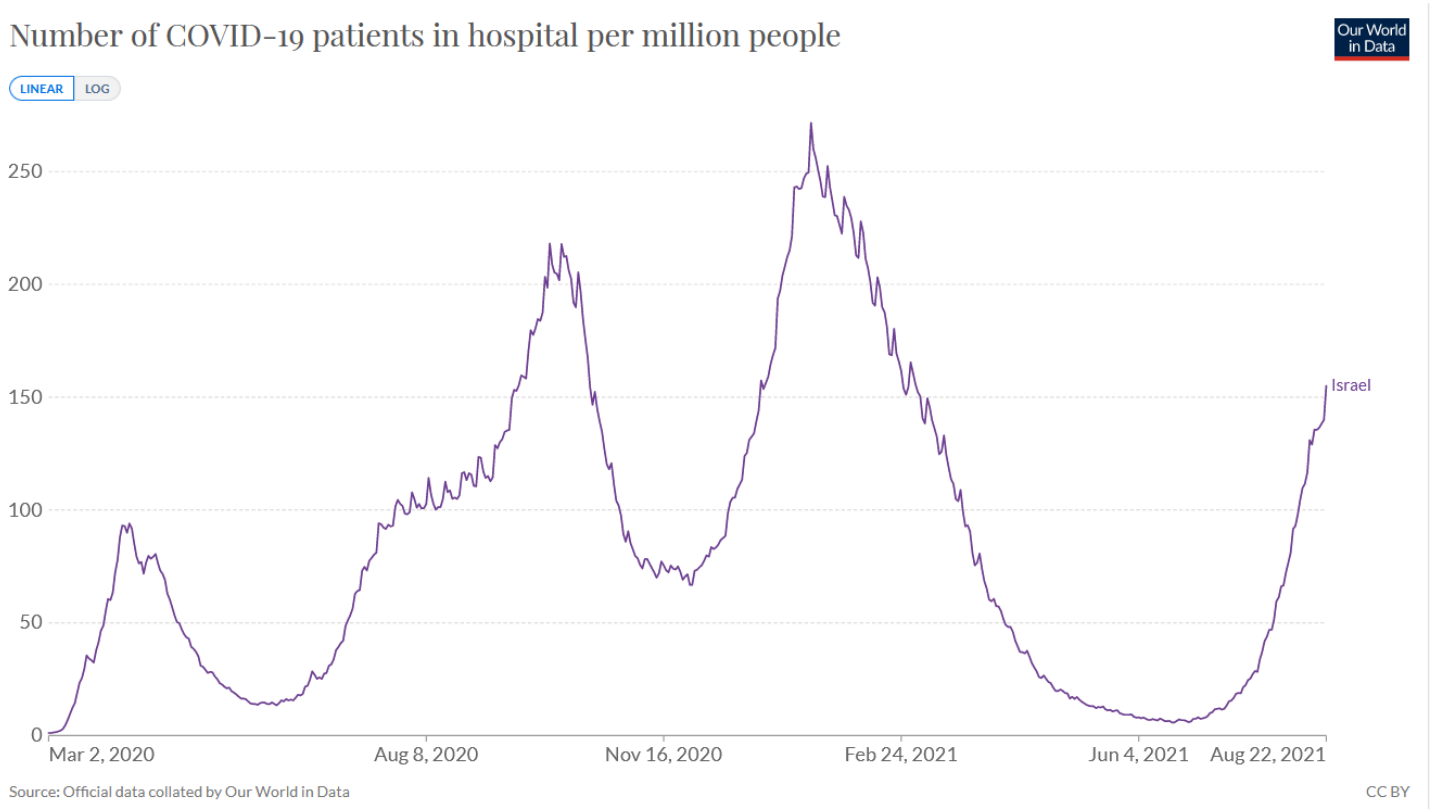
A full course of the Pfizer-BioNTech vaccine was just 39% effective at preventing infections and 41% effective at preventing symptomatic infections caused by the Delta Covid-19 variant, according to Israel's health ministry, **down from early estimates of 64% two weeks ago.** (Emphasis mine)

The figures, based on data from an unspecified number of people between June 20 and July 17, are significantly lower than previous estimates of the vaccine's efficacy against other variants, which initial clinical trials found to be 95%. And remember as reported in an earlier newsletter, the 95% is relative risk reduction.

End of excerpts

https://www.forbes.com/sites/roberthart/2021/07/23/pfizer-shot-just-39-effective-against-delta-infection-but-largely-prevents-severe-illness-israel-study-suggests/?sh=666f825584f1

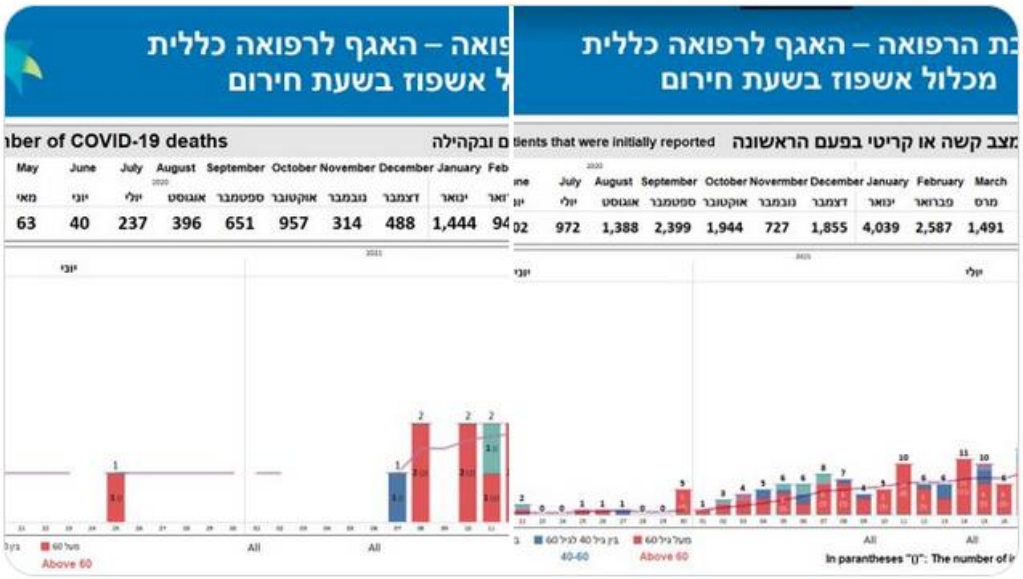
Health Ministry Data- (sorry it's in Hebrew). https://www.gov.il/BlobFolder/reports/vaccine-efficacy-safety-follow-up-committee/he/files_publications_corona_two-dose-vaccination-data.pdf



On the next page you will see a July 29th Tweet by a person that I have been following who is reporting on Israeli health data and someone that I have noticed is being followed by many credible and well-known scientists, is reporting some shocking statistics. And thankfully he can interpret Hebrew.

Ran Israeli @RanIsraeli · Jul 29

New update from the Israeli MoH:
The number of deaths in July - Age 60+:
25 deaths=Fully vaxxed.
6 deaths=Not fully vaxxed.
The number of initially reported severe/critical patients - Age 60+ :
182=Fully vaxxed.
46=Not fully vaxxed.
govextra.gov.il/ministry-of-he...
drive.google.com/file/d/1n7ng6G...



On August 24th, the Daily Beast published an article titled, **Ultra-Vaxxed Israel's Crisis Is a Dire Warning to America**. The article reveals the rapidly escalating increase of infections, hospitalizations and deaths in fully vaccinated individuals.

From the article

In June, there were several days with zero new COVID infections in Israel.

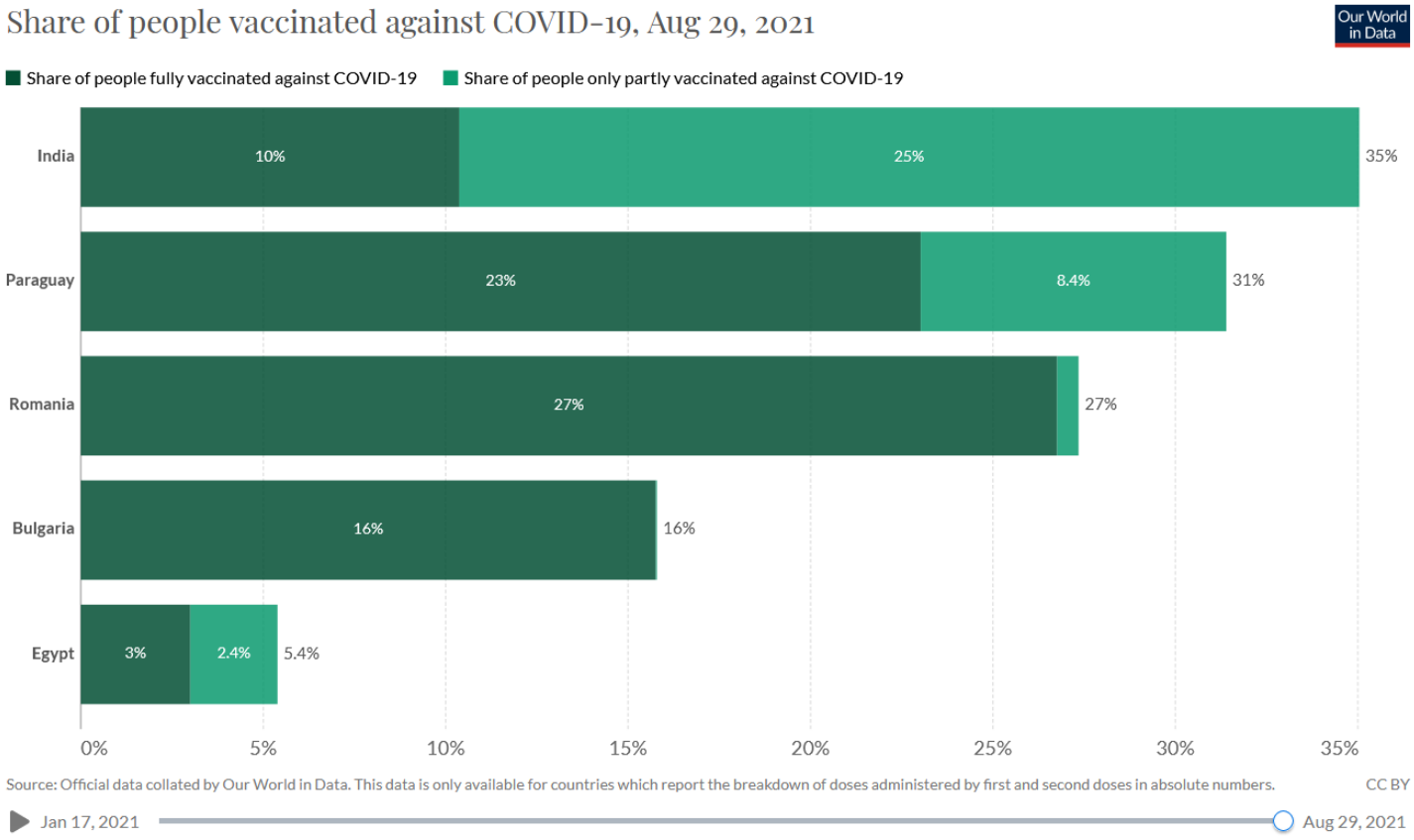
Fast forward two months later: Israel reported 9,831 new diagnosed cases on Tuesday, a hairbreadth away from the worst daily figure ever recorded in the country—10,000—at the peak of the third wave. More than 350 people have died of the disease in the first three weeks of August. In a Sunday press conference, the directors of seven public hospitals announced that they could no longer admit any coronavirus patients. With 670 COVID-19 patients requiring critical care, their wards are overflowing and staff are at breaking point. "I don't want to frighten you," coronavirus czar Dr. Salman Zarka told the Israeli parliament this week. "But this is the data. Unfortunately, the numbers don't lie."

https://www.thedailybeast.com/ultra-vaccinated-israels-debacle-is-a-dire-warning-to-america

How does that the information coming out of all those highly vaccinated countries contrast to what we are hearing from our media and CDC?

How are some of the countries with the lowest vaccination rates doing?

Let's now consider how some of the countries with the lowest vaccination rates are doing with regard to cases and deaths. If the prevailing narrative that the CDC has been pushing through the media is true, we would expect those countries to be having run away cases and deaths.



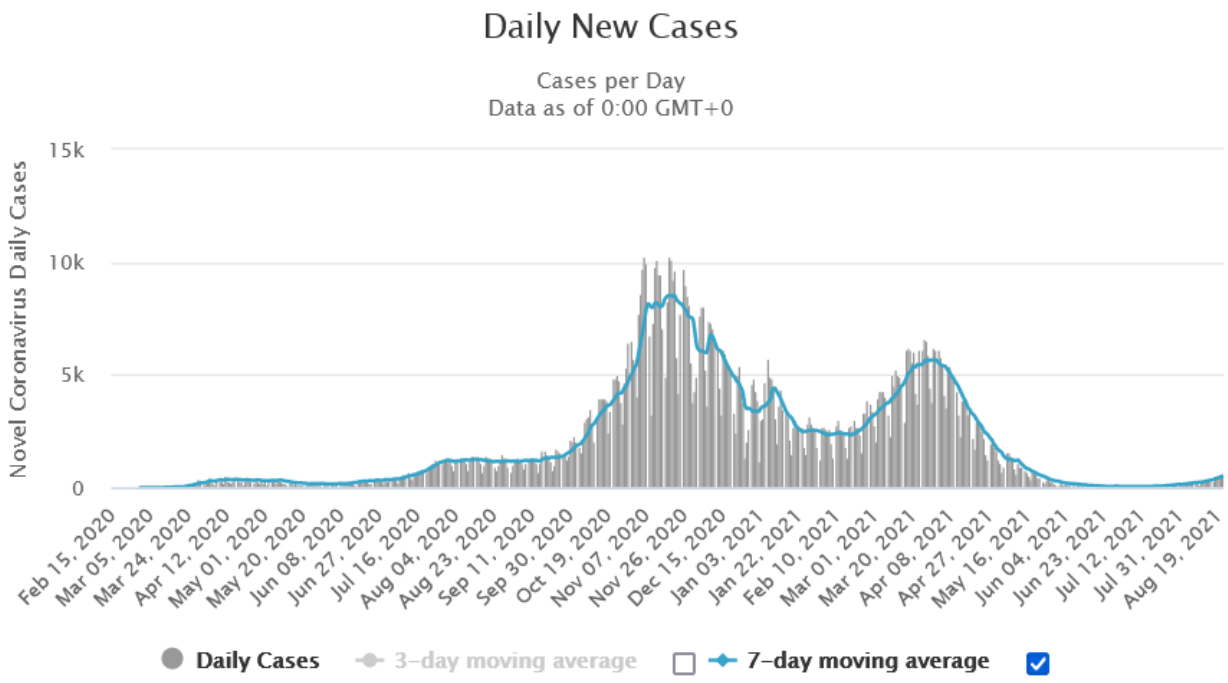
So, let's look at these five countries starting with the one that has the most fully vaccinated people at 27% and finishing with the one that is the least fully vaccinated at 3%.

Continued next page…

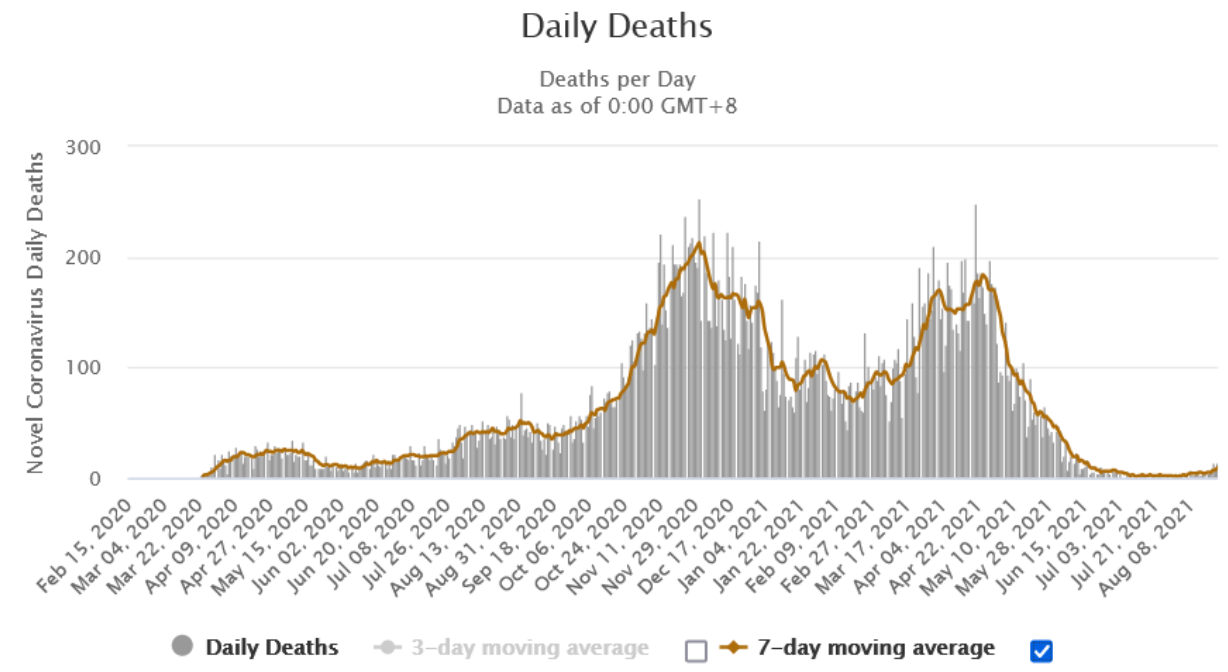
Romania

As of August 29th, just 27% of the population is fully vaccinated.

Daily New Cases in Romania



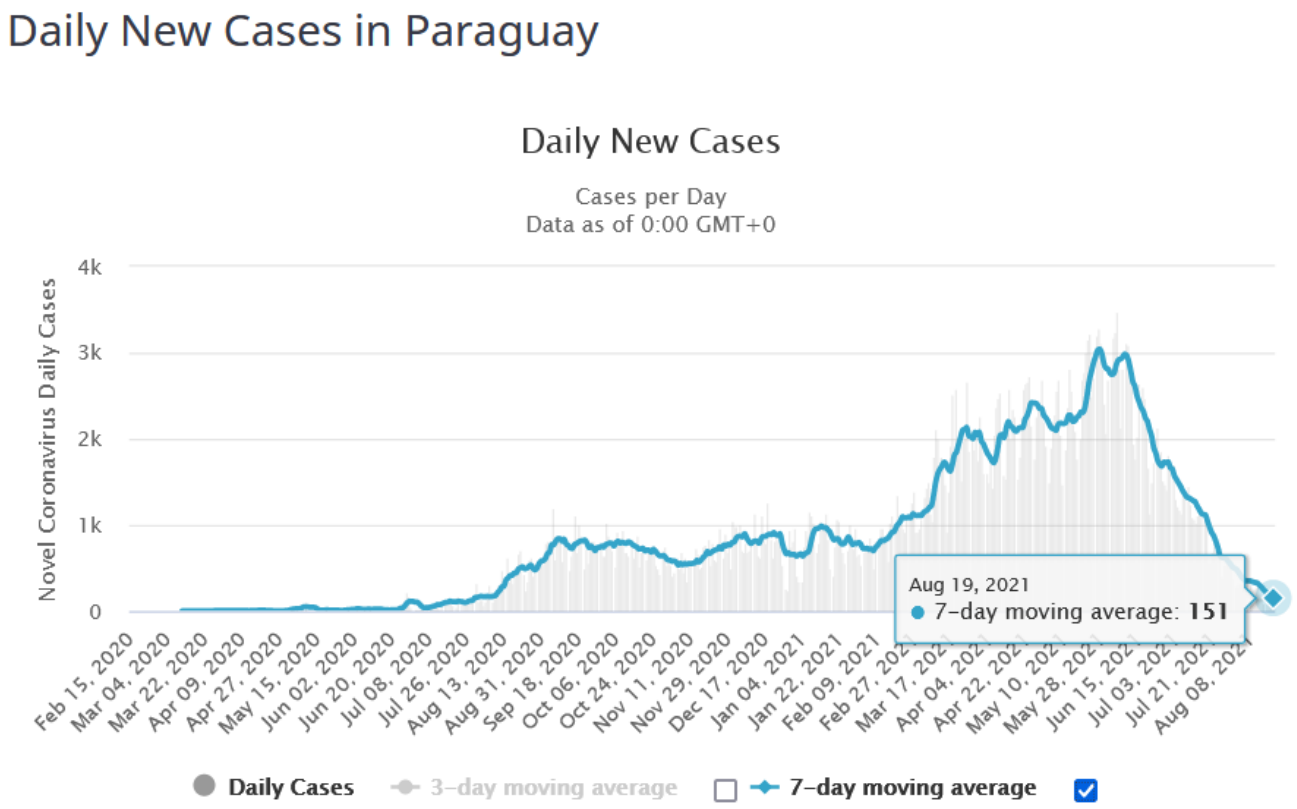
Daily New Deaths in Romania



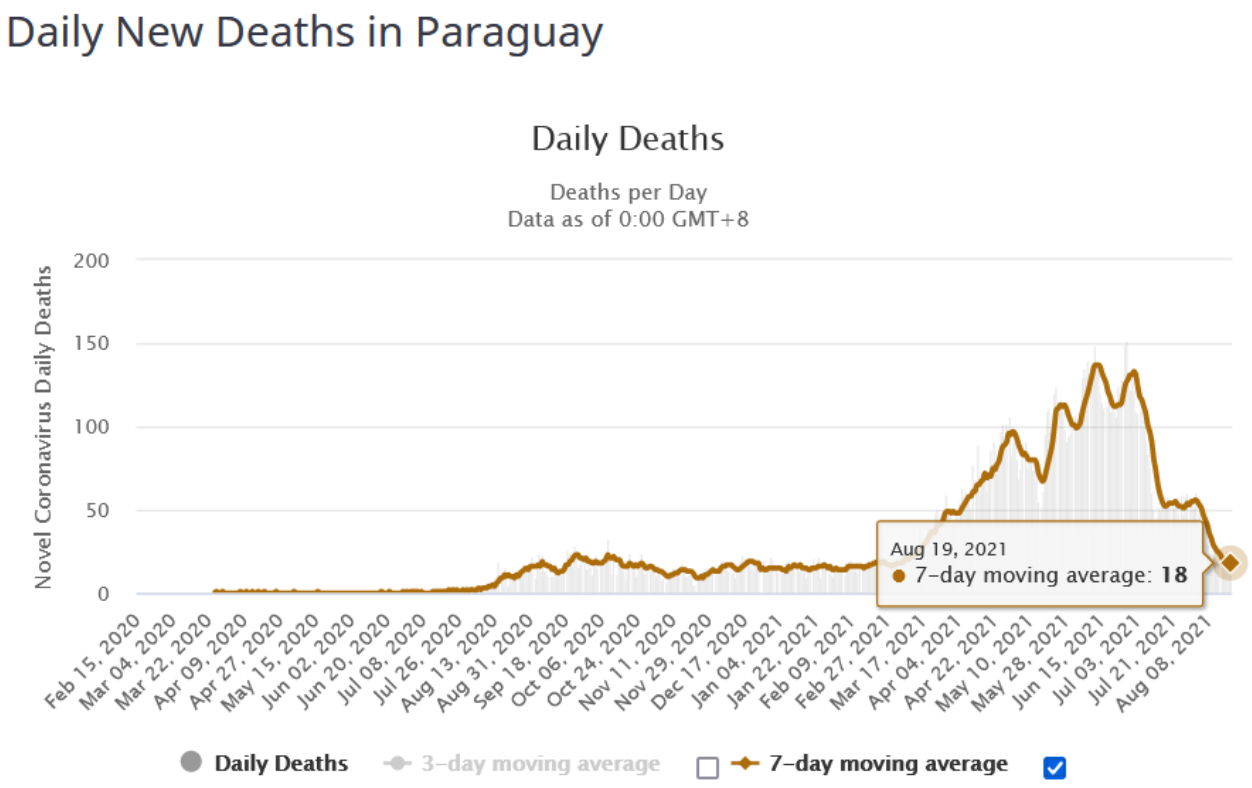
All with only one fourth of the population fully vaccinated they are doing just fine. This could be a case of decrease due to seasonality, or are they possibly nearing natural herd immunity?

Paraguay

As of August 17th, 2021, Paraguay only had 23% of their population fully vaccinated. They had about a 90-day surge in cases in April through June, but now those are dropping precipitously.



The same thing seems to have happened with deaths



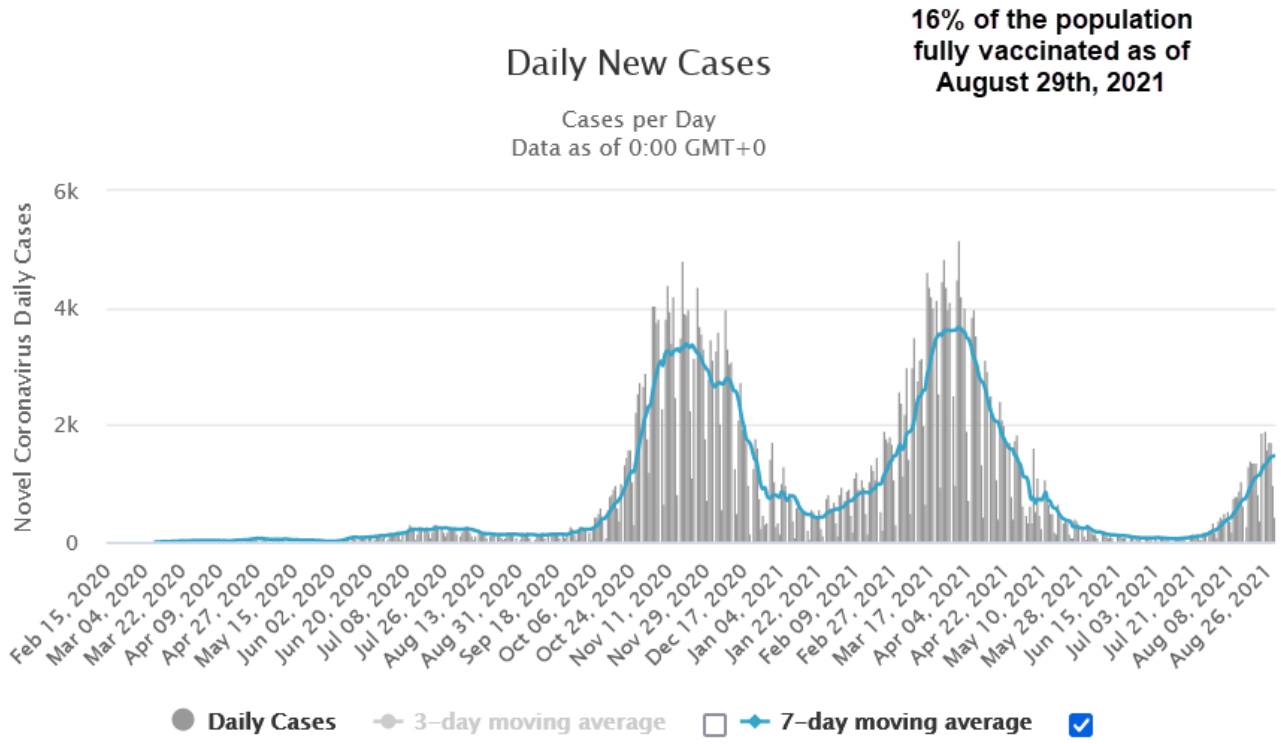
While you can see that Paraguay had a rise in cases and deaths just like so many countries around the world despite vaccination rates, the rates of both have dropped precipitously. This is what happens with viral outbreaks. They have rises and falls based on many factors including seasonality, percentage of the population that have contracted the illness and recovered giving them immunity. Paraguay is a country in South America located in the southern hemisphere. Because it is in the southern hemisphere, they have just passed the middle of their winter. As you can see, they had their spikes in April, May and June, which would be equivalent to our October, November and December which is when cases, hospitalizations and deaths tend to ramp up here in the U.S. And that is the typical respiratory viral season pattern in the northern hemisphere. Sometimes it starts a little later and ends later, but generally these surges run their course in about 90-120 days.

Please scroll to the next page. I am attempting to keep each country's data on a single page.

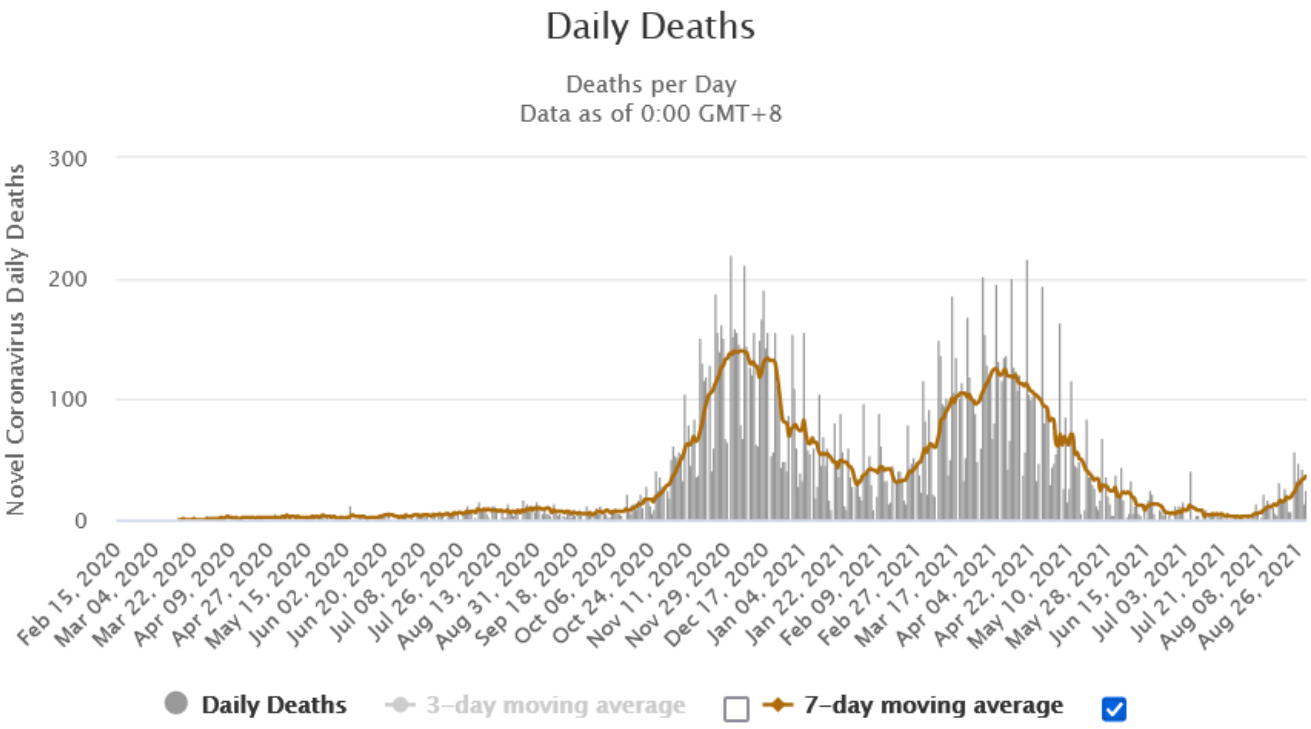
Bulgaria

Just 16% of the population Was fully vaccinated as of August 29th.

Daily New Cases in Bulgaria



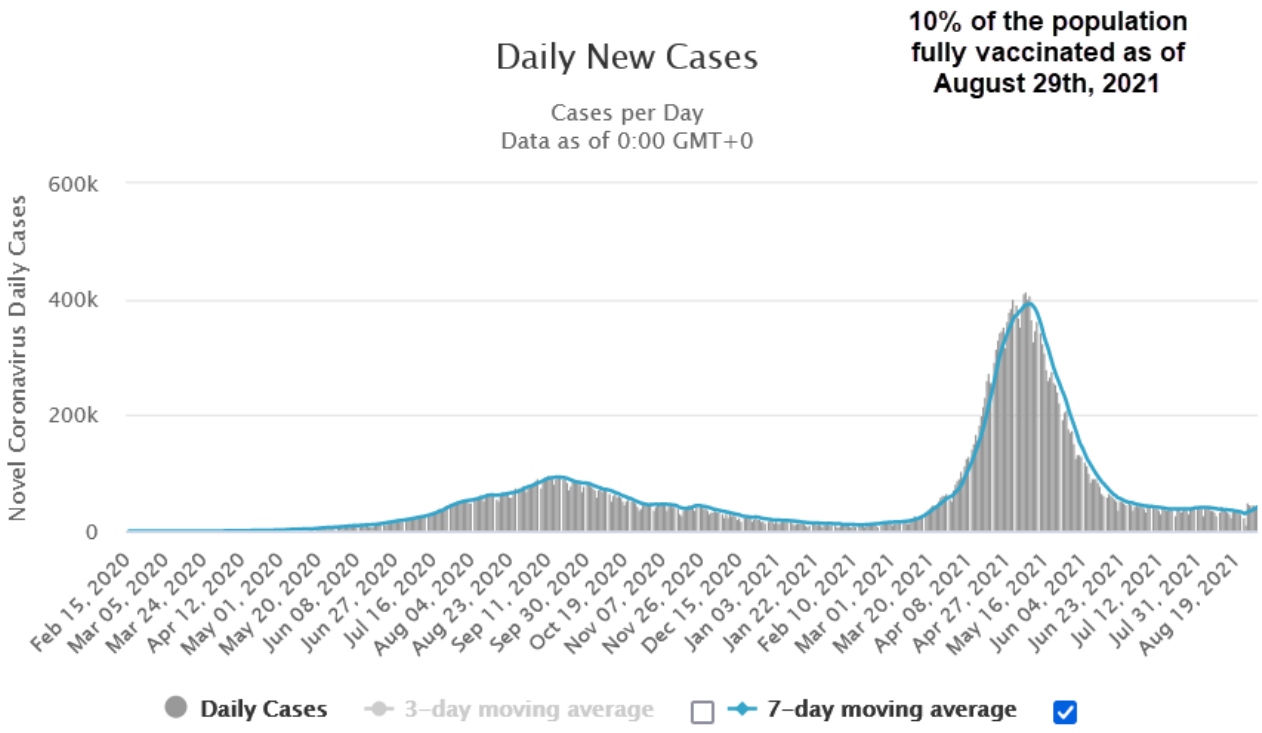
Daily New Deaths in Bulgaria



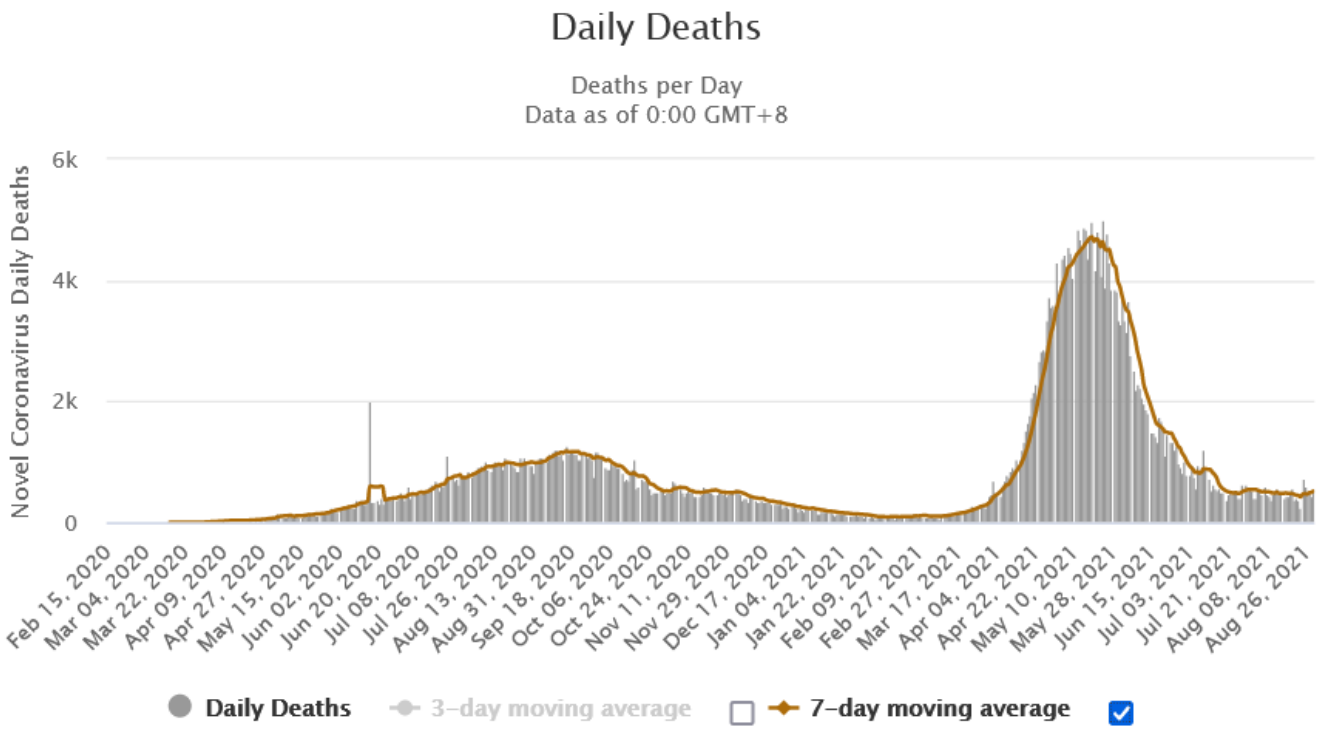
India

Just 10% of the 1.35 billion people in India have been fully vaccinated. So, how are they doing?

Daily New Cases in India



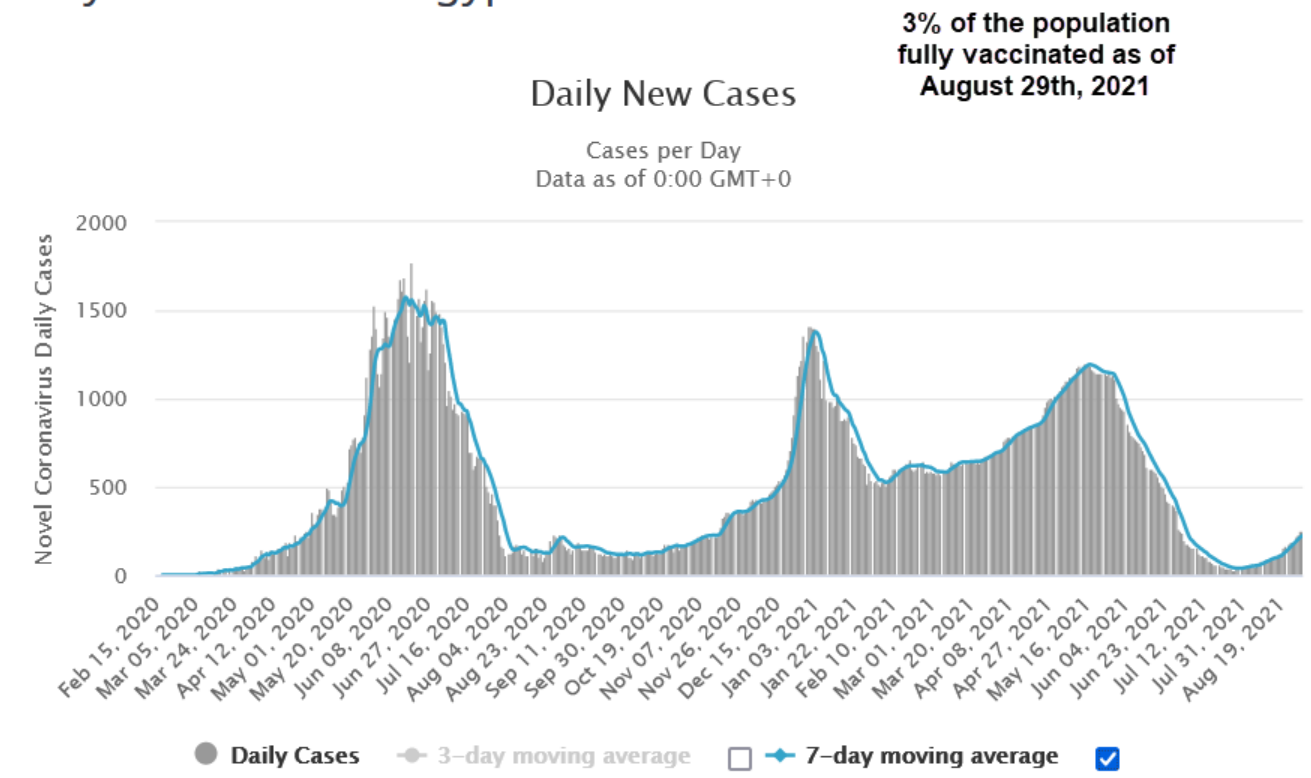
Daily New Deaths in India



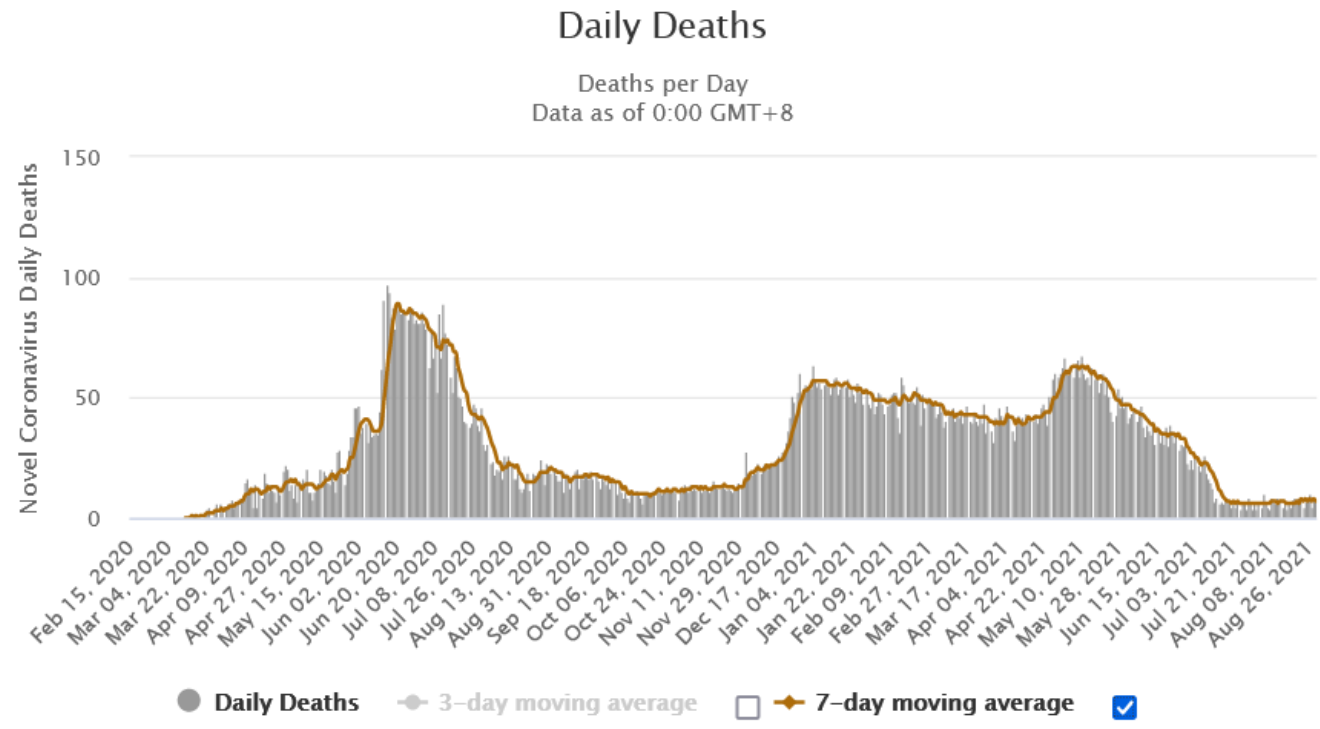
Egypt

Only 3% of the population is fully vaccinated in Egypt.

Daily New Cases in Egypt



Daily New Deaths in Egypt



In looking at these countries, they all seem to be doing extremely well. In fact, when you compare these countries to the most highly vaccinated countries I showed you, it becomes readily apparent that these countries with lower rates of the population vaccinated are doing much better. That sure seems like a paradoxical position compared to what the WHO, CDC, NHS and other public "health" agencies pushing these experimental shots would lead us to believe. Raw data is hard to argue with however.

Percentages of cases in the vaxxed versus the unvaxxed segments of the population. Here are the reasons why the reported narrative is wrong

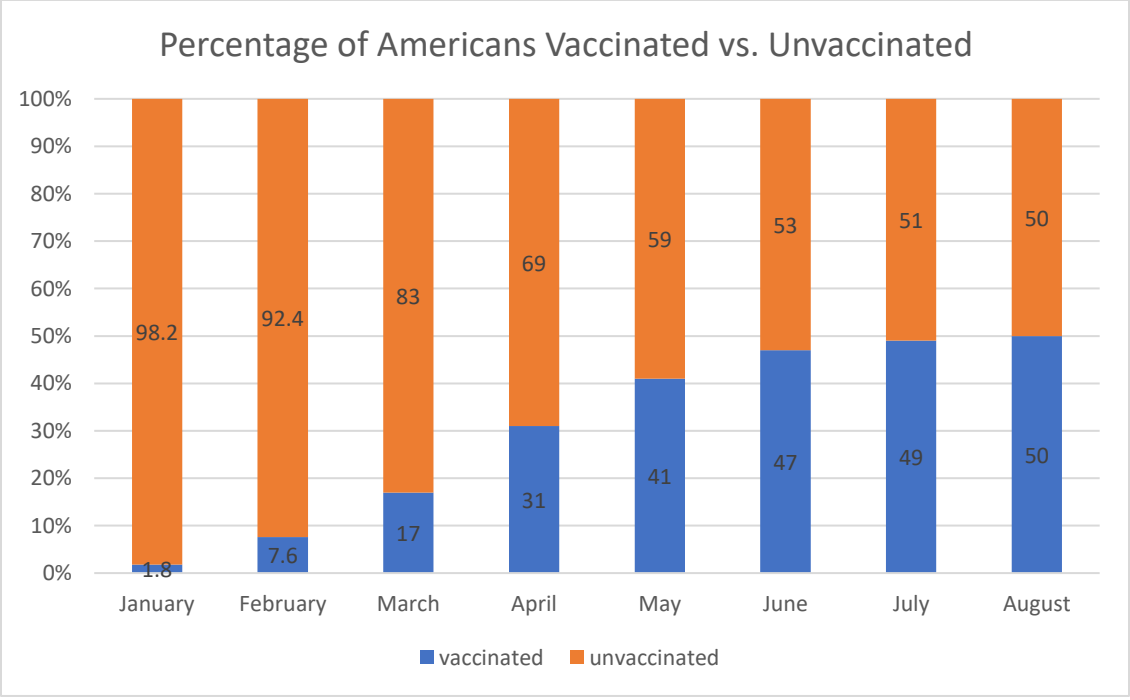
We have all heard reports over the last few months, that the majority of cases are people who are unvaccinated. What is the truth? Last month I covered the statistics coming from Israel and the U.K. showing that the numbers of cases, hospitalizations and deaths have been steadily increasing in the fully vaccinated as the vaccines are failing, especially against the Delta and other variants.

Reason number one…

But for now, one important consideration that must be made is the percentage of the population that have been vaccinated versus unvaccinated at the various points in time since the start of the mass vaccination program. Consider the chart below and this premise. If the exact same percentage of the population that was vaxxed and unvaxxed tested PCR positive for the SARS-CoV-2 virus (*which they call "cases"), the higher numbers would be in the unvaccinated earlier in the campaign by far, simply because there were far fewer people that had been fully vaccinated.

Infections without the manifestation of the symptoms of COVID-19 are not and should not be called "cases". See the commentary on cases near the beginning of this issue…but I digress.

Looking at the chart below, it is obvious that the number of "cases" would be much higher in the unvaccinated as compared to the vaccinated even if the percentages of each group contracting the virus were the same.



The total percentage of unvaccinated vs. vaccinated average over the entire 8 months of this graph is 70% unvaccinated vs. 30% vaccinated. So, as you can see simply by sheer numbers, the unvaccinated would naturally appear like they are affected to a greater degree.

A second reason…

A second reason the numbers are skewed is that **the CDC stopped counting positive cases in the vaccinated portion of the population on May 1st, 2021, unless they were hospitalized or died.** To my knowledge no one has been able to justify this disparate change in counting. If you are going to bother to continue counting the unvaccinated individuals in case counts, why not the vaccinated? By all appearances, it would be to change the narrative that the unvaccinated are the ones that are to blame for the spread of the pandemic. If someone can challenge that assumption rational and logically, have at it.

Proof of the change in policy

From the CDC web page titled, **COVID-19 Vaccine Breakthrough Case Investigation and Reporting**.

"As of May 1, 2021, CDC transitioned from monitoring all reported vaccine breakthrough cases to focus on identifying and investigating only hospitalized or fatal cases due to any cause. This shift will help maximize the quality of the data collected on cases of greatest clinical and public health importance."

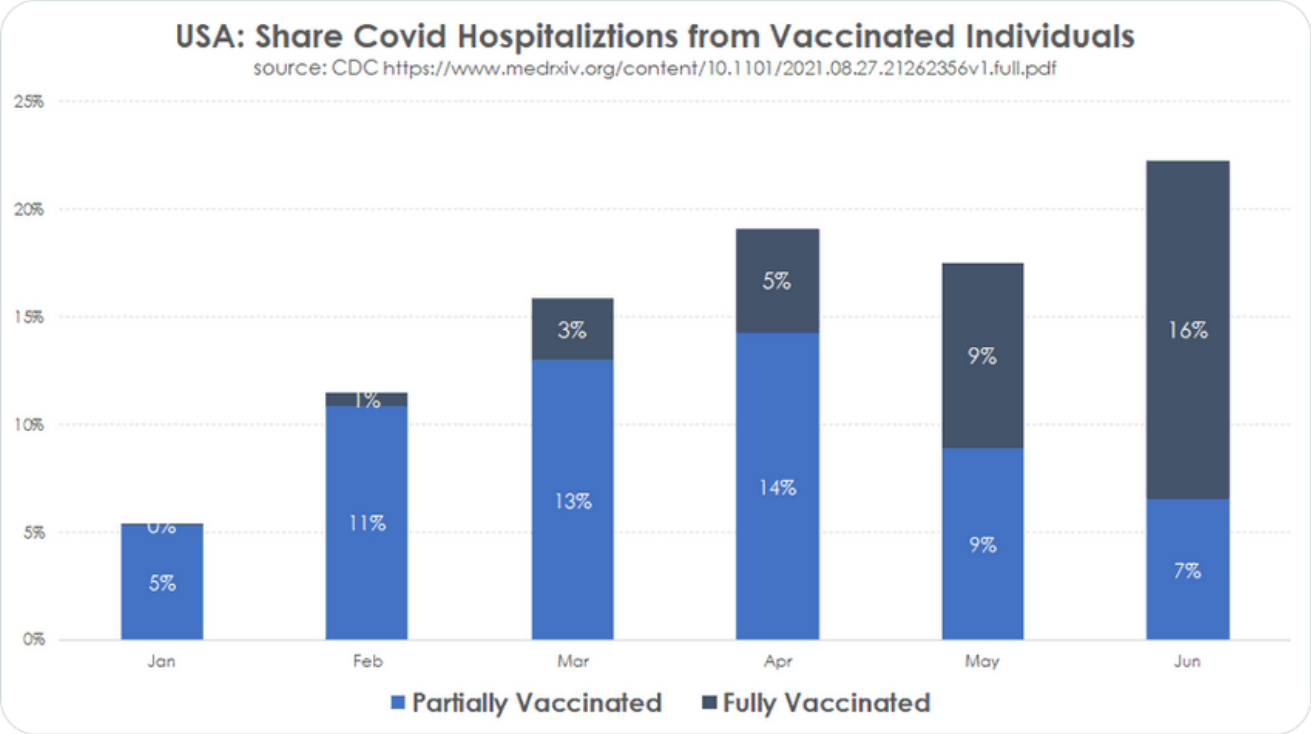
https://www.cdc.gov/vaccines/covid-19/health-departments/breakthrough-cases.html

You don't have to be a statistician to realize that this will skew the case numbers heavily in the direction of the unvaccinated, because the vast majority (probably 99%) of PCR positive cases never reach the doors of the hospital and even fewer become fatalities. Also, isn't it interesting that their decision came as Delta Variant cases began to surge here in the U.S., and after the trend abroad where Delta hit sooner and was exposing the glaring truth that Delta was defeating the protection of the vaccines? Coincidence?

Reason number three…

Because sometimes they just lie…

Here is data from a ***CDC*** sponsored study looking at data through June 2021. If you'll notice, from March through June the percentage of fully vaccinated people being hospitalized has consistently nearly doubled each month. While I couldn't find the data for July in August, one could extrapolate that if this trend continues, July may be nearly 30% fully vaccinated and August at around 55 percent fully vaccinated. This is really not a stretch because it is the trend that we are seeing from countries all over the world. And, I have been hearing from healthcare personnel working in hospitals for many weeks now that they are seeing an increasing number of vaccinated people sick enough to be hospitalized. Yet, even as of this month the headlines have been running with the narrative that 99% of the people hospitalized are unvaccinated. These people need to be exposed for the fools that they are! They are lying to the public as yet another disinformation campaign tactic to increase vaccination levels, which if you



Breaking News on immunity conferred by infection with SARS-CoV-2! New data out of Israel shows conclusively that COVID recovered people have a remarkably smaller chance of reinfection than fully vaccinated people

The study is a pre-print updated August 25th, 2021 and is titled, **Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections.**

Spoiler alert: At the end of the study, researchers found that vaccinated people were 13 times more likely to be infected and 27 times *(2,700%)* more likely to have symptomatic infections as a matched cohort that was previously infected with the Delta variant.

From the study

"This is the largest real-world observational study comparing natural immunity, gained through previous SARS-CoV-2 infection, to vaccine-induced immunity, afforded by the BNT162b2 mRNA vaccine. Our large cohort, enabled by Israel's rapid rollout of the mass-vaccination campaign, allowed us to investigate the risk for additional infection – either a breakthrough infection in vaccinated individuals or reinfection in previously infected ones – over a longer period than thus far described."

"Our analysis demonstrates that SARS-CoV-2-naïve vaccinees had a 13.06-fold increased risk for breakthrough infection with the Delta variant compared to those previously infected, when the first event (infection or vaccination) occurred during January and February of 2021. The increased risk was significant for a symptomatic disease as well."

Conclusions:

This study demonstrated that natural immunity confers longer-lasting and stronger protection against infection, symptomatic disease and hospitalization caused by the Delta variant of SARS-CoV-2, compared to the BNT162b2 two-dose vaccine-induced immunity.

End of excerpts

This is certainly not a surprise, even to Dr. Fauci who has been playing down the lasting and robust immunity conferred to those that have had and recovered from the SARS-CoV-2 infection. And, I have presented at least a couple dozen studies in my monthly newsletters since the start of the outbreak showing the same. Unfortunately, this information doesn't sell vaccines, so it doesn't get air time.

If you would like to get all of that information from my previous newsletters on natural immunity, you can order my eBook titled, **Long-term or Prior Immunity from COVID-19** for just $4.95 **HERE**.

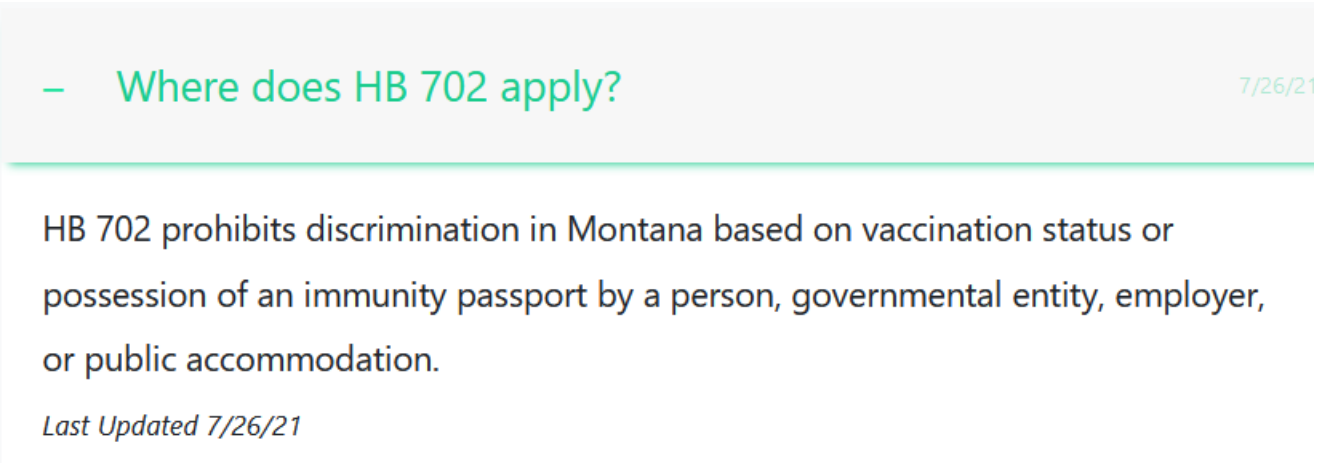
Medical Freedom should be non-negotiable

Medical freedom is not only ensured in our Bill of Rights, but the ***Nuremberg Convention*** which the United States and many other countries of the civilized world signed onto guarantees the right to body autonomy and the freedom to decline any medical intervention. And such intervention cannot be forced, required or made necessary through coercion, which is exactly what we are seeing today.

Montana is the first state to ban vaccine mandates

While Florida and Arizona and other conservative run states have banned vaccine mandates by colleges and state universities, Montana becomes the first state to ban them across the board.

From the Montana Department of Health website.



https://erd.dli.mt.gov/human-rights/human-rights-laws/employment-discrimination/hb-702

An August 20th, article in Fortune online titled, **Montana becomes the first U.S. state to ban vaccine requirements for employees**, portrays the struggle between those that think it is the right and constitutional thing to do and those that think it the worst kind of public health policy.
https://fortune.com/2021/08/20/montana-first-us-state-to-ban-covid-vaccine-requirements-employees/

From the article

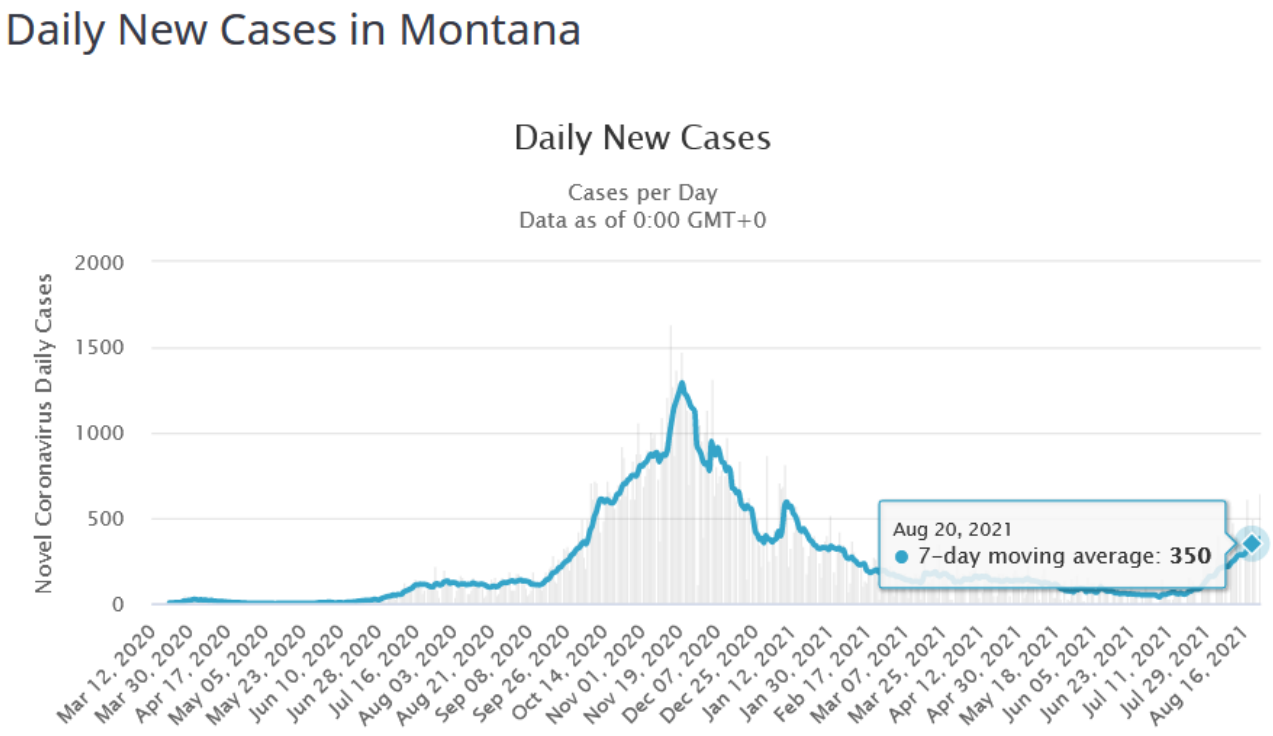
While many large companies across the U.S. have announced that COVID-19 vaccines will be required for their employees to return to work in-person, there is one state where such requirements are banned: Montana. Under a new law passed by the state's Republican-controlled Legislature earlier this year, requiring vaccines as a condition for employment is deemed "discrimination" and a violation of the state's human rights laws. Montana is the only state in the U.S. with a law like this for private employers, said Hemi Tewarson, executive director of the National Academy for State Health Policy.

The law has raised concern among employers across the state **as Montana struggles with a rise in COVID-19 cases that is once again straining the state's health care system.** *(keeping this last statement in mind)…*

End of excerpts

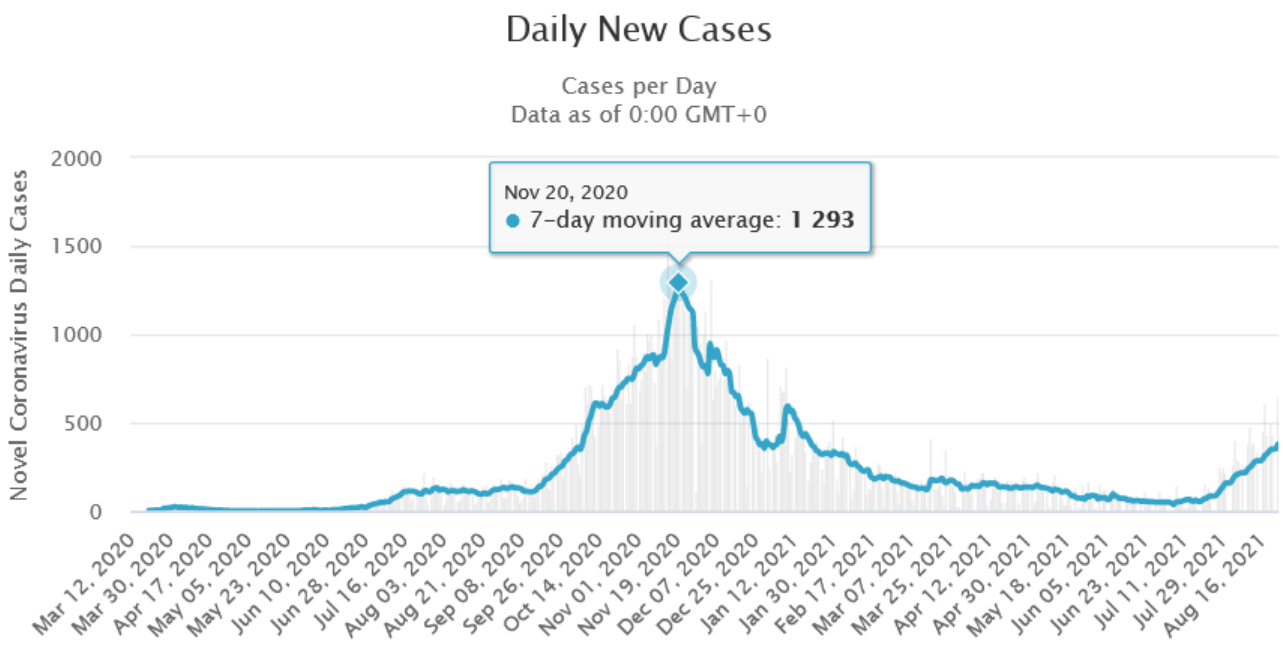
WAIT! Hold the press. Let's look at just how strained the state's health care system really was at the time that this comment was made.

Because I deal in raw data and facts, nor hyperbole and fearmongering let's take a look.



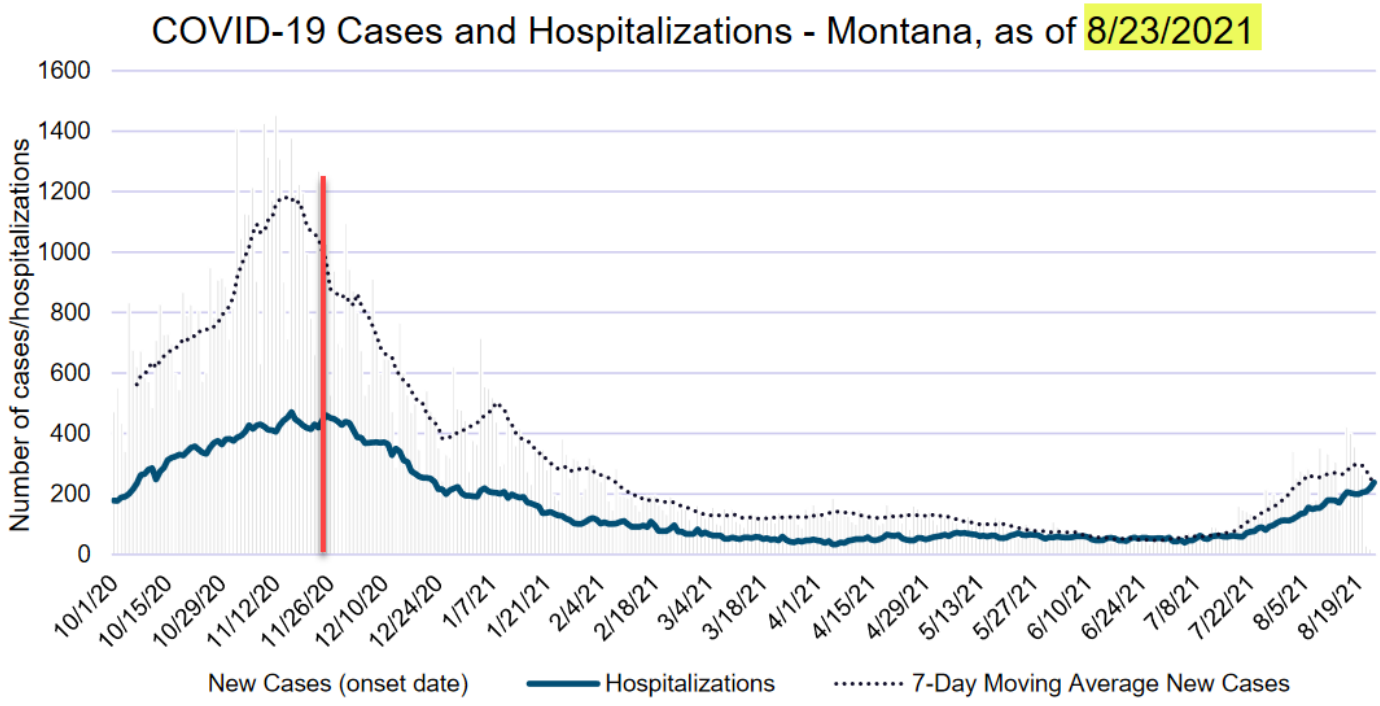
https://www.worldometers.info/coronavirus/usa/montana/

So, the seven-day moving average on August 20th was 350 daily new cases. How does that compare to Montana at its peak of the outbreak which occurred November 20th, 2020.



As you can see the 7-day average number of daily cases is approximately 25% of what it was at the peak. That doesn't sound like much of a strain on the system. Remember we're not talking about hospitalizations or deaths, merely positive PCR tests. Hospitalizations is what really puts the strain on the system.

The number of those PCR positives that are being hospitalized is the more important metric to track.



https://dphhs.mt.gov/assets/publichealth/CDEpi/DiseasesAtoZ/2019-nCoV/Reports/HospitalReport08232021.pdf

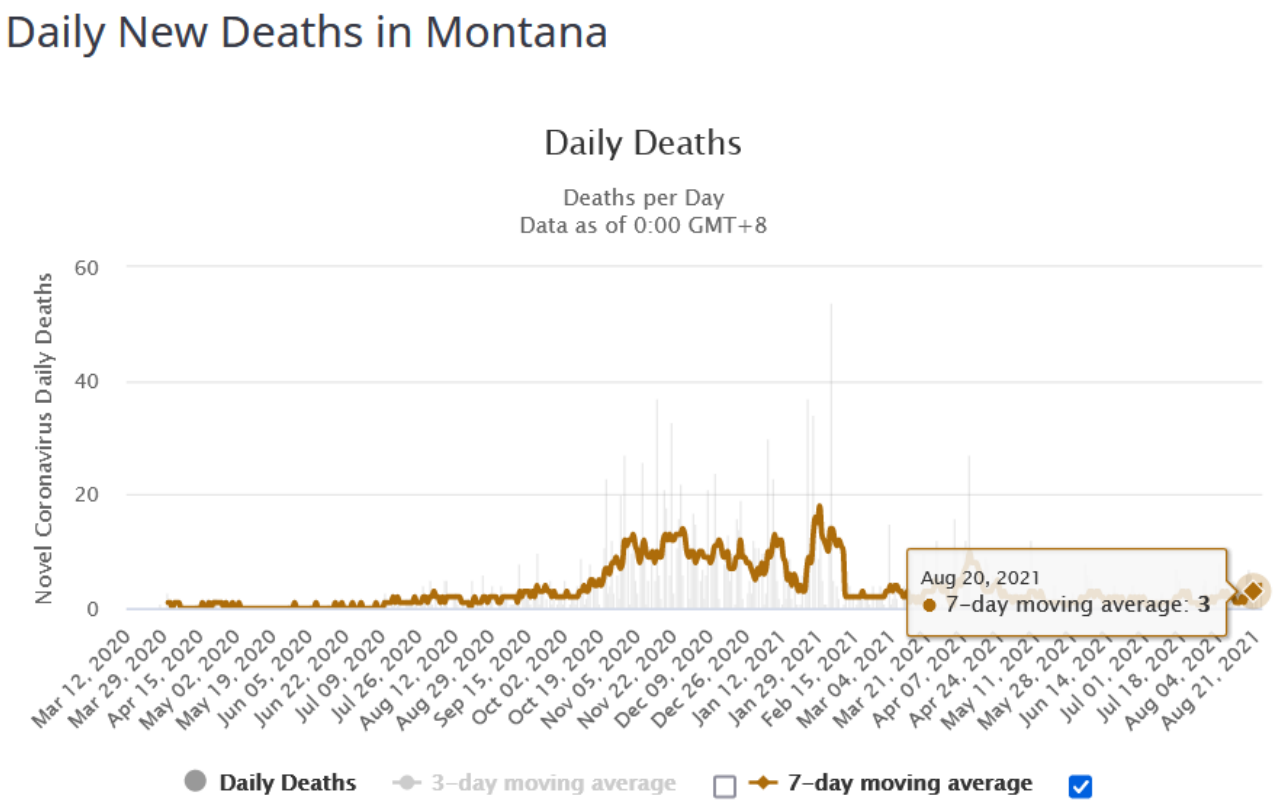
The red line represents November 20th, 2020, when the number of PCR positives reached its peak.

Notice from the table below, that only 5% of cases ever needed to go to the hospital.

Montana as of August 23rd, 2021

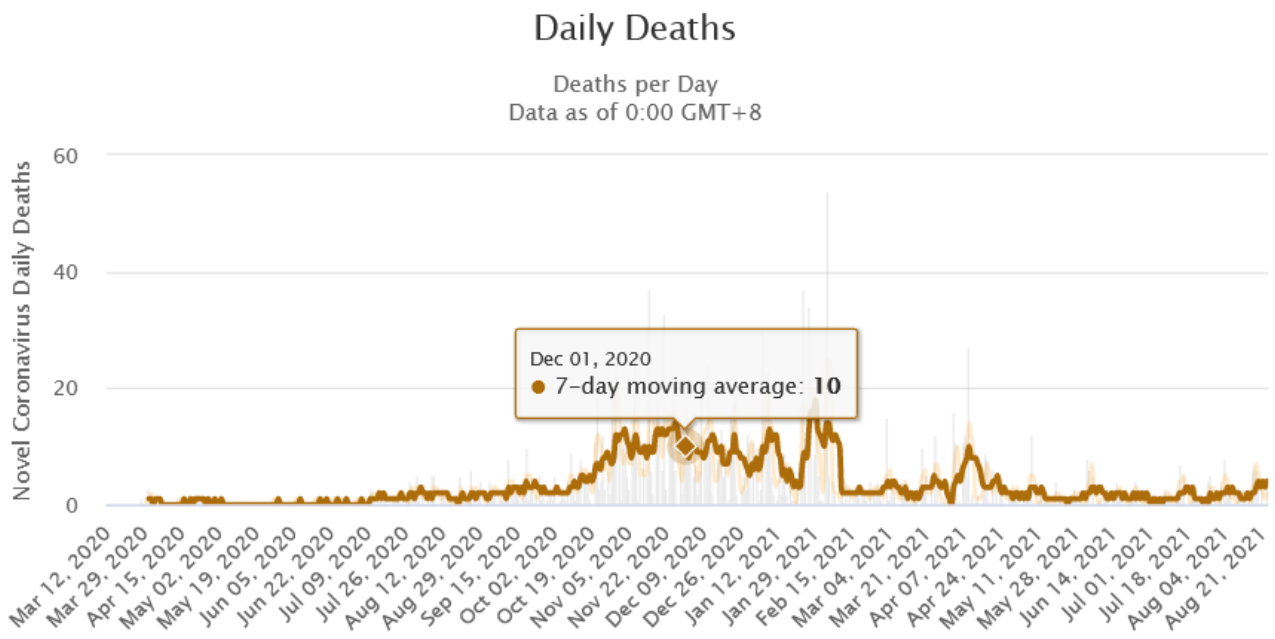
Hospitalization Status	Number of Cases (percent of total)
Ever hospitalized	6201 (5%)
Never hospitalized	117473 (95%)
Total	123674

This first graph represents the seven-day moving average (3 deaths) on August 20th, the date of the article.



The seven-day moving average was only three deaths per day on August 20th, 2021. So, what was it at the peak back in November when the cases hit their all-time peak? I'm going to use December 1st as the number of deaths because that is approximately 10 days later from when the number of cases peaked. There is typically a 10-to-14-day lag time between a case being diagnosed and death in the most severe cases.

Continued next page…



In this case, the average daily deaths were approximately a third on August 20th 2021, compared to what they were on December 1st 2020, at the case peak of the pandemic.
In summary, it appears that the number of hospitalizations are approximately 50% of what they were at the peak late last fall. Obviously, some areas of the state would be higher than that and some lower than that. But I wouldn't exactly call that a strain on the healthcare system. A lot depends on where things go from here, but hopefully we will see a downhill progression like we are seeing in many areas. And for reference, the cases are nearly one forth and the deaths are about a third of what they were at the peak.

Let's hope that more states follow suit in protecting a person's individual medical freedoms and right to have autonomy over one's own body without coercion, force, mandate or threat of penalty. This is a clear violation of the ***Nuremberg Code***. As I have described in this newsletter, the narrative about the unvaccinated spreading COVID-19 and causing the variants is exactly opposite of what is true and what our scientific knowledge about vaccine escape mutants and inappropriate antibiotic use driving antibiotic resistant strains of bacteria have taught us. Of course, it took medicine decades to catch onto how the inappropriate and indiscriminate use of antibiotics causes super germs. And it wouldn't be a stretch to say that a significant percentage of medical doctors still prescribe antibiotics for viral conditions, making the problem even worse. Currently over 100,000 people a year die of antibiotic resistant infections in the U.S. alone. This is a medically caused situation that puts any person entering a hospital at extreme risk. It's unfortunate that we see history repeating itself with these gene therapies being utilized during this pandemic, and we see the definition of insanity playing out before our very eyes. Coming at the public with boosters of the same ineffective vaccines that do not control infection or transmission and very likely are driving the creation of escape variants, is the epitome of doing the same thing over and over and over and expecting a different result.

Breakthrough cases are significantly under-reported by the CDC

It is become obvious to anybody who is digging into the data that the CDC is significantly underreporting the number of breakthrough cases of COVID-19. The question is why?

There are a few different potential reasons.

As I reported earlier in this issue, as of March 1st the CDC stopped counting COVID positive cases in vaccinated individuals. The only exception are for those who are hospitalized or die. Why would they do that?

https://www.cdc.gov/vaccines/covid-19/health-departments/breakthrough-cases.html

Here is more detail on how that is affecting the reported cases (and possibly even hospitalizations and deaths).

An ***NBC News*** investigation found that the CDC was under counting by a magnitude of more than 20 times. NBC contacted various states for their numbers of breakthrough cases. They were able to obtain numbers from 38 states. At the time of the NBC investigation, the CDC was reporting only 6,587 breakthrough cases in the U.S. The NBC investigation found that there were more than 125,000 breakthrough cases and 1,400 of them died. The fact that they were only able to get data from 75% of the states means that maybe over 31,000 cases unaccounted for, bringing the total number of cases to nearly 160,000. **That means that the CDC was only reporting on approximately 4% of the total breakthrough cases** (and that's assuming all the states are doing a good job of counting them).

The title of the story was, **Breakthrough Covid cases: Data shows how many vaccinated Americans have tested positive.**

From the story (bold, italics and highlights are mine)

During the **Face the nation** interview, Fauci adhered to the CDC's position — that breakthrough infections are happening only in a small proportion of fully vaccinated people — while Alroy-Preis said **Israel is seeing breakthrough infections occurring in 50% of those who test positive for COVID.**

Despite mounting evidence COVID vaccine protection is waning over time, Fauci told "Face the Nation": "…the predominant message is that if you are vaccinated and you get a breakthrough infection … you're much, much more protected against getting infected than an unvaccinated [person] who is completely vulnerable."

The Centers for Disease Control and Prevention reported 3,907 hospitalizations and 750 deaths in people fully vaccinated against COVID with an FDA-authorized vaccine as of June 21.

The CDC's latest breakthrough numbers, as of July 25, show 6,587 fully vaccinated people with COVID breakthrough cases. Of those, 6,239 people were hospitalized and 1,263 people died. *(isn't it interesting that according to the CDC, nearly 100% of the vaccinated people who got COVID were hospitalized and nearly a fourth of them died?).*

In May, the CDC revised its guidance for reporting breakthrough cases, stating it would count only those cases that result in hospitalization or death. Previously, the agency had included in its breakthrough count anyone who tested positive for COVID.

According to the CDC, the surveillance system for breakthrough cases is passive and relies on voluntary reporting from state health departments, which may not be complete.

In addition, some breakthrough cases will not be identified due to lack of testing. This is particularly true in instances of asymptomatic or mild illness, the CDC said.

NBC News investigated breakthrough cases not reported by CDC

NBC News contacted health agencies in 50 states and the District of Columbia to collect information on breakthrough cases, citing a lack of comprehensive data available from the CDC.

Data collected from 38 states showed more than 125,000 fully vaccinated Americans tested positive for COVID, and 1,400 died.

This conflicts with the CDC's data published July 26. Research by NBC News indicates the number who have been hospitalized or died passed 7,300 in just 30 states providing data. *(Therefore that number could be over 10,000 as 40% of the states were not reporting).*

The total number of breakthrough cases is likely higher than 125,683, as nine states, including Pennsylvania and Missouri, did not provide information, while 11 states did not provide death and hospitalization totals. Four states gave death and hospitalization numbers, but not total cases.

In addition, vaccinated adults who had breakthrough cases but showed no symptoms could be missing from the data altogether, officials told NBC.

End of excerpts

https://www.nbcnews.com/health/health-news/breakthrough-covid-cases-least-125-000-fully-vaccinated-americans-have-n1275500

Ireland also seeing an uptick of seriously ill, fully vaccinated individuals

Last month I reported from other countries that the rates of cases, hospitalizations and deaths in fully vaccinated cases were rises at accelerating rates. Now this from Ireland.

An August 22nd article in the ***Independent.ie*** from Dublin Ireland titled, **St Vincent's at capacity as 'worried unwell' add to the workload woes- Emergency chief braced for new wave of hospital Covid cases as schools and colleges prepare to reopen**, stated the following:

St Vincent's hospital in Dublin is admitting a "worrying" number of double-vaccinated patients for treatment for Covid-19, emergency department head Professor John Ryan has said.

He emphasised that just because people are double-jabbed does not mean they are immune to the virus. "Right now, we're seeing a significant number of breakthrough cases," he said.

Why is the virus evading the vaccines? These next two stories will shed some light on that. But you will never hear this from the mainstream media.

Vaccine developer and expert Geert Vander Bossche posts a dire new warning about continuing the mass vaccination program

Dr. Vanden Bossche whom I mentioned earlier in this newsletter, posted the following on August 16th 2021 titled, **How remaining in the dark and turning in vicious circles inevitably leads to erroneous decisions.**

Conducting mass vaccination campaigns on a background of high infection rates generates optimal conditions for breeding even more infectious Sars-CoV-2 variants. The combination of massive, spike-directed immune pressure combined with high infectious pressure rapidly allows these variants to reproduce more effectively such as to outcompete previously circulating variants/ strains. Mass vaccination, therefore, promotes viral evolution towards more infectious variants. The resulting enhancement of viral infectious pressure makes it more likely for everyone, including healthy, unvaccinated people to come in contact with the virus, especially in times where infection prevention measures are loosened. To the extent that high infection rates cause people to become re-exposed shortly after a previous asymptomatic infection, their innate Sars-CoV-binding antibodies (Abs) will be suppressed by short-lived, poorly functional anti-spike Abs, known to not be responsible for preventing the infection from becoming symptomatic. It is precisely the suppression of these broadly protective innate Abs that makes previously asymptomatically infected individuals more susceptible to disease. It is also precisely this phenomenon that explains why a first wave of a natural pandemic is followed by a second wave in younger age groups. The even bigger amplitude of that second wave merely reflects the overwhelming contribution of a population's innate immunity to its overall immune protective capacity. So, this is why we're now seeing more and more disease in younger age groups, and even children, although they were perfectly protected during previous waves. Extending mass vaccination campaigns to these younger age groups is the most irresponsible public health proposal (decision?) ever as

1. it results in turning a huge cohort of naturally protected people into subjects who will soon become much more vulnerable because the virus is now becoming increasingly resistant to vaccinal Abs (which, despite poor functionality, are still able to suppress broadly protective innate Abs).

2. it further augments pressure on viral infectiousness (i.e., on spike protein, which happens to be the target of all C-19 vaccines!) and, therefore, will only contribute to expediting viral evolution towards enhanced infectiousness (and eventually full resistance to anti-S Abs). As already mentioned, the higher viral infectivity rates grow, the more the incredibly precious innate immune capacity of the population gets eroded and the faster vaccine-mediated protection will wane as a result of enhanced evolution of the virus towards S-Ab-directed resistance. In the meantime – and for as long the C-19 vaccines protect against disease – mass vaccination is turning healthy people into asymptomatic breeding grounds and spreaders of evolving, more infectious variants, which is quite the opposite effect of what mass vaccination was supposed to do (i.e., to generate herd immunity). We only *begin* to see the early consequences of waning vaccine protection, erosion of innate immunity and fulminant expansion of steadily evolving, more infectious variants.

This is to say that it is the complete lack of understanding of why morbidity rates are now increasing in younger age groups that now prompts short-sighted experts and politicians, who typically have no long-term antennae, to advocate for mass vaccination of younger age groups and children. As they obviously lack any kind of insight into the evolutionary dynamics of a pandemic and how those are driven by the interplay

between viral infectious pressure and host immune pressure in the population, they don't understand that mass vaccination of the younger age groups is only throwing fuel to the devastating fire of a self-amplifying vicious circle. I challenge any expert, regardless of reputation or qualifications, to invalidate or oppose my arguments in a public debate on a mainstream broadcasting channel. If that debate doesn't take place, it should be very straightforward for youngsters, parents, guardians, or even the children themselves, to draw their own conclusions and decide what is best for themselves or the children.

If we could only have politicians and short-sighted 'experts' hanging this sheet over their bed, we might finally be in a position where we could start cleaning up some of the mess they have made and put an end to all of the completely unacceptable and needless animosity it caused between the vaccinated and the unvaccinated. Time has come to turn all this chaos into a constructive effort that is finally driven by 'Science' and 'Solidarity'!

https://www.geertvandenbossche.org/post/how-remaining-in-the-dark-and-turning-in-vicious-circles-inevitably-leads-to-erroneous-decisions

We can only pray that there will be leaders in government and public health that will understand what is happening and demand that the scientific community (at least those that haven't yet been paid off by pharma), come together and debate these concerns openly and freely. I know that is a grandiose wish considering the totalitarian-like control over any free speech, much less scientific debate that has been imposed on our nation and much of the world.

Who is Geert Vander Bossche and is he qualified to make these statements? I certainly believe so. Here are some of the positions that he has held.

- Geert Vanden Bossche received his DVM from the University of Ghent, Belgium, and his PhD degree in Virology from the University of Hohenheim, Germany.

- He held adjunct faculty appointments at universities in Belgium and Germany.

- After his career in Academia, Geert joined several vaccine companies (GSK Biologicals, Novartis Vaccines, Solvay Biologicals) to serve various roles in vaccine R&D as well as in late vaccine development.

- Geert then moved on to join the Bill & Melinda Gates Foundation's Global Health Discovery team in Seattle (USA) as Senior Program Officer.

- He then worked with the Global Alliance for Vaccines and Immunization (GAVI) in Geneva as Senior Ebola Program Manager. At GAVI he tracked efforts to develop an Ebola vaccine. He also represented GAVI in fora with other partners, including WHO, to review progress on the fight against Ebola and to build plans for global pandemic preparedness. Back in 2015, Geert scrutinized and questioned the safety of the Ebola vaccine that was used in ring vaccination trials conducted by WHO in Guinea. His critical scientific analysis and report on the data published by WHO in the Lancet in 2015 was sent to all international health and regulatory authorities involved in the Ebola vaccination program.

- After working for GAVI, Geert joined the German Center for Infection Research in Cologne as Head of the Vaccine Development Office.

- He is at present primarily serving as a Biotech/ Vaccine consultant while also conducting his own research on Natural Killer cell-based vaccines.

An article from the pre-COVID era describes how viruses and bacteria are driven to mutate under pressure from vaccines and antibiotics

The article posted May 10th, 2018 on ***QuantumMagazine.org*** is titled, **Vaccines Are Pushing Pathogens to Evolve.** Just as indiscriminate or inappropriate antibiotics breed resistant bacterial mutations, vaccines can incite viral mutations (variants) that outpace the vaccines and enable diseases to escape their control.

From the article

Andrew Read, a disease ecologist who directs the Pennsylvania State University Center for Infectious Disease Dynamics wrote a **paper** titled, **Imperfect Vaccination Can Enhance the Transmission of Highly Virulent Pathogens**.

In a 2015 paper in *PLOS Biology*, Read and his colleagues vaccinated 100 chickens, leaving 100 others unvaccinated. They then infected all the birds with strains of Marek's that varied in how virulent — as in how dangerous and infectious — they were. The team found that, over the course of their lives, the unvaccinated birds shed far more of the least virulent strains into the environment, whereas the vaccinated birds shed far more of the most virulent strains. The findings suggest that the Marek's vaccine encourages more dangerous viruses to proliferate. This increased virulence might then give the viruses the means to overcome birds' vaccine-primed immune responses and sicken vaccinated flocks.
https://www.quantamagazine.org/how-vaccines-can-drive-pathogens-to-evolve-20180510/

The abstract from Dr. Read's 2015 paper in *PLOS Biology*

Could some vaccines drive the evolution of more virulent pathogens? Conventional wisdom is that natural selection will remove highly lethal pathogens if host death greatly reduces transmission. Vaccines that keep hosts alive but still allow transmission could thus allow very virulent strains to circulate in a population. Here we show experimentally that immunization of chickens against Marek's disease virus enhances the fitness of more virulent strains, making it possible for hyperpathogenic strains to transmit. Immunity elicited by direct vaccination or by maternal vaccination prolongs host survival but does not prevent infection, viral replication or transmission, thus extending the infectious periods of strains otherwise too lethal to persist. Our data show that anti-disease vaccines that do not prevent transmission can create conditions that promote the emergence of pathogen strains that cause more severe disease in unvaccinated hosts.
https://journals.plos.org/plosbiology/article?id=10.1371/journal.pbio.1002198

The virus is evading the vaccines. This is called vaccine escape and the variants are called escape mutants (sounds like something out of a sci-fi movie, doesn't it?) Why is that happening?

It is happening because the virus is mutating to evade the antibodies created by the vaccine's strategy of stimulating the body to produce specific antibodies against the genetically engineered spike protein of the real virus. The vaccine version of the spike protein that the shots cause our bodies to manufacture by the billions, becomes recognized by our immune system by the exact amino acid sequences in that spike protein, just a very small part of the virus. If those sequences along that spike protein are changed (called mutations), the

antibodies produced by the vaccine will not recognize the new patterns of amino acid sequences of the new mutated strain (variant). Therefore, the effectiveness of the vaccines are reduced.

A 2017 study published in the Journal of Autoimmunity titled, **Original antigenic sin: A comprehensive review**, describes how the process called ***Original Antigenic Sin (OAS)*** occurs and the ramifications of that.

The abstract- (bolded sections by me)

The concept of "original antigenic sin" was first proposed by Thomas Francis, Jr. in 1960. This phenomenon has the potential to rewrite what we understand about how the immune system responds to infections and its mechanistic implications on how vaccines should be designed. Antigenic sin has been demonstrated to occur in several infectious diseases in both animals and humans, including human influenza infection and dengue fever. The basis of "original antigenic sin" requires immunological memory, and our immune system ability to autocorrect.

In the context of viral infections, it is expected that if we are exposed to a native strain of a pathogen, we should be able to mount a secondary immune response on subsequent exposure to the same pathogen. "Original antigenic sin" will not contradict this well-established immunological process, **as long as the subsequent infectious antigen is identical to the original one**. But "original antigenic sin" implies that **when the epitope varies slightly, then the immune system relies on memory of the earlier infection, rather than mount another primary or secondary response to the new epitope which would allow faster and stronger responses**. **The result is that the immunological response may be inadequate against the new strain, because the immune system does not adapt and instead relies on its memory to mount a response.**

In the case of vaccines, if we only immunize to a single strain or epitope, and if that strain/epitope changes over time, then the immune system is unable to mount an accurate secondary response.

In addition, depending of the first viral exposure the secondary immune response **can result in an *antibody-dependent enhancement** of the disease or at the opposite, it could induce ***anergy**. Both of them triggering loss of pathogen control and inducing aberrant clinical consequences.

End of abstract

***Definitions**

Antibody Dependent Enhancement (ADE)- AKA disease enhancement. It is a phenomenon in which binding of a virus to suboptimal antibodies enhances its entry into host cells, followed by its replication and leading to an intensified inflammatory response and disease progression in the body. This is the phenomenon that has plagued every other attempt to make a corona virus vaccine in the last 30 years. It is the main reason why those vaccines never made it past the animal studies into humans. The animals appeared to develop a healthy antibody response which was encouraging to researchers. But later when those animals were challenged by the wild virus they developed an out of control immune reaction leading to death in a large number of those affected animals.

Anergy- Passivity or diminished responsiveness to specific antigens.

A new study reveals information that may be a clue that Antibody Dependent Enhancement may be in play with the rising hospitalizations and deaths in vaccinated individuals

A ***bioRxiv*** preprint posted August 23rd, 2021 titled, **The SARS-CoV-2 Delta variant is poised to acquire complete resistance to wild-type spike vaccines,** reveals the failure of the Pfizer vaccine with the Delta variant and describes what is happening which fits the exact scenario in which **Antibody Dependent Enhancement (ADE),** AKA Pathogenic Priming develops. Keep that in mind as you read the **Key points from the study** below.

But first some background…

- Neutralizing antibodies (Nab) are those that bind to the virus at the active site it uses to bind to the cell (the spike protein binding domain), which prevents it from entering or infecting a cell. This prevents the virus from replicating inside the cell and releasing thousands of new viruses.
- Binding antibodies (AKA non-neutralizing antibodies or (n-NAb), are unable to prevent infection. They can bind to the virus but not to the spike protein binding domain. They bind to the envelop protein of other protein (of which 29 have been identified in the SARS-CoV-2 virus). Paradoxically, that can then actually help the virus enter to infect a cell. They are sometimes referred to as Disease Enhancing Antibodies.
- It is believed that ADE develops when the neutralizing antibodies are insufficient to neutralize the virus. This allows the binding antibodies to bind to the virus which can help the virus get into the cell.
- The mRNA vaccines have been shown to be poor at producing neutralizing antibodies from the first shot. In the first shot they produce more binding than neutralizing antibodies. Hence the need for the 2-dose regimen.
- If the neutralizing antibodies "wane" or decrease over time and much more than the non-neutralizing antibodies, which is what is happening within 4-6 months after the mRNA vaccines (beginning at just 6 weeks), a real problem of enhanced infectivity can occur in the vaccinated. We are already seeing that the levels of virus in the nasopharynx of vaccinated individuals can be dozens of times higher than when unvaccinated people become infected. This can then cause an over-reaction by the immune system which goes into hyperdrive and cause runaway inflammation leading to tissue and organ damage.

Key points from the study- (Red comments by me)

- **Here, we found that the Delta variant completely escaped from anti-N-terminal domain (NTD) neutralizing antibodies, while increasing responsiveness to anti-NTD infectivity-enhancing antibodies.** (exactly as I described above)

- Although Pfizer-BioNTech BNT162b2-immune sera neutralized the Delta variant, when four common mutations were introduced into the receptor binding domain (RBD) of the Delta variant (Delta 4+), some BNT162b2-immune sera **lost neutralizing activity and enhanced the infectivity.**

- **Unique mutations in the Delta NTD were involved** in the enhanced infectivity by the BNT162b2-immune sera. (That is why natural immunity is far superior. It isn't just focused on one very small part of the virus)

- **Given the fact that a Delta variant with three similar RBD mutations has already emerged according to the GISAID database, it is necessary to develop vaccines that protect against such complete breakthrough variants.** (Like the old adage says, "If your only tool is a hammer, everything starts looking like a nail")

https://www.biorxiv.org/content/10.1101/2021.08.22.457114v1

Now of course their solution is another vaccine, but they obviously haven't learned a thing. By the time they could develop and roll out a new version of the vaccine, there most likely would be new mutations that would evade the new vaccine from the start. Even if that didn't happen, the vaccines would drive development of new mutations just like the current version has done. You know what doing the same thing over and over and expecting a different result is called don't you? It's the definition of insanity.

A reminder from this article I ran in last month's newsletter about the concerns many scientists and bioethicists have about informing people about the real risk of ADE

In a March 2021 article **FUNDED by the *NIH*** (Tony Fauci's group) and published in ***Perspective- Infectious Diseases*** titled **Informed consent disclosure two vaccine trial subjects of risk of COVID-19 vaccines worsening clinical disease**, authors are critical of the lack of patient informed consent revolving around COVID-19 vaccines the risk of causing Antibody Dependent Enhancement (ADE), or what is sometimes called Pathogenic Priming. The section I have pasted here goes through a nice history of why many top scientists and medical experts have been terrified about the prospect of this developing in some people. In fact, as I have reported in previous issues of this newsletter, there have been thousands of reports world-wide of incidents of previously uninfected people developing severe COVID-19, with many dying after they have had their shots. These have been roundly dismissed as unfortunate coincidences.

From the article-

Results of the study: COVID-19 vaccines designed to elicit neutralizing antibodies may sensitise vaccine recipients to more severe disease than if they were not vaccinated. Vaccines for SARS, MERS and RSV have never been approved, and the data generated in the development and testing of these vaccines suggest a serious mechanistic concern: that vaccines designed empirically using the traditional approach (consisting of the unmodified or minimally modified coronavirus viral spike to elicit neutralising antibodies), be they composed of protein, viral vector, DNA or RNA and irrespective of delivery method, may worsen COVID-19 disease via antibody-dependent enhancement (ADE). This risk is sufficiently obscured in clinical trial protocols and consent forms for ongoing COVID-19 vaccine trials that adequate patient comprehension of this risk is unlikely to occur, obviating truly informed consent by subjects in these trials.

Conclusions drawn from the study and clinical implications: The specific and significant COVID-19 risk of ADE should have been and should be prominently and independently disclosed to research subjects currently in vaccine trials, as well as those being recruited for the trials and future patients after vaccine approval, in order to meet the medical ethics standard of patient comprehension for informed consent.

End of story
https://pubmed.ncbi.nlm.nih.gov/33113270/

Is informed consent about ADE happening? Based on all have heard and found out, the answer is categorically NO. And they want these shots mandated without giving people the truth about ADE and all the other known and potential risks? It's absurd.

A study in the *Journal of Infection* rings the alarm bells about Antibody Dependent Enhancement from the COVID-19 vaccines

The study is from the ***Journal of Infection*** dated August 9th, 2021 titled, **Infection-enhancing anti-SARS-CoV-2 antibodies recognize both the original Wuhan/D614G strain and Delta variants. A potential risk for mass vaccination?** It has some very concerning things to say that may explain the rise in severe cases and deaths from the Delta Variant that we are seeing in fully vaccinated people.

From the article- (emphasis and comments in italics are mine)

Since the Covid-19 pandemic is now dominated with Delta variants, we analyzed the interaction of facilitating antibodies with the NTD of these variants. Using molecular modeling approaches, we show that **enhancing antibodies have a higher affinity for Delta variants than for Wuhan/D614G NTDs.** *(Enhancing antibodies help facilitate the virus into the cells increasing infectivity)*

As the NTD is also targeted by neutralizing antibodies, **our data suggest that the balance between neutralizing and facilitating antibodies in vaccinated individuals is in favor of neutralization for the original Wuhan/D614G strain**. **However, in the case of the Delta variant, neutralizing antibodies have a decreased affinity for the spike protein, whereas facilitating antibodies display a strikingly increased affinity. Thus, ADE may be a concern for people receiving vaccines based on the original Wuhan strain spike sequence (either mRNA or viral vectors).** *(Neutralizing antibodies are the ones that you want, which will bind to the spike protein of the virus and prevent it from infecting the cell. In this case with the Delta variant, it says that the neutralizing antibodies have a decreased affinity for the spike protein. That is NOT a good thing).*

Since our data indicate that **Delta variants are especially well recognized by infection enhancing antibodies** targeting the NTD, the possibility of ADE should be further investigated as **it may represent a potential risk for mass vaccination during the current Delta variant pandemic.** *(Once again, especially well recognized by infection enhancing antibodies in NOT a good thing).*

End of excerpts

https://pubmed.ncbi.nlm.nih.gov/34384810/

A perspective on why the spike protein was a bad choice for the shots (other than the fact that the spike protein acts as a toxin in the body).

A paper published pre-vaccine development in April 2020 describes the proposed target spike protein for vaccine development.

The paper titled, **Computers and viral diseases. Preliminary bioinformatics studies on the design of a synthetic vaccine and a preventative peptidomimetic antagonist against the SARS-CoV-2 (2019-nCoV, COVID-19) coronavirus**, describes it this way…

1.4. Coronavirus spike protein as therapeutic target
More specifically focus is on the Class I fusion protein of the coronaviruses which is a glycoprotein known as the spike protein (S) that protrudes extensively from the virus envelope surface. It is responsible for binding to the receptor on the host cell as well as mediating the fusion of host and viral membranes [4]. S, most frequently referred to as the "spike protein" or "spike glycoprotein" below, is synthesized as a single-chain precursor of approximately 1300 amino acids and forms a trimer of 3 S proteins on folding. The trimeric SARS coronavirus (SAR-S-CoV) spike glycoprotein consists of three S1–S2 heterodimers and binds the cellular receptor angiotensin-converting enzyme 2 (ACE2). It mediates fusion of the viral and cellular membranes through a pre-to post fusion conformation transition. Airway protease cleavage site along the amino acid sequence of SARS-CoV S glycoprotein have been identified.

My comment: The 1,300 amino acid chain mentioned is where the mutations that affect the effectiveness of the vaccines occur diminishing the effectiveness of the vaccines and driving the development of new variants.

Vaccine researcher admits 'big mistake,' says spike protein is dangerous 'toxin'

May 31, 2021 (LifeSiteNews) — New research shows that the coronavirus spike protein from

COVID-19 vaccination unexpectedly enters the bloodstream, which is a plausible explanation for thousands of reported side-effects from blood clots and heart disease to brain damage and reproductive issues, a Canadian cancer vaccine researcher said last week.

"We made a big mistake. We didn't realize it until now," said Byram Bridle, a viral immunologist and associate professor at University of Guelph, Ontario, in an interview with Alex Pierson last Thursday, in which he warned listeners that his message was "scary."

"We thought the spike protein was a great target antigen, we never knew the spike protein itself was a toxin and was a pathogenic protein. So by vaccinating people we are inadvertently inoculating them with a toxin," Bridle said on the show, which is not easily found in a Google search but went viral on the internet this weekend.

Bridle, a vaccine researcher who was awarded a $230,000 government grant last year for research on COVID vaccine development, said that he and a group of international scientists filed a request for information from the Japanese regulatory agency to get access to what's called the "biodistribution study."

"It's the first time ever scientists have been privy to seeing where these messenger RNA [mRNA] vaccines go after vaccination," said Bridle. "Is it a safe assumption that it stays in the shoulder muscle? The short answer is: absolutely not. It's very disconcerting."

Vaccine researchers had assumed that novel mRNA COVID vaccines would behave like "traditional" vaccines and the vaccine spike protein — responsible for infection and its most severe symptoms — would remain mostly in the vaccination site at the shoulder muscle. Instead,

the Japanese data showed that the infamous spike protein of the coronavirus gets into the blood where it circulates for several days post-vaccination and then accumulated in organs and tissues including the spleen, bone marrow, the liver, adrenal glands, and in "quite high concentrations" in the ovaries.

"We have known for a long time that the spike protein is a pathogenic protein. It is a toxin. It can cause damage in our body if it gets into circulation," Bridle said.

FDA warned of spike protein danger

Pediatric rheumatologist J. Patrick Whelan had warned a vaccine advisory committee of the Food and Drug Administration of the potential for the spike protein in COVID vaccines to cause microvascular damage causing damage to the liver, heart, and brain in "ways that were not assessed in the safety trials."

While Whelan did not dispute the value of a coronavirus vaccine that worked to stop transmission of the disease (which no COVID vaccine in circulation has been demonstrated to do), he said, "it would be vastly worse if hundreds of millions of people were to suffer long-lasting or even permanent damage to their brain or heart microvasculature as a result of failing to appreciate in the short-term an unintended effect of full-length spike protein-based vaccines on other organs." Vaccine-associated spike protein in blood circulation could explain myriad reported adverse events from COVID vaccines, including the 4,000 deaths to date, and nearly 15,000 hospitalizations, reported to the U.S. government's Vaccine Adverse Event Reporting System (VAERS) as of May 21, 2021. Because it is a passive reporting system, these reports are likely only the tip of an iceberg of adverse events since a Harvard Pilgrim Healthcare study found that less than one percent of side-effects that physicians should report in patients following vaccination are in fact reported to VAERS.

See more of the full article here: https://www.lifesitenews.com/news/vaccine-researcher-admits-big-mistake-says-spike-protein-is-dangerous-toxin/

The following is a follow-up post from ***LifeSiteNews.com*** dated June 1st, 2021

A focus of the statement was the risk to children and teens who are the target of the latest vaccine marketing strategies, including in Canada.

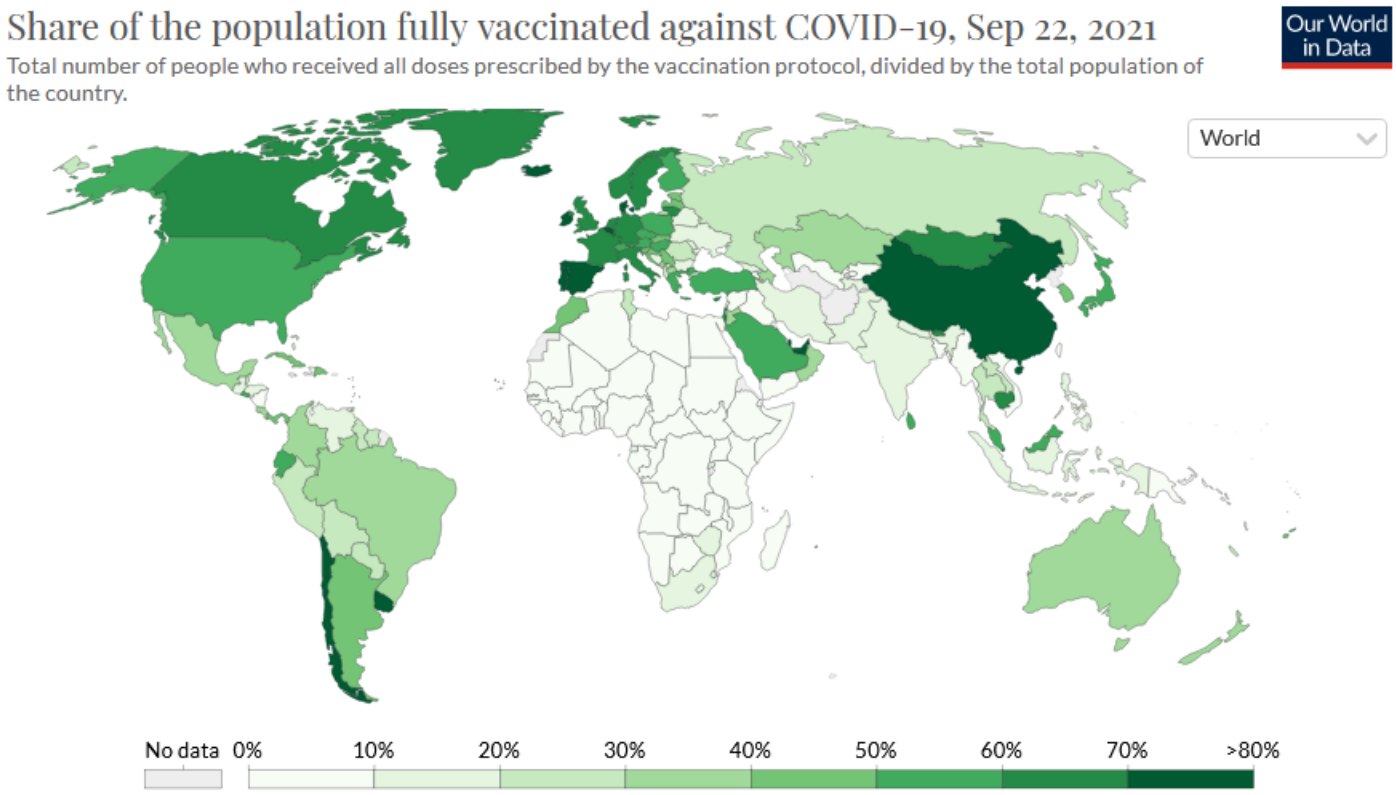
As of May 28, 2021, there have been 259,308 confirmed cases of SARS-CoV-2 infections in Canadians 19 years and under. Of these, 0.048% were hospitalized, but only 0.004% died, according to the CCCA statement. "Seasonal influenza is associated with more severe illness than COVID-19."

Given the small number of young research subjects in Pfizer's vaccine trials and the limited duration of clinical trials, the CCCA said questions about the spike protein and another vaccine protein must be answered before children and teens are vaccinated, including whether the vaccine spike protein crosses the blood-brain barrier, whether the vaccine spike protein interferes with semen production or ovulation, and whether the vaccine spike protein crosses the placenta and impacts a developing baby or is in breast milk.

LifeSiteNews sent the Public Health Agency of Canada the statement of CCCA and asked for a response to Bridle's concerns. The agency responded that it was working on the questions but did not send answers before publication time.

Pfizer, Moderna, and Johnson & Johnson did not respond to questions about Bridle's concerns. Pfizer did not respond to questions about how long the company was aware of its research data that the Japanese agency had released, showing spike protein in organs and tissue of vaccinated individuals.

October 01, 2021 update



U.K. regulators admit that there has been four times the number of deaths reported from the COVID-19 vaccines in 8 months than all vaccines combined in the last 20 years

The ***Medicine and Healthcare Products Regulatory Agency*** for the just the ***United Kingdom*** has responded to a Freedom of Information Request and revealed that there have been 404 deaths reported from all vaccines in the UK since 2001.
https://theexpose.uk/wp-content/uploads/2021/09/FOI-21-907-Response-1.pdf (see page 3)

Since the onset of the COVID-19 vaccine program in the UK, there have been the following deaths reported associated with these different vaccines.

AstraZeneca/Oxford- 1,083
Pfizer- 534
Moderna- 17
Total = 1,634

https://rightsfreedoms.wordpress.com/2021/09/28/uk-medicine-regulator-confirms-there-have-been-four-times-as-many-deaths-due-to-the-covid-19-vaccines-in-8-months-than-deaths-due-to-all-other-vaccines-combined-in-20-years/

The mRNA vaccines use technology the suppresses the immune system so the lipid nanoparticles can get through the body's defenses to deliver the payload to our cells. What are the frightening prospects of that?

An excellent article published September 12th, 2021 on ***UKColumn.org*** tiled, **Stabilising the Code**, does a fantastic job of explaining how the developers of the mRNA vaccines were able to suppress the body's innate immune system to keep it from destroying the lipid nanoparticles before they can deliver their payload, the genetically engineered spike protein into the cells of the injected person. The unintended consequences of doing this may be profound however!

This discovery was adopted in the mRNA technology used in Covid vaccines, in order that the foreign vaccine mRNA could enter cells without being destroyed. Below is the mRNA code from the Pfizer vaccine demonstrating the modified Uridine nucleoside by denoting it as **Ψ** (modified) instead of its natural form U (Uridine). To be precise: every Uridine (U) has been replaced by 1-methyl-3'-pseudouridylyl (Ψ).

Sequence / Séquence / Secuencia

```
GAGAAΨAAAC ΨAGΨAΨΨCΨΨ CΨGGΨCCCCA CAGACΨCAGA GAGAACCCGC   50
CACCAΨGΨΨC GΨGΨΨCCΨGG ΨGCΨGCΨGCC ΨCΨGGΨGΨCC AGCCAGΨGΨG  100
ΨGAACCΨGAC CACCAGAACA CAGCΨGCCΨC CAGCCΨACAC CAACAGCΨΨΨ  150
ACCAGAGGCG ΨGΨACΨACCC CGACAAGGΨG ΨΨCAGAΨCCA GCGΨGCΨGCA  200
CΨCΨACCCAG GACCΨGΨΨCC ΨGCCΨΨΨCΨΨ CAGCAACGΨG ACCΨGGΨΨCC  250
ACGCCAΨCCA CGΨGΨCCGGC ACCAAΨGGCA CCAAGAGAΨΨ CGACAACCCC  300
GΨGCΨGCCCΨ ΨCAACGACGG GGΨGΨACΨΨΨ GCCAGCACCG AGAAGΨCCAA  350
CAΨCAΨCAGA GGCΨGGAΨCΨ ΨCGGCACCAC ACΨGGACAGC AAGACCCAGA  400
GCCΨGCΨGAΨ CGΨGAACAAC GCCACCAACG ΨGGΨCAΨCAA AGΨGΨGCGAG  450
ΨΨCCAGΨΨCΨ GCAACGACCC CΨΨCCΨGGGC GΨCΨACΨACC ACAAGAACAA  500
CAAGAGCΨGG AΨGGAAAGCG AGΨΨCCGGGΨ GΨACAGCAGC GCCAACAACΨ  550
GCACCΨΨCGA GΨACGΨGΨCC CAGCCΨΨΨCC ΨGAΨGGACCΨ GGAAGGCAAG  600
CAGGGCAACΨ ΨCAAGAACCΨ GCGCGAGΨΨC GΨGΨΨΨAAGA ACAΨCGACGG  650
CΨACΨΨCAAG AΨCΨACAGCA AGCACACCCC ΨAΨCAACCΨC GΨGCGGGAΨC  700
ΨGCCΨCAGGG CΨΨCΨCΨGCΨ CΨGGAACCCC ΨGGΨGGAΨCΨ GCCCAΨCGGC  750
AΨCAACAΨCA CCCGGΨΨΨCA GACACΨGCΨG GCCCΨGCACA GAAGCΨACCΨ  800
GACACCΨGGC GAΨAGCAGCA GCGGAΨGGAC AGCΨGGΨGCC GCCGCΨΨACΨ  850
AΨGΨGGGCΨA CCΨGCAGCCΨ AGAACCΨΨCC ΨGCΨGAAGΨA CAACGAGAAC  900
GGCACCAΨCA CCGACGCCGΨ GGAΨΨGΨGCΨ CΨGGAΨCCΨC ΨGAGCGAGAC  950
AAAGΨGCACC CΨGAAGΨCCΨ ΨCACCGΨGGA AAAGGGCAΨC ΨACCAGACCA 1000
GCAACΨΨCCG GGΨGCAGCCC ACCGAAΨCCA ΨCGΨGCGGΨΨ CCCCAAΨAΨC 1050
ACCAAΨCΨGΨ GCCCCΨΨCGG CGAGGΨGΨΨC AAΨGCCACCA GAΨΨCGCCΨC 1100
ΨGΨGΨACGCC ΨGGAACCGGA AGCGGAΨCAG CAAΨΨGCGΨG GCCGACΨACΨ 1150
CCGΨGCΨGΨA CAACΨCCGCC AGCΨΨCAGCA CCΨΨCAAGΨG CΨACGGCGΨG 1200
ΨCCCCΨACCA AGCΨGAACGA CCΨGΨGCΨΨC ACAAACGΨGΨ ACGCCGACAG 1250
CΨΨCGΨGAΨC CGGGGAGAΨG AAGΨGCGGCA GAΨΨGCCCCΨ GGACAGACAG 1300
GCAAGAΨCGC CGACΨACAAC ΨACAAGCΨGC CCGACGACΨΨ CACCGGCΨGΨ 1350
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By modifying the Uridine in the Pfizer vaccine mRNA code, the foreign mRNA is able to bypass part of the body's first line of defense — the Innate Immune System.

The body possesses two broad parts to its immune system: innate and specific. The innate is the first to go into action against foreign invaders, including foreign mRNA from a vaccine.

How does that simple removal of one letter of code from mRNA achieve that?
It does so by affecting Toll Like Receptors (TLR): the alarm signal of the Innate Immune System.
The key TLRs affected are TLR 3, TLR 7 and TLR 8. They act as sentries, whose job is to recognise foreign invaders by way of their form or patterns; a bit like an aircraft spotter in World War II. If the wrong type of shape is recognised in the sky then alarm bells sound and anti-aircraft fire kicks in. In the case of TLRs, the immune system gets activated.

What if you could by-pass those spotters? No alarms, no immune system response; and your payload, foreign mRNA in this example, gets through safely. Then your drug/vaccine has a much greater chance of working.
At that point in the original experiments to discover how to *turn off* toll-like receptors (and subsequently in the design of the vaccines), the question should have been asked: *but what would be the consequences of switching off that important early warning system?*

If that question was raised it appears to have fallen on deaf ears and not been answered until, possibly, now.
Aberrant immune response

The BNT162b2 mRNA vaccine against SARS-CoV-2 reprograms both adaptive and innate immune responses

F. Konstantin Föhse, Büsranur Geckin, Gijs J. Overheul, Josephine van de Maat, Gizem Kilic, Ozlem Bulut, Helga Dijkstra, Heidi Lemmers, S. Andrei Sarlea, Maartje Reijnders, Jacobien Hoogerwerf, Jaap ten Oever, Elles Simonetti, Frank L. van de Veerdonk, Leo A.B. Joosten, Bart L. Haagmans, Reinout van Crevel, Yang Li, Ronald P. van Rij, Corine GeurtsvanKessel, Marien I. de Jonge, Jorge Domínguez-Andrés, Mihai G. Netea

doi: https://doi.org/10.1101/2021.05.03.21256520

Dominguez-Andres et al addressed that question May 6th 2021.

They state:
Certain vaccines such as Bacillus Calmette-Guérin (BCG) and the measles, mumps, and rubella (MMR) vaccine also induce long term functional reprogramming of cells of the innate immune system. (Netea et al., 2020). This biological process is also termed trained immunity when it involves increased responsiveness, or **innate immune tolerance** when it is characterized by decreased cytokine production (Ifrim et al., 2014). Although these effects have been proven mainly for live attenuated vaccines, we sought to investigate whether the BNT162b2 [Pfizer] vaccine might also induce effects on innate immune responses against different viral, bacterial and fungal stimuli. [Emphasis added].
Their answer?

The BNT162b2 vaccine also modulated the production of inflammatory cytokines by innate immune cells upon stimulation with both specific (SARS-CoV-2) and non-specific (viral, fungal and bacterial) stimuli. **The response of innate immune cells to TLR4 and TLR7/8 ligands was lower after BNT162b2 vaccination.** [Emphasis added].

They continue:

[W]e observed a significant reduction in the production if IFN-α secreted after stimulation with poly I:C and R848 after the administration of the second dose of the vaccine (Figure 1H, 1I). **This may hamper the initial innate immune response against the virus**, as defects in TLR7 have been shown to result in and increased susceptibility to COVID-19 in young males (Van Der Made et al., 2020). **These results collectively demonstrate that the effects of the BNT162b2 vaccine go beyond the adaptive immune system and can also modulate innate immune responses.** [Emphasis added].

Three concerns are raised by the above.

1. The ability of the immune system to fight viruses has been diminished; specifically, the ability to fight SARS-CoV-2 may be affected;
2. Vaccine-induced innate immune tolerance may affect other vaccines; and finally
3. What other parts of the immune system may be affected.

If this story intrigues you, I highly recommend that you read the entire article. There are several different references that support the concerns over the alteration of the immune system by these experimental biological products.

https://www.ukcolumn.org/article/stabilising-the-code

Also, Del Bigtree and Jefferey Jaxon of the ***Highwire*** did a great story on this during ***the Jaxon Report*** of **Episode 234- Rise of the Resistance**
https://thehighwire.com/videos/episode-234-rise-of-the-resistance/

Reports of rapidly growing cancers are on the rise in COVID-19 vaccinated individuals and this doctor has a plausible theory as to why that is happening

Lifesite news posted an article on September 13th 2021 titled, **Idaho doctor reports a '20 times increase' of cancer in vaccinated patients.**

The article

'Post-vaccine, what we are seeing is a drop in your killer T-cells, in your CD8 cells," said Dr. Ryan Cole.

"Since January 1, in the laboratory, I'm seeing a 20 times increase of endometrial cancers over what I see on an annual basis," reported Dr. Cole in the video clip shared on Twitter.

"I'm not exaggerating at all because I look at my numbers year over year, I'm like 'Gosh, I've never seen this many endometrial cancers before'," he continued.

Explaining his findings at the March 18 event, Cole told Idahoans that the vaccines seem to be causing serious autoimmune issues, in a way he described as a "reverse HIV" response.

Cole explained that two types of cells are required for adequate immune system function: “Helper T-cells,” also called “CD4 cells,” and “killer T-cells,” often known as “CD8 cells.”

According to Cole, in patients with HIV, there is a massive suppression of “helper T-cells” which cause immune system functions to plummet, and leave the patient susceptible to a variety of illnesses.

Similarly, Cole describes, “post-vaccine, what we are seeing is a drop in your killer T-cells, in your CD8 cells,” “And what do CD8 cells do? They keep all other viruses in check,” he continued.
Much like HIV causes immune system disruption by suppressing CD4 “helper” cells, the same thing happens when CD8 “killer” cells are suppressed. In Dr. Cole’s expert view, this is what seems to be the case with the COVID-19 jabs.

Cole goes on to state that as a result of this vaccine-induced “killer T-cell” suppression, he is seeing an “uptick” of not only endometrial cancer, but also melanomas, as well as herpes, shingles, mono, and a “huge uptick” in HPV when “looking at the cervical biopsies of women.”

This is not the first time the COVID-19 vaccines have been linked to serious issues regarding women’s health.

According to a German research study, polyethylene glycol, an ingredient found in the Pfizer and Moderna jabs, has been found to pose a “potential toxicity risk” to women’s ovaries.

Dr. Michael Yeadon, a former vice president at Pfizer, has cited the German study as a possible explanation for the large number of menstrual irregularities and miscarriages being reported by vaccinated women.
Yeadon warns young women to avoid the vaccine for, in his expert opinion as a toxicologist, the shots will likely impede a woman’s ability to get pregnant and carry a baby to term.

Dr. Cole states in his video that, not only are melanomas showing up more frequently, like endometrial cancers, the melanomas are also developing more rapidly, and are more severe in younger people, than he has ever previously witnessed.

“Most concerning of all, there is a pattern of these types of immune cells in the body keeping cancer in check,” stated the doctor.

“I’m seeing invasive melanomas in younger patients; normally we catch those early, and they are thin melanomas, [but] I’m seeing thick melanomas skyrocketing in the last month or two,” he added.

Cole came into prominence in January of 2021 when the Idaho government put in place an effort called “Capitol Clarity,” with the stated goal of keeping Idahoans informed about the facts surrounding COVID-19. Capitol Clarity has since hosted Dr. Ryan Cole multiple times to provide information to the public about vaccine safety and COVID-19 measures more broadly.

The videos of Dr. Cole at these events, which were originally posted on YouTube, have since been deleted by the Google owned video platform in a continual effort of censorship by Big Tech.

“You’re not being told the truth,” said Yeadon “Thinking about this, I try to imagine that I was speaking to my own young adult daughters, for whom I would be very concerned if they got these vaccines.”

https://www.lifesitenews.com/news/idaho-doctor-reports-a-20-times-increase-of-cancer-in-vaccinated-patients/

Another dire warning about continuing the mass vaccination program from vaccine developer Dr. Geert Vanden Bossche

His article is titled **The Last Post**

From the article

Who's wrong, who's right?

These are the key points one has to understand to be able to capture the never-ending discussion on whether or not mass vaccination campaigns work.

1. Pandemics are by definition not static but dynamic events
2. Pandemics have both detrimental and beneficial effects (e.g., waves of morbidity & death and generation of herd immunity, respectively) that are phased in time
3. Pandemic waves hit populations of different age groups at different points in time
4. Normally (I should say: 'naturally'), a pandemic starts with some bad news (a number of lives are lost) and ends with plenty of good news (all of the population protected by herd immunity)

Other segments…
…Likewise, mass vaccination campaigns may have a beneficial short-time effect in that they reduce viral spread and protect vulnerable people from disease (e.g., elderly people and those with underlying disease), but will eventually drive the propagation of more infectious variants. Dominant circulation of the latter will lead to a resurgence of viral infectious pressure, thereby eroding the innate immune defense of the unvaccinated (i.e., mostly younger age groups including children) and thus making them more susceptible to contracting Covid-19 disease. This already explains why mass vaccination campaigns conducted in the middle of a pandemic will only cause Sars-CoV-2 to engender more disease and claim more human lives. Because of this mass vaccination program, waves of morbidity will continue for much longer, as more (recovery from) disease cases will be required to compensate for the erosion of the population's innate immunity and, therefore, to make up for the latter's deficient contribution to HI.

…There should be no doubt that non-transmission-blocking vaccines (i.e., so-called 'leaky' or 'imperfect' vaccines) can never ever control a pandemic, even though they may temporarily protect against disease. Only temporarily? Yes, indeed. Given the globally increasing immune pressure and concomitant infectious viral pressure, genomic epidemiologists have no doubt that this pandemic roller coaster will not stop before it takes us over the cliff into the abyss of *complete viral resistance to anti-spike (S) antibodies*. That is where all runaway trains of the *different ongoing pandemics of highly infectious variants* will be coming together and converge into a big whirl where they can no longer be distinguished from one another. The first stages of this evolution is what we now begin to see in countries which have already massively vaccinated their population (e.g., Israel). There is no doubt that other countries like the United Kingdom and the United States will soon go down the same path. Due to increasing resistance to neutralizing anti-S antibodies (Abs), these countries are now even beginning to shift from a primarily beneficial (i.e., less susceptible to severe disease) to a primarily

detrimental effect (more susceptible to severe disease) in the vaccinated as compared to the unvaccinated (https://www.gov.uk/government/publications/investigation-of-novel-sars-cov-2-variant-variant-of-concern-20201201).

…Conclusively, mass vaccination campaigns during a pandemic of highly infectious variants fail to control viral transmission. Instead of contributing to building HI, they dramatically delay natural establishment of HI (Vanden Bossche, August 2021). This is why *the ongoing universal vaccination campaigns are absolutely detrimental to public and global health*.

End of excerpts

https://www.geertvandenbossche.org/post/the-last-post

Perhaps this series of September 13th Tweets by Dr. Vanden Bossche sums up the vaccinated vs unvaccinated debate most succinctly

"This time, in a nutshell: All unvaccinated people who're susceptible to C-19 disease (because of re-exposure shortly after primary infection due to high infectious pressure, or if otherwise immune suppressed, or if immunosenescent) and all vaccinees contribute to the ongoing explosive expansion of more infectious and increasingly anti-spike-Ab-resistant immune escape variants."

"However, ALL of the unvaccinated but not vaccinated (= still predominantly asymptomatically infected) contribute to herd immunity, either by virtue of naturally acquired immunity (i.e., those who were susceptible and recovered from C-19 disease) or by preventing or abrogating infection by ANY Sars-CoV-2 variant (i.e., all the unvaccinated who're not susceptible to C-19 disease for lack of immune suppression of their multispecific innate immune effectors)."

"We, therefore, have to rely on the unvaccinated to prevent dominant, highly infectious variants from rapidly evolving towards full resistance to the vaccines. We need, therefore, more unvaccinated people to protect the vaccinees."

"Hence, it's imperative that we make love (=> baby boom to replenish reservoir of unvaccinated!) and no war (=> STOP mass vaccination). When presenting with first signs & symptoms, ALL MUST have free access to immune-strengthening supplements (mostly sufficient for the young & previously healthy) and early multidrug treatment (mostly required for the vulnerable & elderly). We're in this TOGETHER and, once again, I am BEGGING the WHO to give me a chance to explain all of the above."

In case you are new to this newsletter or are not familiar with Dr. Vanden Bossche's qualifications, here they are…

Who is Geert Vander Bossche and is he qualified to make these statements? I certainly believe so. Here are some of the positions that he has held.

- Geert Vanden Bossche received his DVM from the University of Ghent, Belgium, and his PhD degree in Virology from the University of Hohenheim, Germany.

- He held adjunct faculty appointments at universities in Belgium and Germany.

- After his career in Academia, Geert joined several vaccine companies (GSK Biologicals, Novartis Vaccines, Solvay Biologicals) to serve various roles in vaccine R&D as well as in late vaccine development.

- Geert then moved on to join the Bill & Melinda Gates Foundation's Global Health Discovery team in Seattle (USA) as Senior Program Officer.

- He then worked with the Global Alliance for Vaccines and Immunization (GAVI) in Geneva as Senior Ebola Program Manager. At GAVI he tracked efforts to develop an Ebola vaccine. He also represented GAVI in fora with other partners, including WHO, to review progress on the fight against Ebola and to build plans for global pandemic preparedness. Back in 2015, Geert scrutinized and questioned the safety of the Ebola vaccine that was used in ring vaccination trials conducted by WHO in Guinea. His critical scientific analysis and report on the data published by WHO in the Lancet in 2015 was sent to all international health and regulatory authorities involved in the Ebola vaccination program.

- After working for GAVI, Geert joined the German Center for Infection Research in Cologne as Head of the Vaccine Development Office.

- He is at present primarily serving as a Biotech/ Vaccine consultant while also conducting his own research on Natural Killer cell-based vaccines.

If you are trying to explain the concepts Dr. Vanden Bossche is concerned about in a simpler way to someone else, perhaps this may help. It is my response to a post I saw on Facebook.

I saw a post the other day that said the people who have not gotten the V are the reason for development of the variants.

I have another opinion shared by Geert Vanden Bossche, a lifetime V developer formerly working for GAVI (the Global Alliance for Vaccines and Immunizations) and the Gates Foundation. He says that because the V's are leaky, Meaning that they don't prevent a person from getting infected or being able to spread it, that the V'inated are the depots for encouraging the virus to mutate. Think about it like giving an antibiotic that isn't quite strong enough to kill a type of bacteria. That bacteria will mutate to get stronger and be more resistant to that antibiotic. Same principle can happen with V's for viruses.

If the V was completely effective against a person becoming infected or transmitting the virus to others, it would be a completely different story. We now know that isn't the case. And to continue the insanity of increasing V'ination rates and perpetuating this problem even further, we will be creating even more resistant strains. This is one of the reasons why so many of the mutations in the Delta variant are along the spike protein, the very single component these V's force the body to manufacture.

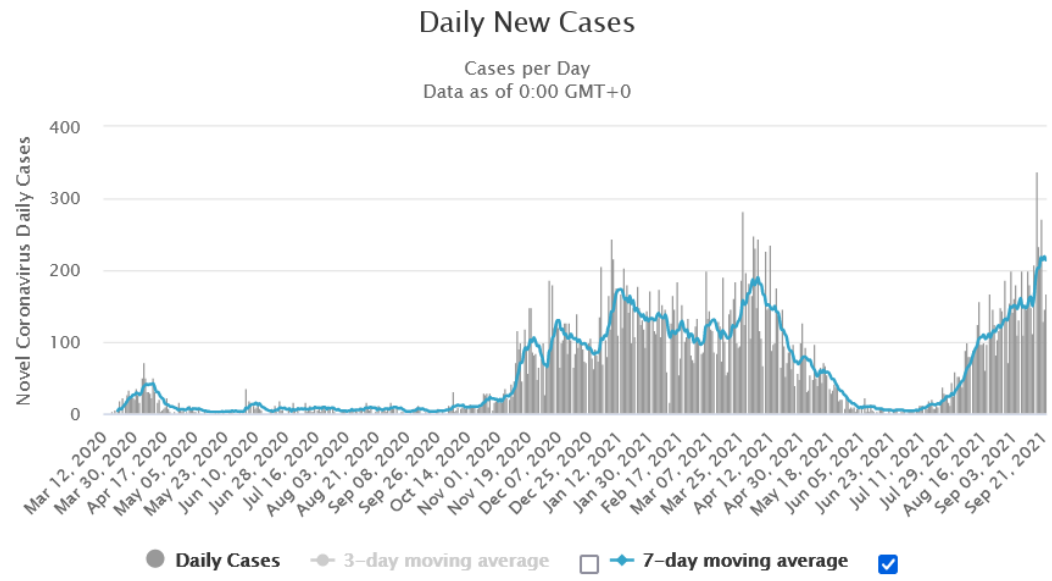
Unfortunately, it took the medical profession decades to learn this lesson with the indiscriminate use of antibiotics. And it's the reason we have not been able to keep up with bacterial mutations and the creation of these bacterial "super germ" variants. Now, well over 100,000 people a year die in the U.S. from antibiotic resistant infections.

You can go to Dr Vanden Bossche's website and read his dire warnings to the world about this. His website is https://geertvandenbossche.org.

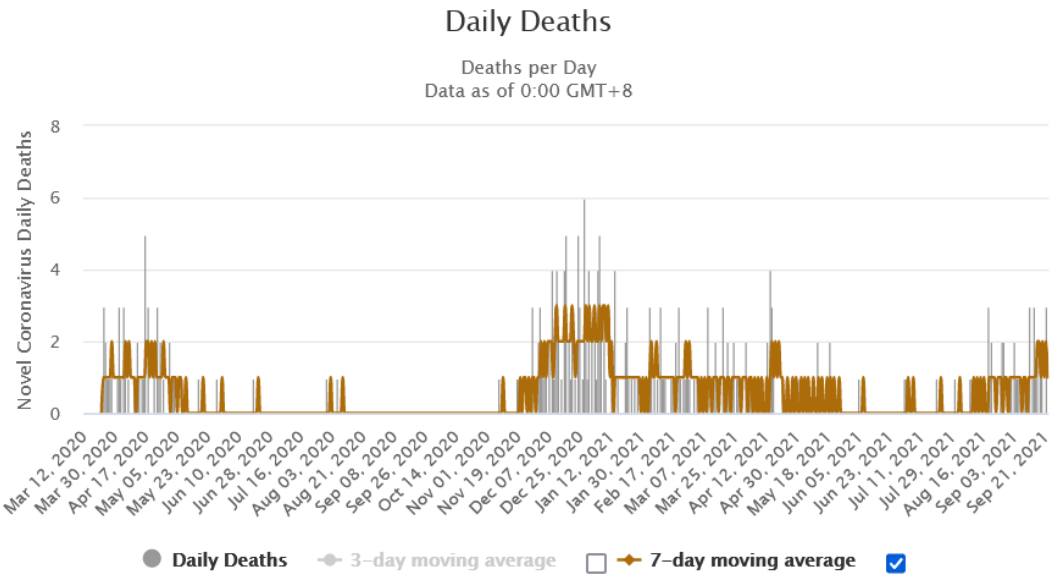
Vermont, the highest vaccinated state in the U.S. has skyrocketing cases, hospitalizations and deaths

Vermont is not a very populace state at approximately 620,000 persons, so the total numbers are not large. But that doesn't change the correlation of the rates of vaccination and the numbers. As of September 25th, 2021, 69.2% of the state's population has been fully vaccinated.

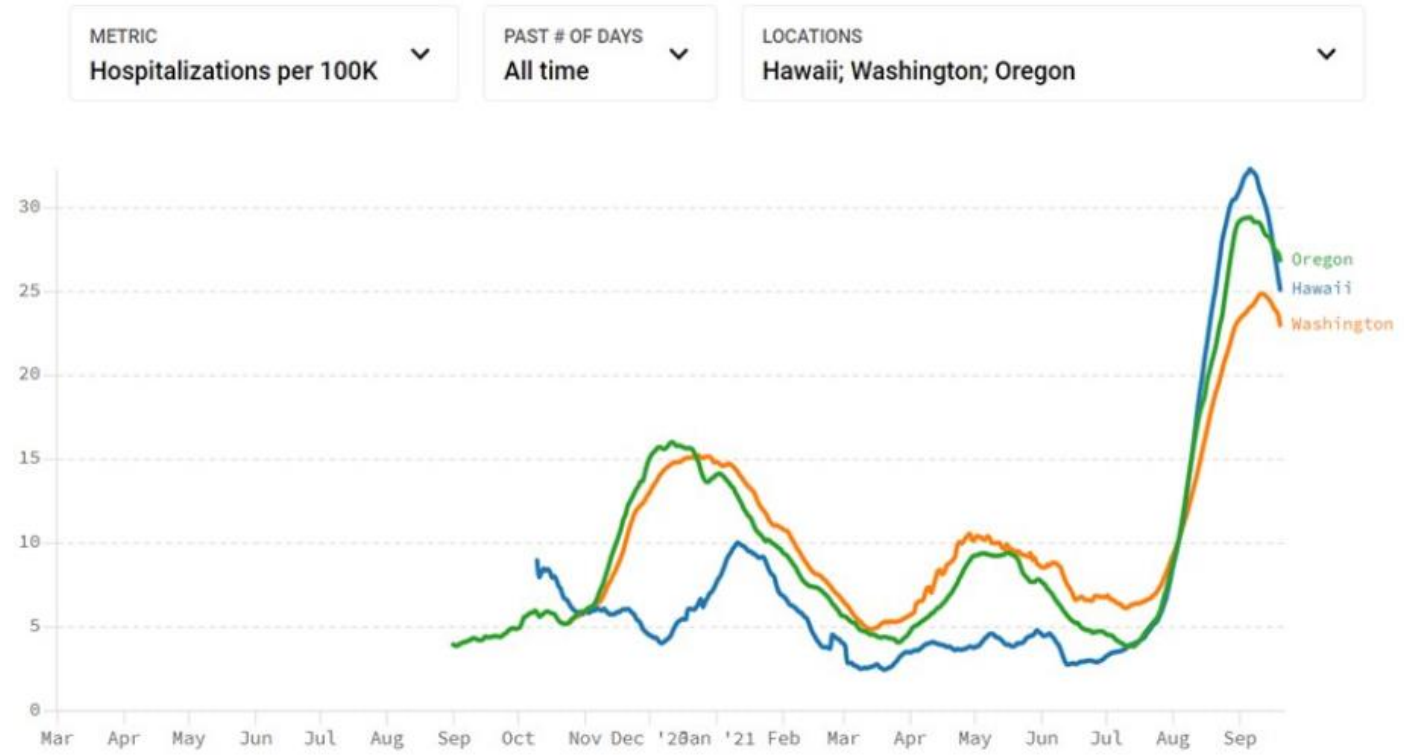
Daily New Cases in Vermont



Daily New Deaths in Vermont



Three states with the highest vaccination rates also have some of the highest hospitalizations for COVID-19



The first report of mass breakthrough cases in the U.S. came in July 2021

The first mainstream media coverage of mass breakthrough cases came in July 2021 from Massachusetts by way of a CDC report titled, **Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021**

From the report (emphasis mine)
Among the 469 cases in Massachusetts residents, 346 **(74%) occurred in persons who were fully vaccinated**; of these, 301 (87%) were male, with a median age of 42 years. Vaccine products received by persons experiencing breakthrough infections were Pfizer-BioNTech (159; 46%), Moderna (131; 38%), and Janssen (56; 16%); among fully vaccinated persons in the Massachusetts general population, 56% had received Pfizer-BioNTech, 38% had received Moderna, and 7% had received Janssen vaccine products. **Among persons with breakthrough infection, 274 (79%) reported signs or symptoms, with the most common being cough, headache, sore throat, myalgia, and fever. Among fully vaccinated symptomatic persons, the median interval from completion of ≥14 days after the final vaccine dose to symptom onset was 86 days (range = 6–178 days).** Among persons with breakthrough infection, four (1.2%) were hospitalized, and no deaths were reported. **Real-time RT-PCR Ct values in specimens from 127 fully vaccinated patients (median = 22.77) were similar to those among 84 patients who were unvaccinated, not fully vaccinated, or whose vaccination status was unknown (median = 21.54)** (Figure 2).

These results clearly show an abject failure of the vaccines.

- Three-quarters of the individuals in the outbreak we're fully vaccinated.
- The average time of breakthrough infection was less than three months from the point at which the person was fully vaccinated.
- Eight out of ten people who were fully vaccinated experienced a variety of symptoms from the infection.
- And the level of viral load in the vaccinated individuals was nearly identical to that of the unvaccinated positive cases.

https://www.cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm?s_cid=mm7031e2_w

Fauci's predictions on the success of the vaccines was, well let's just say it, 180 degrees wrong

Just how badly did vaccine failure surprise Fauci?

This badly: on May 20 (May!) he said the US might be able to eliminate Sars-Cov-2 entirely. Three months later he was begging for boosters double-quick. True story.

Alex Berenson
Sep 16
Unreported truths

From his SubStack

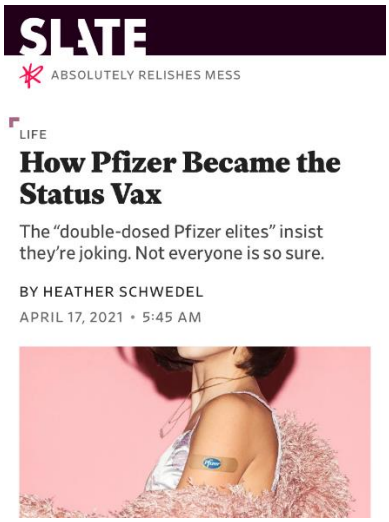
Let's go to the videotape!

On May 20, Dr. Anthony S. Fauci (People's Sexiest Man Alive for 12 straight years) took time from his busy day for an interview the Washington Post.

Beyond its cringe-inducing title - "Coronavirus: Leadership During Crisis" - the interview is noteworthy because it came at the moment of peak overconfidence in the mRNA vaccines.

Sars-Cov-2 had basically disappeared in Israel, which was the first country to begin a mass mRNA vaccination campaign. With about 80 percent of adults vaccinated, new cases were down 99.5 percent from their January peak *and still falling.* Deaths had dropped nearly as much.

On Twitter and off, the word “miracle” was getting thrown around a lot. Slate and the Atlantic had turned their attention to the vitally important question of which vaccine was the coolest (Pfizer! Pfizer was the coolest!)


SLATE

ABSOLUTELY RELISHES MESS

LIFE

How Pfizer Became the Status Vax

The “double-dosed Pfizer elites” insist they’re joking. Not everyone is so sure.

BY HEATHER SCHWEDEL

APRIL 17, 2021 • 5:45 AM

And the only thing standing in the way of herrrrd immunity were the mouth-breathing Trump fans (and some African-Americans who remembered Tuskegee, but no one blamed them) who refused to submit to the miracle.

No matter, though. The vaccines were that good! How good? Dr. Fauci can speak for himself:
Q: Vaccinations are rising, but is there a concern about a resurgence in the latter part of the year as the weather gets colder? And how much of this hinges upon what our understanding is of how long these vaccines are effective?

DR. FAUCI: Well, I don't think we should be that concerned right now about how long they're effective. **I think they will be effective long enough that we will get to the point where we are not going to be necessarily worrying about a surge…**[as] highly effective as these vaccines are and you get a substantial proportion of the population vaccinated, **the chances of there being a surge are extraordinarily low**.

But what about boosters, Dr. F.? Boosters? Boosters? We don’t need no stinking boosters!

Q: One thing that you've talked about is that people might need a booster shot within a year or so of being vaccinated. What is the timeline right now for when people might need to start getting that?

A: …I really don't think it's accurate to say that we will need boosters X number of months from now. We may not need it for quite a while… Will this be a situation **where over the years, we may need intermittent boosts?** Again, you want to be prepared for that, Yasmeen, but you don't know definitely if we'll need it…-

But Fauci wasn’t done with his answer. He had a prediction to make.

A: When you have an infectious disease and you want to, in essence, address it appropriately, there are three possibilities. One, you could eradicate it. That's a very high bar because we've only eradicated one human infectious disease in our entire history, and that is smallpox, with a highly successful vaccination campaign.

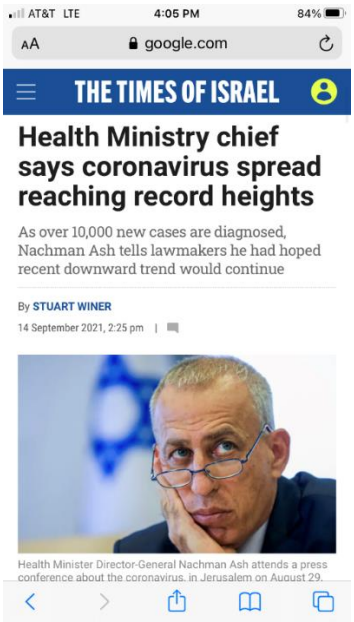
The next thing is you can eliminate, and you generally do that by having certain countries, usually with good vaccination programs, essentially eliminate the presence of a particular pathogen in society. We've done that with polio in the United States. We've done that with measles in the United States and other developed nations.

So, that's called elimination, and the other is control. You have a very, very low level in the community, not enough to be a public health issue but enough to know that you haven't completely eliminated it. We don't know where we're going to be with SARS-CoV-2 and with COVID-19. **I would hope it would be much closer to elimination than just control.** That's going to depend entirely on the success, which I believe we're going in the right direction, of the vaccine program…

Elimination?

Control?

At this point I think we’d all settle for zero efficacy, zero long-term side effects.
Of course, the vaccine fanatics (including the ones in the White House) will note that the United States didn’t duplicate Israel’s success at vaccinating nearly its entire adult population. Lucky us.



I’m a terrible Jew today, I shouldn’t be working (and I usually on Yom Kippur), but under the circumstances I hope whoever is in charge gives me a pass. Also my temple won’t let me go to services in-person since I’m not vaccinated, because science!

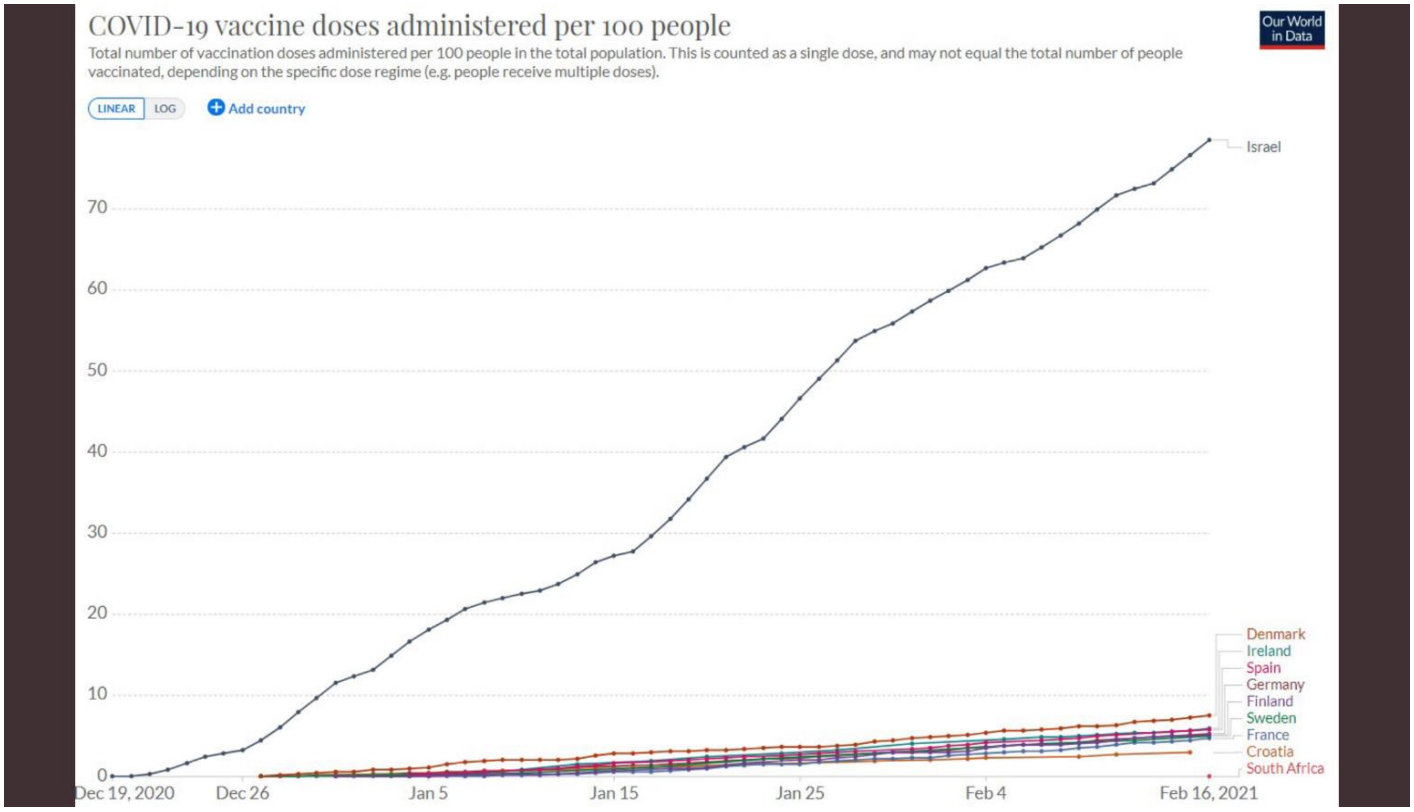
Anyway the Haftarah from Isaiah is what really matters.

Hope you're having an easy fast.

SOURCE: https://www.washingtonpost.com/washington-post-live/2021/05/20/coronavirus-leadership-during-crisis-with-anthony-s-fauci/

How can we tell what will happen in the near future with the effectiveness of the vaccines, cases, hospitalizations and deaths in the U.S. if we keep going?

We watch Israel. One of the highest vaccinated countries in the entire world. And one that right out of the gate was the world's leader by far in the percentage of their population vaccinated. In case you didn't see this in an earlier newsletter, this is what that looked like as of February 16th, 2021.



Pfizer's vice president and chief scientist, Dr. Philip Dormitzer appeared on a zoom call speaking to Israeli scientists recently.

Here is some of what he had to say.

"Early in the pandemic, we'd established a relationship with the Israeli Ministry of Health where they used exclusively the Pfizer vaccine and they monitored it very closely. So, we had sort of a laboratory where we could could see the effect. They immunized a very high proportion of their population very early. So, it's been a way that we could almost look ahead. What we see happening in Israel, happens again in the U.S. a couple of months later."

This of course is not playing very well with many people in Israel. To hear the vice president of the company making the experimental agent intended by your own government to be injected into the entire population, communicate his perception of Israel as a "laboratory" (essentially an experiment), to learn what is going to happen in the United States two months later has to bring back horrific connotations to many who suffered or had relatives who suffered and were murdered during the Holocaust.

You can see the video here… https://www.youtube.com/watch?v=rUIGgYT6L8Y&t=139s

Yet, the reality of what he is saying is true. Much of what we have seen over the last nine months here in the U.S. has been precluded by what has happened in the weeks and months prior in Israel. Therefore, wouldn't you think that our federal health officials who are supposed to be intelligent people, would look at what's happened in Israel with the out-of-control cases, hospitalizations and deaths in fully vaccinated people and change course here? Up to the writing of this newsletter, we haven't seen much else except full speed ahead and punish those that are hesitant to get the shots with loss of their careers and often social ostracizing. That is until recently. While Israel has gone all-in with the booster shots and is already talking about a fourth, the FDA may be pumping the breaks by not recommending them for the general population….yet. Whether that is a form of virtue signaling made to look as though they are finally following the data and the science, or if they really are realizing that with Delta and some other variants and the obvious capability of this virus to shape-shift and morph like Houdini to escape vaccine protection, there needs to be a different approach.

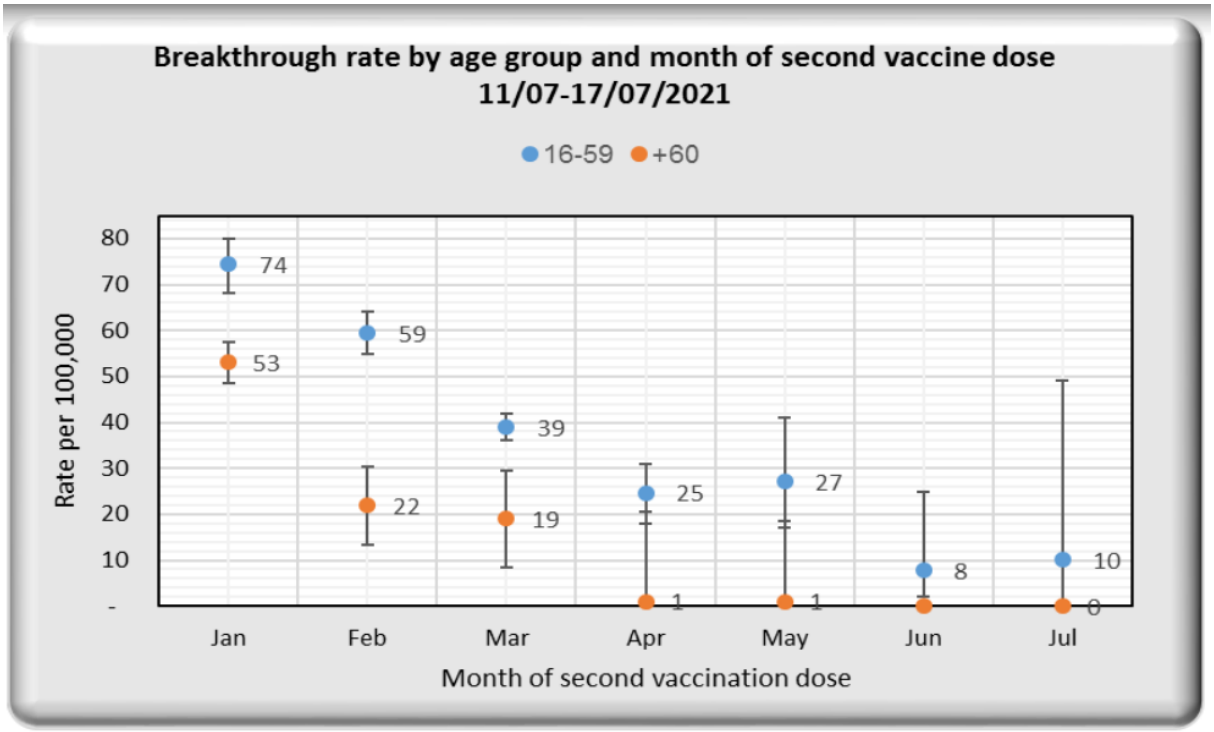
Hopefully that approach will be the one that I and thousands of other physicians and scientists have been advocating for nearly a year and a half now. And that is **EARLY** treatment with the widely available, non-patented, inexpensive, and safe medications like Hydroxychloroquine with Zinc, Ivermectin and Budesonide among others. And, making sure that Vitamin D levels are optimized and immune building lifestyle habits like a healthy diet, nutritional supplementation, exercise, quality sleep and addressing emotional health are at the forefront of everyone's mind.

Hopefully, the time of telling people to hunker down or go back home and come back to the hospital when they are turning blue will be a thing of the past soon. Early treatment to prevent viral replication is the key. Unfortunately, recently I have had a very sick relative and a friend that were still both told to go back home and stay there until they get so bad that they are having difficulty breathing or their oxygen levels dropped below 90. Even when EMS was called for one of them, her oxygen levels were not quite low enough, so the paramedic said that they didn't recommend that she go because the hospitals are trying to save room for the worst cases (even though they weren't over-run. Now, that may be ok if they would have been given a referral for an outpatient visit with a doctor who could have determined what treatment would have been best for them at the time and started intervention. But no other options were offered.

See how Israel is doing now on the next page…

So, how is Israel doing with breakthrough cases?

The graph below is from the ***Israeli Ministry of Health*** and shows the rates of breakthrough cases in people that had their second shot in various months throughout the first half of 2021.



As can be seen, people aged 16-59 that had their second shot in January are exhibiting breakthrough cases at the rate of 74 per 100,000 people. People 60+ at the rate of 53/100,000.

As you move to the right on the horizontal (x) axis, the rate of breakthrough infections drops. In other words, if you have had your second shot in June or July you have a much lower risk of breakthrough infection (so far).

As a point of reference, the vaccination campaign in Israel launched like it was shot out of a cannon on December 19th, 2020. By mid-February 2021, approximately 80% of the population had been vaccinated. This was the most aggressive mass vaccination campaign of any country in the world. The nice thing about that is, that this allows us to get an idea of how lasting the relative risk reduction effectiveness of the vaccines is. That would have been much harder to track if the vaccination campaign were more of a gradual rollout. But, as can be seen in the graph above, the vaccine effectiveness starts to diminish after approximately 2 months and really drops off at about month 4.

An unknown is how the Israeli government is tracking breakthrough infections. As I reported last month, as of May 1st, 2021, the CDC is not tracking breakthrough infections for vaccinated individuals unless they are hospitalized.

The table below, shows the vaccine efficacy as measured in Relative Risk Reduction (RRR). As I've mentioned in a previous newsletter, the relative risk reduction is he's somewhat deceptive measure of effectiveness.

More on that on the next page…

Data from June 20, 2021 through July 17, 2021

Outcome	20/06-17/07		
	VE	Lower CI	Upper CI
SARS-CoV-2 cases	39.0%	9.0	59.0
Symptomatic COVID-19*	40.5%	8.7	61.2
COVID-19 hospitalization	88.0%	78.9	93.2
Severe COVID-19**	91.4%	82.5	95.7

* Fever and/or respiratory symptoms on epidemiologic investigation
** Including severe, critical and deceased COVID-19 (Severe – respiratory rate > 30/minute, oxygen saturation < 94%, and/or PaO2/FiO2 < 300; Critical – invasive mechanical ventilation, shock or major organ failure)

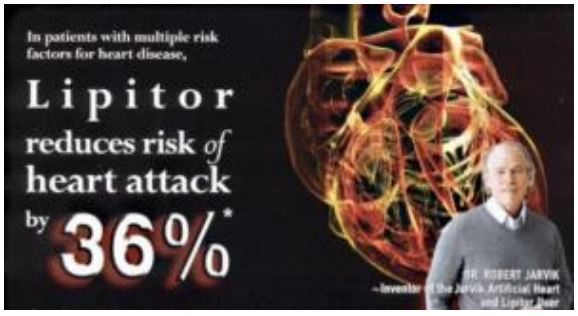
https://www.gov.il/BlobFolder/reports/vaccine-efficacy-safety-follow-up-committee/he/files_publications_corona_two-dose-vaccination-data.pdf

***VE = Vaccine efficacy. Bear in mind that this is referring to the relative risk reduction (RRR) as we discuss it in this next section.**

Let's look at how the "vaccine effectiveness" number can be deceptive

Vaccine efficacy is generally reported as a relative risk reduction (RRR). It uses the relative risk (RR)—ie, the ratio of attack rates with and without a vaccine—which is expressed as 1–RR. **Ranking by reported efficacy gives relative risk reductions of 95% for the Pfizer–BioNTech, 94% for the Moderna–NIH, 90% for the Gamaleya, 67% for the J&J, and 67% for the AstraZeneca–Oxford vaccines.** However, RRR should be seen against the background risk of being infected and becoming ill with COVID-19, which varies between populations and over time. **Although the RRR considers only participants who could benefit from the vaccine, the absolute risk reduction (ARR), which is the difference between attack rates with and without a vaccine, considers the whole population. ARRs tend to be ignored because they give a much less impressive effect size than RRRs: 1·3% for the AstraZeneca–Oxford, 1·2% for the Moderna–NIH, 1·2% for the J&J, 0·93% for the Gamaleya, and 0·84% for the Pfizer–BioNTech vaccines.**

***Here's a classic example*:** This Pfizer ad makes it look like taking their drug, Lipitor, will reduce your chances of having a heart attack by a whopping 36%. But that's the relative risk reduction. It tends to exaggerate the benefit. (That's why you'll often see relative numbers featured in advertisements.)



This 36% number comes from a randomized trial called ASCOT-LLA published in The ***Lancet*** in 2003. It showed that 1.9% of people taking Lipitor suffered a heart attack, while 3.0% of the placebo group had one. The *relative risk reduction*, or RRR, is the ratio of the two risks and is calculated by subtracting the Lipitor heart attack rate (1.9) from the placebo group rate (3.0) and dividing the difference (1.1) by the placebo group rate (3.0). This equals 36%.

But the ***absolute risk reduction*****, or ARR**, is calculated by simply subtracting the two risks, so 3.0% – 1.9% = 1.1%.

In reality, Lipitor reduced the risk of heart attack from 3% to about 2%, and this 1% difference is the number that people care about. But the Lipitor ad is more interested in promoting than informing, which is why it describes this difference as a "36%" reduction rather than a more helpful and accurate 1% reduction.

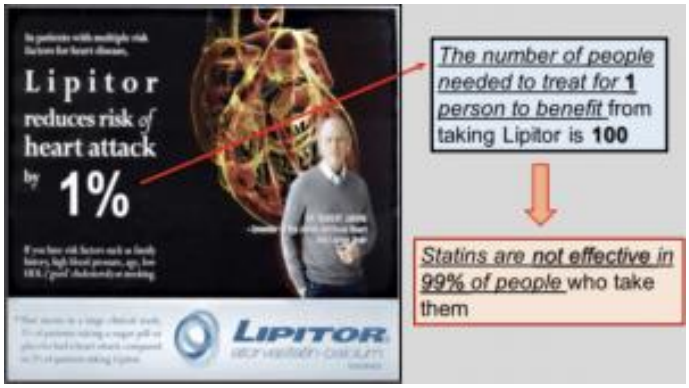
A much more important calculation would be the number of people needing to get the vaccine or treatment, also called the NNT or Number Needed to Treat in order to protect one person. Let's take a look at that.

To calculate the NNT, you first have to find out the absolute risk reduction, or ARR. That's the amount that your risk is reduced by the treatment compared with people who didn't get it.

The ARR is not a number most people are used to seeing. Studies, news reports, and other media messages are much more likely to focus on a different number, known as the "relative risk reduction," or RRR, that can be misleading.

So, let's calculate the NNT using the ARR of 1%, and see how it reframes the drug's benefits in a more user-friendly way. The NNT is simply the inverse of the ARR; it can be calculated by taking 100 and dividing it by the ARR (1).

100/ 1 = 100



How NNT helps

This means that 99 people need to take the drug, pay for it, run the risk of side effects, and stand no chance of benefit. Of course, no one knows going in who will be that lucky 1 out of 100 who does benefit.

This is the power of NNT. It gives a sense of scale to discussions regarding potential harms and benefits. In the Lipitor example, if all you read about was the relative risk reduction of 36% highlighted in headlines and advertisements (a likely scenario), your response might be: *"Wow! I can cut my risk of a heart attack by over one-third!"*

But if you were lucky enough to read some thoughtful news coverage that included the absolute risk reduction of just 1% you might think: *"Hmm, that's a far cry from 36%. I'm going to ask my doctor what she thinks."*

And if you were armed with the NNT number of 100 — realizing you probably won't be that lucky one person out of 100 who actually benefits from the drug — you might not hesitate to say: *"I don't like those odds at all; especially given the costs and risks."*

Originally, the NNT for the Pfizer Vaccine was calculated at 119. That means that 119 people would have needed to be vaccinated in order for one person to benefit. This is a graph from the study that I reported previously.

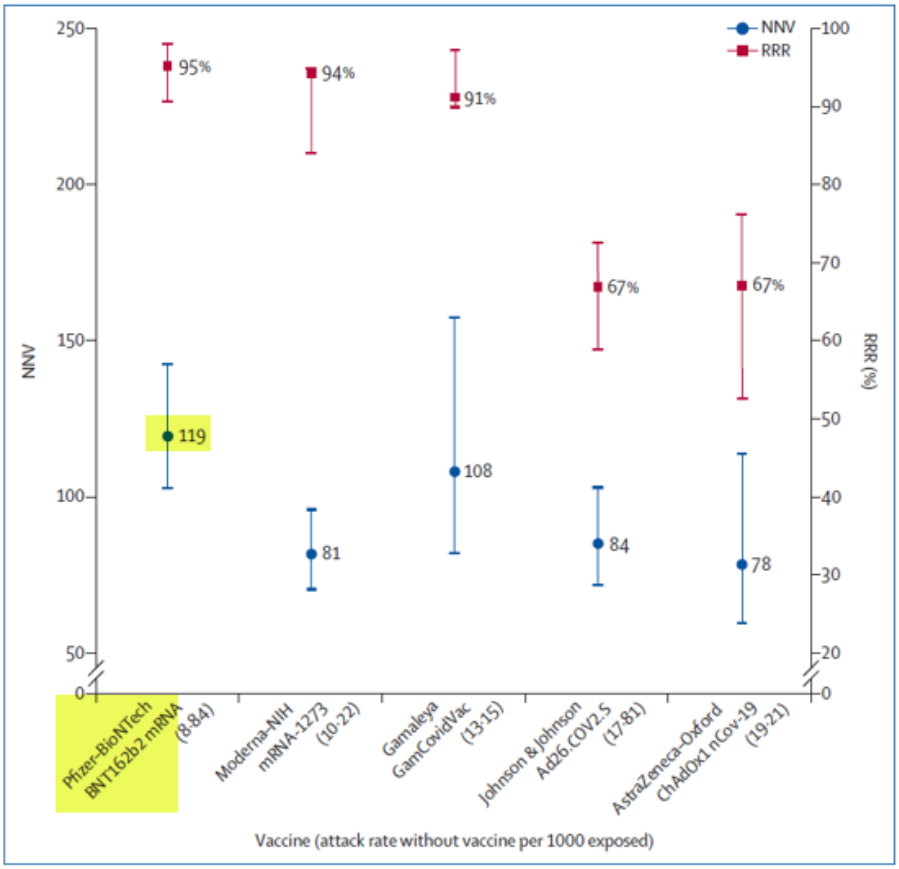


Figure: **RRR and NNV with 95% CI ranked by attack rate in the unvaccinated (placebo) group for five COVID-19 vaccines**
The lower the NNV and the higher the RRR, the better the vaccine efficacy. Details are in the appendix (p 3). RRR=relative risk reduction. NNV=numbers needed to vaccinate. NIH=US National Institutes of Health.

https://www.thelancet.com/journals/lanmic/article/PIIS2666-5247(21)00069-0/fulltext

As you can see, the Relative Risk Reduction (RRR) at 95% sounds much more impressive than the Number Needed to Vaccinate (NNV) at 119 people vaccinated for one to benefit.

The NNV of 119 was for the clinical trial. What has that number been estimated to be for the Pfizer "experiment" in the Israeli population?

The only reported indication of vaccine effectiveness is the Israeli mass vaccination campaign using the Pfizer–BioNTech product. Although the design and methodology are radically different from the randomised trial, Dagan and colleagues report an RRR of 94%, which is essentially the same as the RRR of the phase 3 trial (95%) but with an ARR of 0·46%, which translates into an NNV of 217 (when the ARR was 0·84% and the NNV was 119 in the phase 3 trial). This means in a real-life setting, 1·8 times more subjects might need to be vaccinated to prevent one more case of COVID-19 than predicted in the corresponding clinical trial.

These are excerpts from the Dagan study cited above explaining why the clinical trial results may look better than once the vaccines are rolled out to the general population.…

Mass vaccination campaigns using newly approved vaccines against the severe acute respiratory syndrome coronavirus (SARS-CoV-2)1,2 are beginning in many parts of the world. Randomized clinical trials of mRNA-based vaccines reported efficacies for preventing coronavirus 2019 (Covid-19) in the range of 94%2 to 95%.1

Although randomized clinical trials are considered the "gold standard" for evaluating intervention effects, they have notable limitations of sample size and subgroup analysis, restrictive inclusion criteria, and a highly controlled setting that may not be replicated in a mass vaccine rollout. For example, the phase 3 trial of the BNT162b2 mRNA vaccine against Covid-19 included 21,720 persons who were randomly assigned to the vaccinated group, which permitted estimates of vaccine efficacy in only a small number of subpopulations.1 Moreover, patients with chronic diseases were included only if the conditions were deemed stable by the investigators.3

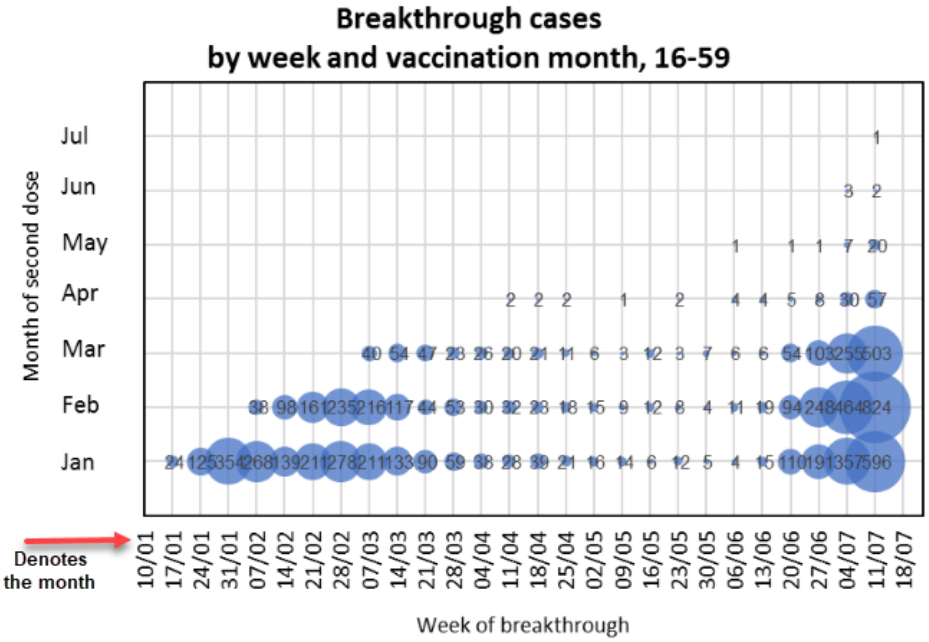
End of excerpts

It's important to point out that these decisions are personal, and different people may make different decisions about treatment based on the same information. Furthermore, different people have different baseline risk profiles and different risk tolerance. This means clinical decisions should not be based on NNT alone. It's just one piece of information that needs to be interpreted in a clinical context and under medical supervision.

One last thing worth looking at regarding the Israeli data, is the number of breakthrough infections early in the vaccination campaign.

See the graph next page…

Breakthrough cases



The first shot typically doesn't produce ample levels of neutralizing antibodies, but instead produces more non neutralizing antibodies. It's the neutralizing antibodies that are the most important to prevent infection. The second shot appears to produce more of the neutralizing antibodies to the spike protein. That is why the CDC does not deem a person fully vaccinated until 14 days after their second shot. So that may be six weeks after their first injection. There is some fuzzy math that can tend to go on with regard to these details. The question is, are all of the people that were infected earlier on in the campaign considered unvaccinated or vaccinated with breakthrough infections. It appears from the Israeli data that they are considering people contracting early infections as breakthrough infections. It's my understanding that the CDC here in the US is not categorizing them that way, but as unvaccinated people becoming infected. This is important because categorizing people that get infected within the first six weeks of the trial as unvaccinated pumps up the numbers of infections in the unvaccinated subjects. It also reduces the amount of time that the fully vaccinated subjects are part of the trial, making it obvious that they would have less time as “fully vaccinated” to catch the virus. If the trial period is only 90 days long and for the first half of that 90 days, the vaccinated subjects are considered unvaccinated, it's obvious to see how the numbers would be skewed to make it look like the unvaccinated subjects had more infections.

Scroll to next page…

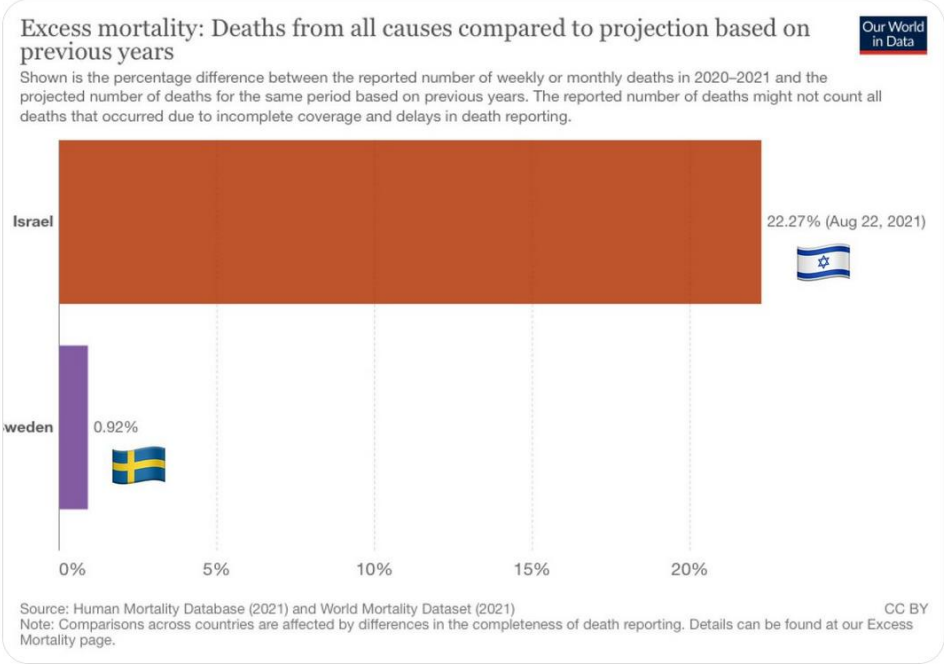
A comparison of deaths in Sweden with triple vaxxed Israel

It appears that this graph is for August 2021 compared to previous years all-cause mortality. What may have made the difference? Israel launched it’s 3rd shot booster program on July 31st, 2021.

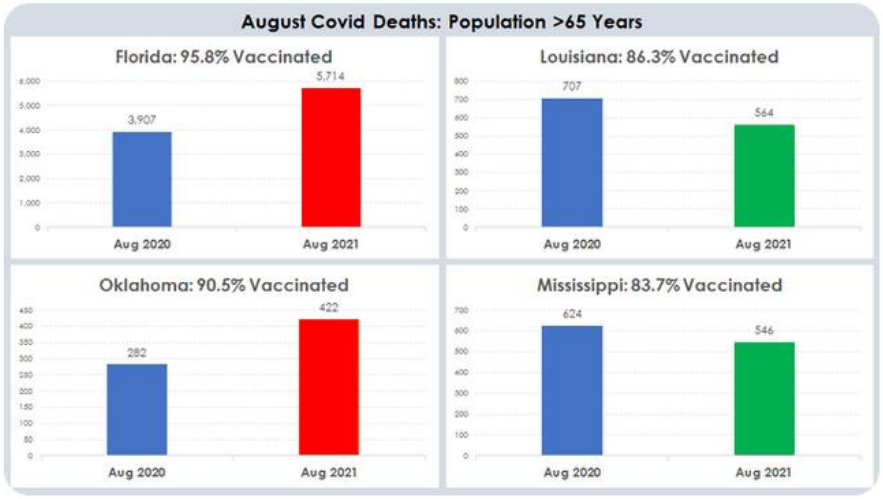
Dr. Eli David
@DrEliDavid

Excess mortality in Israel🇮🇱, the only triple vaxxed country in the world, with draconian Covid pass for everyone aged 12+.

H/t: @MrPitt11



Another interesting comparison of the month of August 2020 to August 2021 in higher and lower vaccinated states in those over 65 years of age.



In urgent appeal to the European Medicines Agency to stop the vaccination program and launch a large-scale independent investigation into the injuries and deaths caused by the vaccines

An urgent report by the ***Evidence-Based Consultancy Medicine Ltd*** June 9th, 2021, calls for action to mitigate the damage caused by the COVID-19 vaccines.

We are sharing this preliminary report due to the urgent need to communicate information that should lead to cessation of the vaccination roll out while a full investigation is conducted. According to the recent paper by Seneff and Nigh (1), potential acute and long-term pathologies include:

- Pathogenic priming, multisystem inflammatory disease and autoimmunity
- Allergic reactions and anaphylaxis
- Antibody dependent enhancement

The
- Activation of latent viral infections
- Neurodegeneration and prion diseases
- Emergence of novel variants of SARSCoV2
- Integration of the spike protein gene into the human DNA

The nature and variety of ADRs reported to the Yellow Card System are consistent with the potential pathologies described in this paper and supported by other recent scientific papers on vaccine-induced harms, which are mediated through the vaccine spike protein product (2,3). It is now apparent that these products in the blood stream are toxic to humans. An immediate halt to the vaccination programme is required whilst a full and independent safety analysis is undertaken to investigate the full extent of the harms, which the UK Yellow Card data suggest include thromboembolism, multisystem inflammatory disease, immune suppression, autoimmunity and anaphylaxis, as well as Antibody Dependent Enhancement (ADE).
Due to the need for expedience, we have not detailed all ADRs in this preliminary report. The existing Yellow Card data covering just under a five-month period indicate that the extent of morbidity and mortality associated with the COVID-19 vaccines is unprecedented. Age and gender specific data, as well as the time from vaccination, are required to further our analysis of these data and we have sent Freedom of Information Requests (FOIRs) to the MHRA in this regard.

In addition, urgent independent expert evaluation and discussion is required to assess whether the novel vaccines may be causing gene mutations among recipients, as suggested by the occurrence of usually extremely rare genetic disorders, such as Paroxysmal Extreme Pain Disorder (PEPD). In addition to the 11 cases of PEPD on the Yellow Card system, there are currently 12 reports of this extremely rare condition on the WHO's Vigiaccess.org database and 10 on the European Medicines Agency's (EUDRA) pharmacovigilance database. Are these ADRs occurring in babies of vaccinated pregnant women, or spuriously among vaccinated adults? This question needs urgent attention.

As pharmacovigilance data are known to be substantially under-reported, we recommend that the MHRA urgently publicises these ADR data and assists people with their ADR reporting, to facilitate full elucidation and clarification of the extent of the problem.

The MHRA now has more than enough evidence on the Yellow Card system to declare the COVID-19 vaccines unsafe for use in humans. Preparation should be made to scale up humanitarian efforts to assist those harmed by the COVID-19 vaccines and to anticipate and ameliorate medium to longer term effects. As the mechanism for harms from the vaccines appears to be similar to COVID-19 itself, this includes engaging with numerous international doctors and scientists with expertise in successfully treating COVID-19.
(Highlighted by me)

https://ebmcsquared.org/wp-content/uploads/2021/08/Urgent-Preliminary-Report-of-Yellow-Card-Data-9-6-2021.pdf

In a follow-up report issued August 9th, 2021, summarizing data through June 30th, 2021, ***The Evidence-Based Medicine Consultancy LTD*** did a fabulous job of pointing out the data and concerns. If you want to dig deeper into what they have found I would highly recommend that you take the time to read this report. This report is found by scrolling about halfway down the web page at this link… https://ebmcsquared.org/urgent-preliminary-report-of-yellow-card-data

The following is an urgent appeal to take immediate actions.

As noted in the CHM's Expert Working Group report on COVID-19 vaccine safety surveillance (1), **MHRA has statutory responsibility for undertaking post-authorisation safety monitoring in the UK.** We ask the MHRA **to take action as follows, in line with its statutory obligation to minimize risk to individuals,** pending full investigation of vaccine safety and efficacy **and re-assessment of risk-benefit ratios** by MHRA/CHM/CHM EAGs and independent experts using real world empirical evidence and assuming use of known effective treatment protocols:

• **Suspend the COVID-19 vaccines immediately in all children** so plans to vaccinate children aged 12 & over are cancelled, incl. imminent plans in those at higher risk of COVID-19, who would be most vulnerable to vaccine side-effects, and plans in 16-17 year olds.

• **Suspend** the use of COVID-19 vaccines in all adults

• **Suspend enrolment** in trials in UK of COVID-19 vaccines

• **Communicate to healthcare workers and vaccine recipients** the potential risk of Guillain-Barré Syndrome with the AstraZeneca COVID-19 vaccine and that 'Vaccinated persons need to seek immediate medical attention if they develop weakness and paralysis in the extremities, possibly progressing to the chest and face, after vaccination, as these could be signs of Guillain-Barré Syndrome'.

• **Communicate to healthcare workers and vaccine recipients** known treatment protocols for COVID-19 (acute and long) and for post-vaccination side-effects, including Covid Vaccination (CoVAC) Syndrome, so that people can receive timely care. We have collated health guidance from international clinical expert groups on managing these conditions, which we can share with you for distribution.

• **Postpone** any EUA assessment of booster vaccinations

• **Conduct a comprehensive overhaul** of the UK's Yellow Card system

I recommend sharing this excellent rapid drawing video discussing the risks of the COVID-19 vaccines

https://rumble.com/vkjkcu-dont-get-jabbed-be-informed.html

Also consider sharing a free download of an article I wrote regarding the risks from COVID to children compared to the risks of the vaccines for children and pregnant women. You can access that document here: https://www.wellnessdoc.com/the-risk-vs-reward-of-the-covid-19-vaccines-for-children/

Naturally acquired immunity from SARS-CoV-2 infection continues to be ignored in the push to vaccinate everyone, despite the overwhelming scientific evidence

Watch this 6-minute video from October 1st, 2021, where Rand Paul torches HHS Sec. Becerra on the reluctance to acknowledge naturally acquired immunity and the forced mandates of the vaccines.

https://www.youtube.com/watch?v=ml1W0k0yaJk

I have covered at least 2 dozen studies in my newsletter over the last 17 months that show strong, resilient, and lasting immunity to reinfection from SARS-CoV-2 in people that have previously been infected. If you would like to check out those studies, you can download my eBook on Natural Immunity after SARS-CoV-2 infection here: https://www.wellnessdoc.com/ebooks-and-publications/

In addition, Rand Paul mentions the recent Israeli study that was a massive study looking at 800,000 Israelis and concluded that those with natural immunity had superior protection form infection and symptoms of COVID-19 disease.

The study is a pre-print updated August 25th, 2021 and is titled, **Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections.**

Spoiler alert: At the end of the study, researchers found that vaccinated people were 13 times more likely to be infected and 27 times *(2,700%)* more likely to have symptomatic infections as a matched cohort that was previously infected with the Delta variant.

From the study

"This is the largest real-world observational study comparing natural immunity, gained through previous SARS-CoV-2 infection, to vaccine-induced immunity, afforded by the BNT162b2 mRNA vaccine. Our large cohort, enabled by Israel's rapid rollout of the mass-vaccination campaign, allowed us to investigate the risk for additional infection – either a breakthrough infection in vaccinated individuals or reinfection in previously infected ones – over a longer period than thus far described."

“Our analysis demonstrates that SARS-CoV-2-naïve vaccinees had a 13.06-fold increased risk for breakthrough infection with the Delta variant compared to those previously infected, when the first event (infection or vaccination) occurred during January and February of 2021. The increased risk was significant for a symptomatic disease as well.”

Conclusions:
This study demonstrated that natural immunity confers longer-lasting and stronger protection against infection, symptomatic disease and hospitalization caused by the Delta variant of SARS-CoV-2, compared to the BNT162b2 two-dose vaccine-induced immunity.

https://www.medrxiv.org/content/10.1101/2021.08.24.21262415v1

Our federal health agencies have been corrupted by the financial influence of the drug industry

In an excellent article by Dr. Mercola, including a video by Russell Brand, the glaring conflicts of interest within the FDA are revealed. Unfortunately, Dr. Mercola has been forced to remove his content after 48 hours of posting. You can watch the video here if you would like. The video has been seen nearly 900,000 times in the first 10 days of posting. https://www.youtube.com/watch?v=7fQ6JklHjBc&t=1s

From the article/video
Take the U.S. Food and Drug Administration, for example. In years past, the FDA was funded entirely by U.S. taxpayers. Today, nearly 45% of its annual budget comes from user fees paid by the drug companies that seek approval for a given product, Brand says. This transition from public to corporate funding has had a significant impact on how the agency operates, and it’s clearly not in the public’s best interest.

Brand cites data showing the FDA has gone from a drug approval rate of 38% in 2005 to 61% in 2018. In situations where a drug is aimed at a disease where few medication options already exist, 89% of new drug applications are approved on the first try.

Has drug development simply gotten that much better? Probably not. The fact is that drug companies view the FDA’s user fees as payment for service rendered, and that service includes approval. They’re not paying for the FDA to turn them down.

Why FDA and Big Pharma Have a Trust Problem

In response to the COVID-19 pandemic, the FDA issued emergency use authorizations for completely novel types of “vaccine” in a matter of weeks. While some applaud this speediness, it’s worth remembering that as speedy approvals have increased with other drugs, so have the number found to be harmful after the fact. Data cited by Brand show that 21% of FDA approved medications ultimately had to be removed from the market or be given a black box warning. Essentially, if you’re taking a newly approved drug, the chances that this drug will be found to be extremely dangerous is 1 in 5, which is hardly encouraging!

A 2017 Yale study[1] (https://news.yale.edu/2017/05/09/new-safety-concerns-identified-1-3-fda-approved-drugs) found the situation is even more dire than that, showing nearly 1 in 3 FDA approved drugs ends up having new safety issues detected in the years following approval.

The FDA is also allowing drug makers to profit at the expense of public health by allowing them to "claim success in trials based on proxy measurements instead of clinical outcomes like survival rates or cures, which take more time to evaluate," Caroline Chen notes in a June 2018 ProPublica article.[2] https://www.propublica.org/article/fda-repays-industry-by-rushing-risky-drugs-to-market

FDA Advisers Receive Payouts to Approve Drugs

In addition to that, "pay-later conflicts of interest" are widespread, according to an investigation by the journal Science.[3] https://www.science.org/news/2018/07/hidden-conflicts-pharma-payments-fda-advisers-after-drug-approvals-spark-ethical This is when doctors who advise the FDA or sit on drug panels that are in charge of drug approval are paid by drug makers AFTER the approval is a done deal.

Science examined 107 physician FDA advisers who voted on drug approvals. Of those, 40 ended up receiving more than $10,000 in post hoc earnings from the drug company whose drug they voted to approve; 26 of them got more than $100,000 and six were paid more than $1 million. FDA advisers who help drug makers gain approval also reap rewards in other ways. As noted by Science:[4]

"The FDA says its rules, along with federal laws, stop employees from improperly cashing in on their government service. But Science found that employees at the agency often reap later rewards — jobs or consulting work — from the makers of the drugs …

A 2016 study found that 15 of the 26 employees who left the agency later worked or consulted for the biopharmaceutical industry. Of the more than $24 million in personal payments or research support from industry to the 16 top-earning advisers, 93% came from the makers of drugs those advisers previously reviewed."

FDA Has Already Lost Most of Its Credibility

As argued by Brand, the data is rather unequivocal. It tells us corruption is rampant and the FDA has completely abandoned its charter to ensure public health and safety. It's really just there to give the appearance that someone is looking out for public health, while in actuality it's a venue through which drug makers are enabled to profit from unsafe and unproven drugs.

The sad reality is that while FDA approval used to mean something, today it has basically lost all meaning. Just because a drug is FDA-approved doesn't mean it's been proven safe and effective.

Again and again, drugs are found to have serious safety issues in the years after their approval. As a result, drug companies are allowed to benefit while public health is sacrificed, which is precisely the situation that the FDA was created to prevent.

End of excerpts

The risk of Antibody Dependent Enhancement (ADE) is increased by the COVID-19 vaccines according to a study in the Journal of Infection

This article appeared in the ***Journal of Infection*** August 16th 2021 and was titled, **Infection-enhancing anti-SARS-CoV-2 antibodies recognize both the original Wuhan/D614G strain and Delta variants. A potential risk for mass vaccination?**

The abstract- (My comments in red)

Antibody dependent enhancement (ADE) of infection is a safety concern for vaccine strategies. In a recent publication, Li et al. (Cell 184 :4203–4219, 2021) have reported that infection-enhancing antibodies (meaning they make the infection worse) directed against the N-terminal domain (NTD) of the SARS-CoV-2 spike protein facilitate virus infection in vitro, but not in vivo. However, this study was performed with the original Wuhan/D614G strain. Since the Covid-19 pandemic is now dominated with Delta variants, we analyzed the interaction of facilitating antibodies with the NTD of these variants. Using molecular modeling approaches, we show that enhancing antibodies have a higher affinity for Delta variants than for Wuhan/D614G NTDs these enhancing antibodies making the infection worse are more evident against Delta than the original strain). We show that enhancing antibodies reinforce the binding of the spike trimer to the host cell membrane by clamping the NTD to lipid raft microdomains. This stabilizing mechanism may facilitate the conformational change that induces the demasking of the receptor binding domain. As the NTD is also targeted by neutralizing antibodies, our data suggest that the balance between neutralizing and facilitating antibodies in vaccinated individuals is in favor of neutralization for the original Wuhan/D614G strain (that is what you want is the neutralizing antibodies and they were more active against the original strain). However, in the case of the Delta variant, neutralizing antibodies have a decreased affinity for the spike protein (once again, not good), whereas facilitating antibodies display a strikingly increased affinity (again, really bad). Thus, ADE may be a concern for people receiving vaccines based on the original Wuhan strain spike sequence (either mRNA or viral vectors) This is all of the vaccines currently in use). Under these circumstances, second generation vaccines with spike protein formulations lacking structurally-conserved ADE-related epitopes should be considered.

The top diagram is showing that the vaccines against the original Wuhan SARS-CoV-2 virus show stronger neutralization and lighter or less risk of ADE against that strain.

The lower diagram shows that those same vaccines have a much have a lighter or weaker neutralization effect and a much heavier or stronger risk of ADE with the Delta Variant.

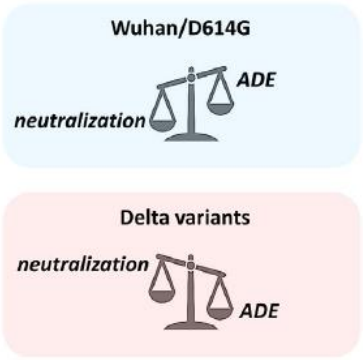


Fig. 2. Neutralization vs ADE balance according to SARS-CoV-2 strains.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8351274/

If you are a physician or scientist, consider signing on to the Rome Physician's Declaration. It asserts that radical changes must be made in the way public health agencies have interfered with doctors ability to practice medicine

Read about it here: https://globalcovidsummit.org/news/welcome-to-the-global-covid-summit

Sign the document here: https://doctorsandscientistsdeclaration.org/

Calculate your risk of hospitalization and death from COVID-19

QCovid. The risk calculator

QCovid® has been developed using the ***University of Oxford*** hosted QResearch database which has anonymised data from primary care, hospitals, COVID-19 test results and death registries. This was used to determine which factors were associated with poor outcomes during the first wave of COVID-19 and create a risk prediction model - QCovid® - that provides a weighted, cumulative calculation of absolute risk using the variables associated with poor COVID-19 outcomes. The factors incorporated in the model include age, ethnicity, level of deprivation, obesity, whether someone lived in residential care or was homeless, and a range of existing medical conditions, such as cardiovascular disease, diabetes, respiratory disease and cancer.

This model was then tested in two independent sets of data, one from January to April 2020 and one from May 2020 to June 2020, to find out whether it accurately predicted severe outcomes due to COVID-19 during the first wave of the pandemic in England.

The research, published in the BMJ, showed that the model performed well in predicting severe outcomes due to COVID-19 (death and hospitalisation).

Go here to calculate your risk- https://www.qcovid.org/Calculation

This is my risk calculation

The risk table

The table shows the absolute risk of catching and dying COVID-19 over a 90-day period based on data from the first peak of the pandemic. There is a comparison with the risk for a person of the same age and sex but with no risk factors. The relative risk is the absolute risk divided by this average risk.

	Absolute risk (a)		Absolute risk with no risk factors (b)		Relative risk (a/b)
COVID associated death	0.0228%	**1 in 4386**	0.0227%	**1 in 4405**	1.0044
COVID associated hospital admission	0.1029%	**1 in 972**	0.101%	**1 in 990**	1.0188

KEY POINT: One very important thing to consider when looking at this risk analysis, is that it doesn't take into consideration vitamin D status or many other health and lifestyle factors. The other important

consideration is that the absolute and relative risk of you being hospitalized or dying from COVID in this method is that it uses statistics from the very deficient treatment system that has been in place whereby people were sent home to sicken in place without treatment. Using the "shunned" early treatment medications upon contracting the infection, could reduce your chance of hospitalization and death by a tremendous amount according to hundreds of studies from around the world. So, just know that depending on your particular lifestyle, nutritional status, overall health picture and advanced preparation for what to do if you get sick, can reduce your risk considerably.

Speaking of risk from COVID-19, a new CDC funded study looks at over a half million people to determine the highest risk factors for hospitalization and death

A July 1st, 2021 study posted on the ***CDC's*** website titled, **Underlying Medical Conditions and Severe Illness Among 540,667 Adults Hospitalized With COVID-19, March 2020–March 2021**, identified risk factors that had been identified before and also some new surprises.

The abstract

Introduction

Severe COVID-19 illness in adults has been linked to underlying medical conditions. This study identified frequent underlying conditions and their attributable risk of severe COVID-19 illness.

Methods

We used data from more than 800 US hospitals in the Premier Healthcare Database Special COVID-19 Release (PHD-SR) to describe hospitalized patients aged 18 years or older with COVID-19 from March 2020 through March 2021. We used multivariable generalized linear models to estimate adjusted risk of intensive care unit admission, invasive mechanical ventilation, and death associated with frequent conditions and total number of conditions.

Results

Among 4,899,447 hospitalized adults in PHD-SR, 540,667 (11.0%) were patients with COVID-19, of whom 94.9% had at least 1 underlying medical condition. Essential hypertension (50.4%), disorders of lipid metabolism (49.4%), and obesity (33.0%) were the most common. The strongest risk factors for death were obesity (adjusted risk ratio [aRR] = 1.30; 95% CI, 1.27–1.33), anxiety and fear-related disorders (aRR = 1.28; 95% CI, 1.25–1.31), and diabetes with complication (aRR = 1.26; 95% CI, 1.24–1.28), as well as the total number of conditions, with aRRs of death ranging from 1.53 (95% CI, 1.41–1.67) for patients with 1 condition to 3.82 (95% CI, 3.45–4.23) for patients with more than 10 conditions (compared with patients with no conditions).

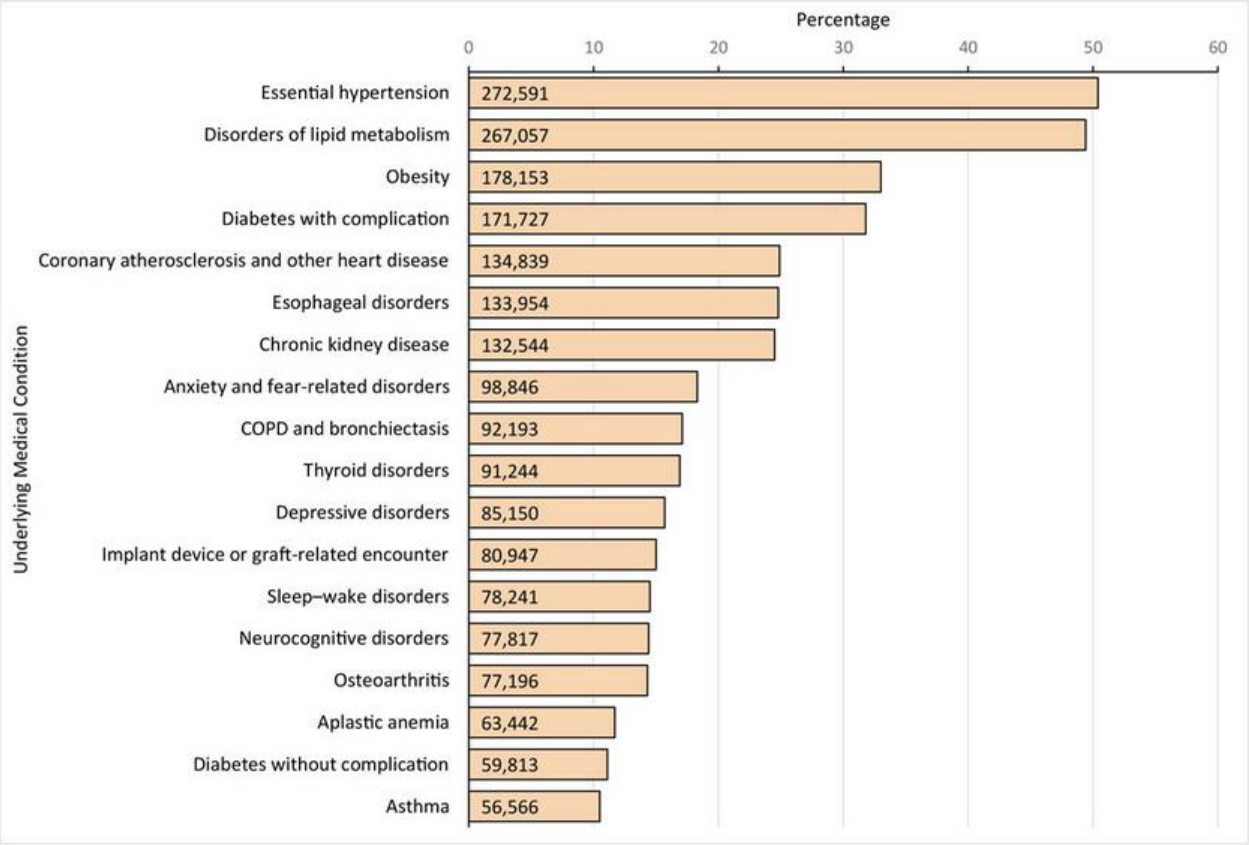
Conclusion

Certain underlying conditions and the number of conditions were associated with severe COVID-19 illness. Hypertension and disorders of lipid metabolism were the most frequent, whereas obesity, diabetes with complication, and anxiety disorders were the strongest risk factors for severe COVID-19 illness. Careful evaluation and management of underlying conditions among patients with COVID-19 can help stratify risk for severe illness.

See the graph on the next page…

From the study

Figure 1.
Prevalence of the most frequent underlying medical conditions in a sample of adults hospitalized with COVID-19 in Premier Healthcare Database



Relative risk of death in the full model was:

- 30% higher with obesity
- 28% higher with anxiety and fear-related disorders
- 26% higher with diabetes with complication
- 21% higher with Chronic Kidney Disease (CKD)
- 18% higher with neurocognitive disorders including dementia and Alzheimer's disease
- 18% higher with chronic obstructive pulmonary disease and bronchiectasis
- 17% higher with aplastic anemia including anemia in CKD
- 14% higher with coronary atherosclerosis and other heart disease

Age-stratified analysis showed that the number of frequent underlying medical conditions (present in ≥10.0% of patients) was higher with older age. The most frequent conditions were obesity, diabetes, and essential hypertension among patients younger than 65, and disorders of lipid metabolism, essential hypertension, diabetes, and coronary atherosclerosis among patients aged 65 or older. Among patients aged 18 to 39, essential hypertension was associated with a 26% higher risk of death (95% CI, 10%–44%), 25% higher risk of IMV (95% CI, 17%–35%), and an 11% higher risk of ICU admission (95% CI, 7%–15%). In the same age group, asthma was frequent and was associated with a 9% (95% CI, 5%–13%) higher risk of ICU admission but was not significantly associated with higher risk of IMV or death. Other specified status (CCSR category indicating a

need for specific medical support, such as a wheelchair or renal dialysis) was a frequent category among patients aged 40 to 64 and 65 or older and was associated with a 7% (1%–13%) and 4% (1%–6%) higher risk of death, respectively.

We found a dose–response association between the total number of underlying medical conditions and risk of severe COVID-19 illness…

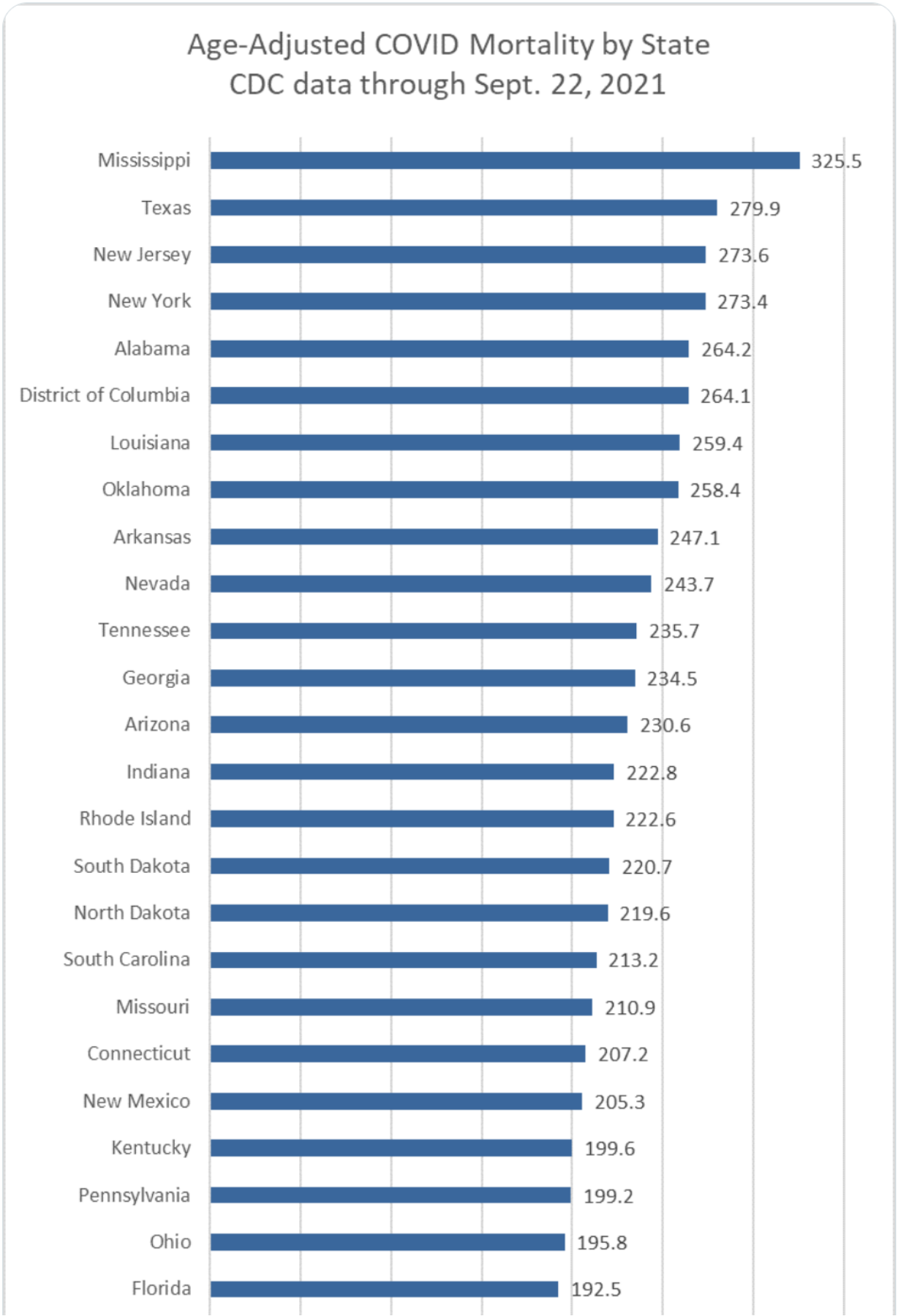
Compared with patients with no documented underlying medical conditions, patients' risk of death was

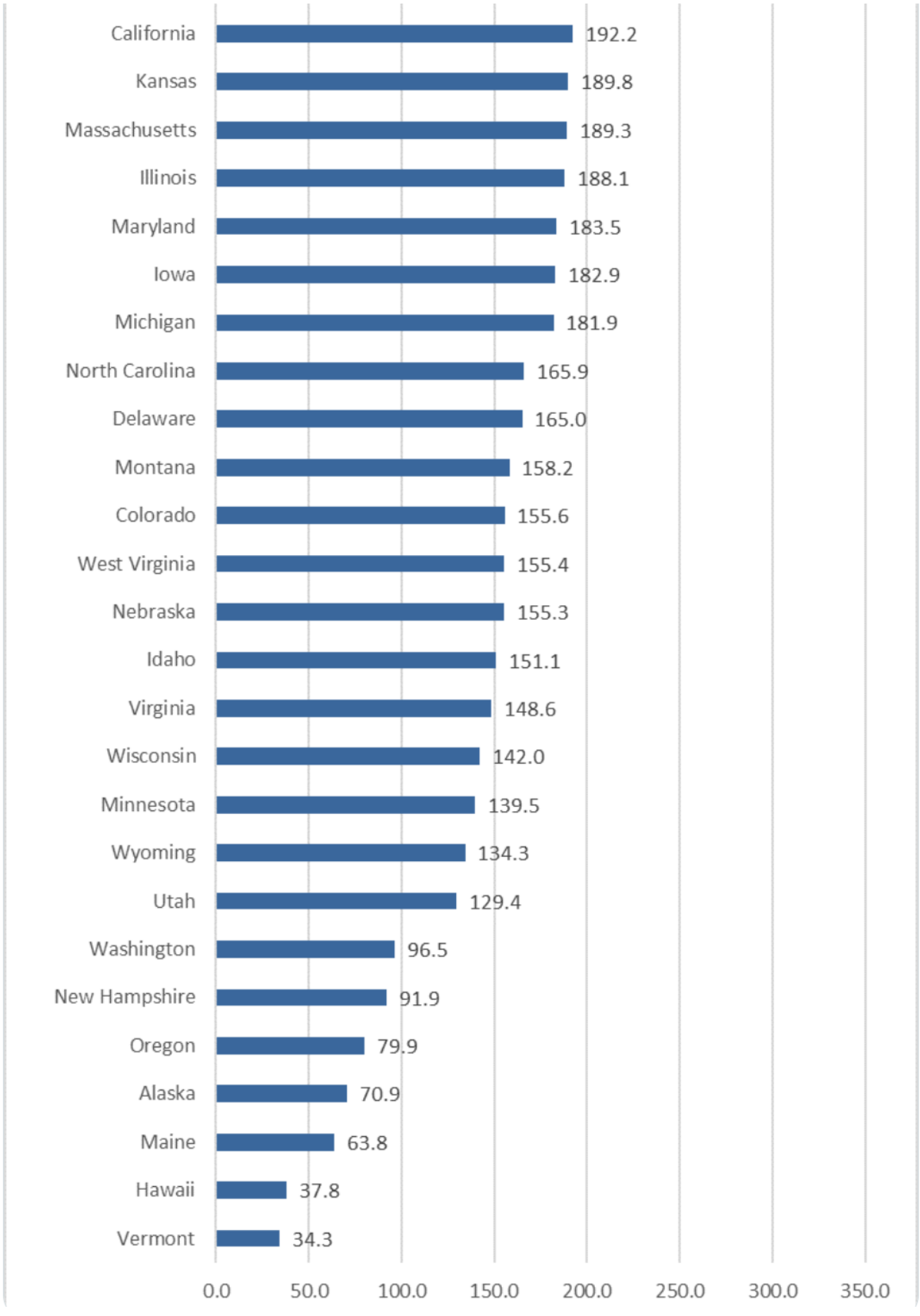
- 1.53 times (95% CI, 1.41–1.67) as high if they had 1 condition,
- 2.55 times (95% CI, 2.32–2.80) as high if they had 2 to 5 conditions,
- 3.29 times (95% CI, 2.98–3.63) as high if they had 6 to 10 conditions,
- 3.82 times (95% CI, 3.45–4.23) as high if they had more than 10 conditions.

https://www.cdc.gov/pcd/issues/2021/21_0123.htm

Scroll to next page due to image size…

How do the different states compare in COVID-19 death rates?

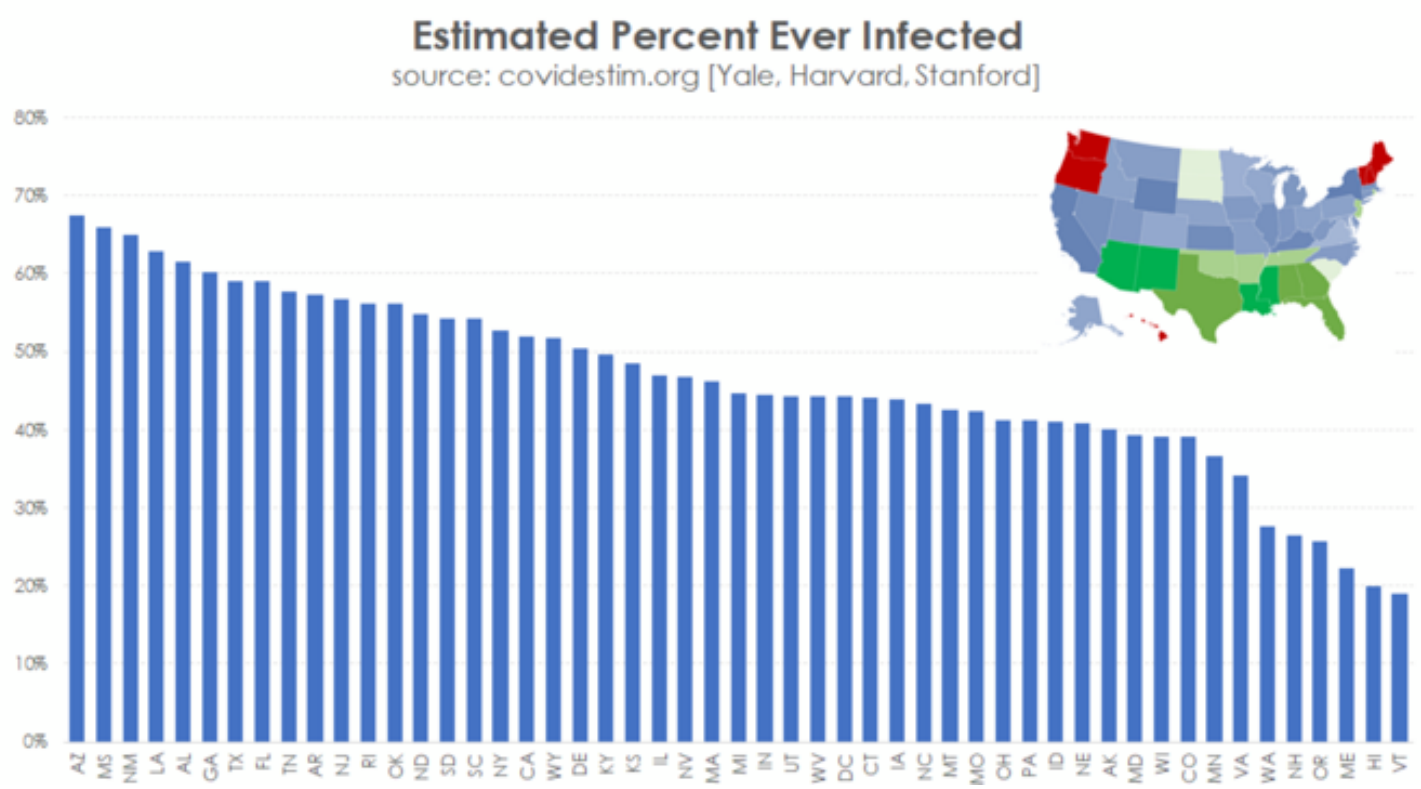



California 192.2
Kansas 189.8
Massachusetts 189.3
Illinois 188.1
Maryland 183.5
Iowa 182.9
Michigan 181.9
North Carolina 165.9
Delaware 165.0
Montana 158.2
Colorado 155.6
West Virginia 155.4
Nebraska 155.3
Idaho 151.1
Virginia 148.6
Wisconsin 142.0
Minnesota 139.5
Wyoming 134.3
Utah 129.4
Washington 96.5
New Hampshire 91.9
Oregon 79.9
Alaska 70.9
Maine 63.8
Hawaii 37.8
Vermont 34.3
0.0 50.0 100.0 150.0 200.0 250.0 300.0 350.0

A look at the estimated percentage of the population that have been infected by SARS-CoV-2 in the various U.S. states

There are so many variables that may come into play with regard to the amount that the virus has moved through the population in different states. One could be the stringency of the public health measures such as lockdowns. I have shown in multiple instances throughout the last 18 months of doing my monthly newsletter that lockdowns while they may delay the spread of the virus, they do not stop the inevitable population infectivity or change the outcomes related to mortality or morbidity. Yet they do have very damaging effects economically, societally, emotionally and with negative health outcomes from all other diseases suffering delayed diagnosis and treatment. Other variables with regard to spread could relate to the demographics of population movement or population density.

The obvious benefit of a high percentage of the population having been infected is the benefit of herd immunity. It's becoming more and more apparent as the vaccines fail due to viral escape, that natural immunity from recovered infection is going to give us the best possibility to develop herd immunity and a pathway forward back to normalcy. While this virus may remain in some capacity as endemic along with the many other viruses we encounter, natural immunity gives a person the widest array of protection as the virus continues to evolve and mutate.



We are starting to see the bravado of forcing healthcare and emergency medical responders to be vaccinated begin to crumble

An article appearing on ktvz.com website titled, **Jefferson County commissioners declare state of emergency, call on state to scrap vaccine mandate,** Describes the concern over the coming shortages of health care workers and emergency responders due to the vaccine mandates.

From the article
"The Board of Commissioners requests that the state of Oregon immediately withdraw its vaccine mandate to prevent further exhaustion and departure of providers of core public services, including first responders, health care providers, educators and related staff, emergency service providers and public safety providers, that are essential for the safety and well-being of Oregonians living in, visiting and traveling through Jefferson County," the resolution concluded.

"By doing this declaration, we are setting the stage for requesting state and/or federal assistance to assist local resources and capabilities. In rural counties all over the state, we are faced with the possibility of not being able to provide adequate Public Safety service. We do not want to lose any of our service providers, and it is extremely hard to find replacements in rural Oregon should there be no alternatives.

End of excerpts

Hopefully this is the start of towns cities and municipalities coming to their senses and realizing that forcing an experimental product with no long term safety data, a risk profile that has shown hundreds of thousands of vaccine injuries in the United states alone and is proving to be increasingly ineffective against the delta variant to be a ludicrous proposition.

https://ktvz.com/news/2021/09/15/jefferson-county-commissioners-declare-state-of-emergency-call-on-state-to-scrap-vaccine-mandate/

Now unfortunately, this story does not appear to be the case in all parts of the country. Led by Joe Biden's edicts, states cities municipalities and private companies are forcing valuable and loyal employees out of their jobs. Many of these people have naturally acquired immunity, which is far better than the vaccines can provide. Many have legitimate medical concerns over getting the shots and many have religious objections. And many don't want to risk the known short-term potential well documented harms and the unknown long-term potential harms of taking an experimental product. And yes, the vaccines are still experimental as the clinical trials are not scheduled to be completed until the end of 2022 and early 2023 for Pfizer and Moderna. Stay tuned as I am hoping that we will see a flurry of class-action lawsuits being unleashed against these unconstitutional, human rights violations.

November 1st, 2021

The nonsensical policies of pretending that vaccines that can't prevent infection or transmission to participate in society just became all the more ridiculous

In a medRvix pre-print article dated, August 24th, 2021 titled, **Shedding of Infectious SARS-CoV-2 Despite Vaccination**, what we already knew became even more obvious. And, that is that fully vaccinated people incubate virus at as high and even higher levels than people that are not vaccinated. Watch for this

study to be shadow banned or retracted. They excluded people who are either only partially vaccinated, or for whom vaccination status was unknown from the study.

The Abstract

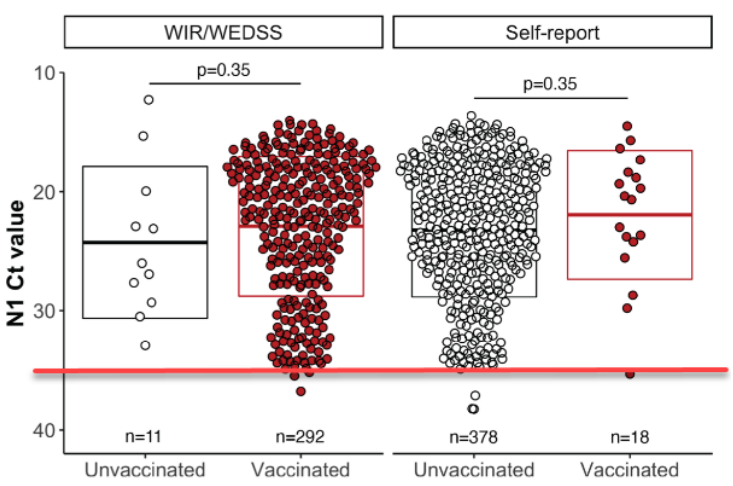
The SARS-CoV-2 Delta variant might cause high viral loads, is highly transmissible, and contains mutations that confer partial immune escape. Outbreak investigations suggest that vaccinated persons can spread Delta. We compared RT-PCR cycle threshold (Ct) data from 699 swab specimens collected in Wisconsin 29 June through 31 July 2021 and tested with a qualitative assay by a single contract laboratory. Specimens came from residents of 36 counties, most in southern and southeastern Wisconsin, and 81% of cases were not associated with an outbreak. **During this time, estimated prevalence of Delta variants in Wisconsin increased from 69% to over 95%. Vaccination status was determined via self-reporting and state immunization records. (Supplemental Figure 1).**

Supplemental figure 1

A

Vaccinated per WIR or WEDSS	Vaccinated per self-report: Yes	Vaccinated per self-report: No
Yes	124	33
No	0	8

B



My comments: **The red horizontal wine was added by me.** If you look at the Ct value on the vertical axis on the left, you will see that the line intersects at about 35 cycles. We have discussed the many faults of the PCR testing numerous times over the last 18 months. As you can see in the diagram there was little if any positives that were triggered beyond the 35-cycle threshold. Yet, our CDC directed labs to run 42 as many as 45 amplification cycles on samples. Keep in mind, that the higher the number of amplification cycle thresholds run before triggering a positive test, the less likely that person has any viable infectious virus. As I have shown in previous issues of the newsletter by presenting various studies, it becomes very difficult to be able to culture virus after 28 to 30 amplification cycles.

Back to the study:

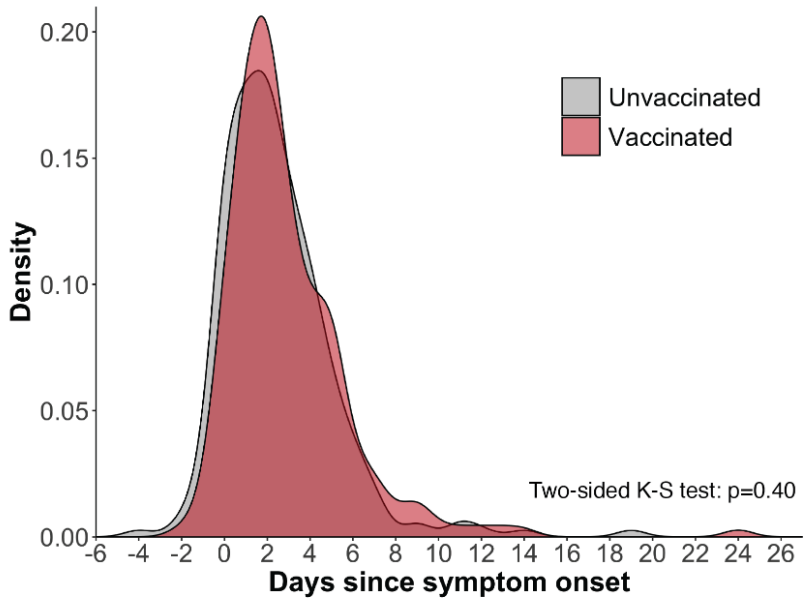
Low Ct values were detected in vaccinated people regardless of symptoms at the time of testing.

My comment: that they could pick up the virus at low CT levels means that the person Had a high viral load and was very infectious.

(**Figure 1C**). Ct values <25 were detected in 7 of 24 unvaccinated (29%; CI: 13-51%) and 9 of 11 fully vaccinated asymptomatic individuals (82%; CI: 48-97%), and 158 of 232 unvaccinated (68%, CI: 62-

74%) and 156 of 225 fully vaccinated (69%; CI: 63-75%) symptomatic individuals. Time from symptom onset to testing did not vary by vaccination status (p=0.40; **Supplemental Figure 2**). Infectious virus was detected in the sole specimen tested from an asymptomatic fully vaccinated individual. Although few asymptomatic individuals were sampled, these results indicate that even asymptomatic, fully vaccinated people might shed infectious virus.

Supplemental figure 2



Supplemental figure 2. Density distributions of unvaccinated and vaccinated specimen collection dates by day since symptom onset. Day 0 on the x-axis denotes self-reported day of symptom onset. Negative values for days indicate specimen collection prior to symptom onset. Symptom onset data were available for n=263 unvaccinated cases and n=232 vaccinated cases.

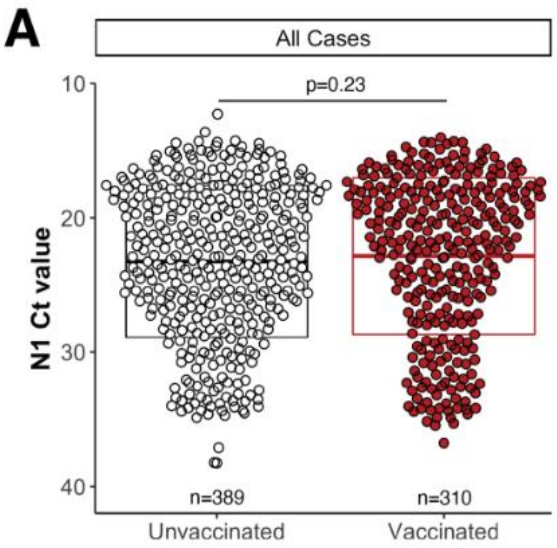
Combined with other studies 2–5, these data indicate that vaccinated and unvaccinated individuals infected with the Delta variant might transmit infection. Importantly, we show that infectious SARS-CoV-2 is frequently found even in vaccinated persons when specimen Ct values are low. The inclusion of viruses from Pango lineages B.1.617.2, AY.2, and AY.3, and multiple counties without a linking outbreak, indicate that Delta-lineage SARS-CoV-2 can achieve low Ct values consistent with transmissibility in fully vaccinated individuals across a range of settings. Vaccinated and unvaccinated persons should get tested when symptomatic or after close contact with someone with suspected or confirmed COVID-19. Continued adherence to non-pharmaceutical interventions during periods of high community transmission to mitigate spread of COVID-19 remain important for both vaccinated and unvaccinated individuals.

Figure 1. Individuals infected with SARS-CoV-2 despite full vaccination have low Ct values and shed infectious virus.

1, A. Ct values for SARS-CoV-2-positive specimens grouped by vaccination status.

We observed low Ct values (<25) in 212 of 310 fully vaccinated (68%; Figure 1A) and 246 of 389 (63%) unvaccinated individuals.

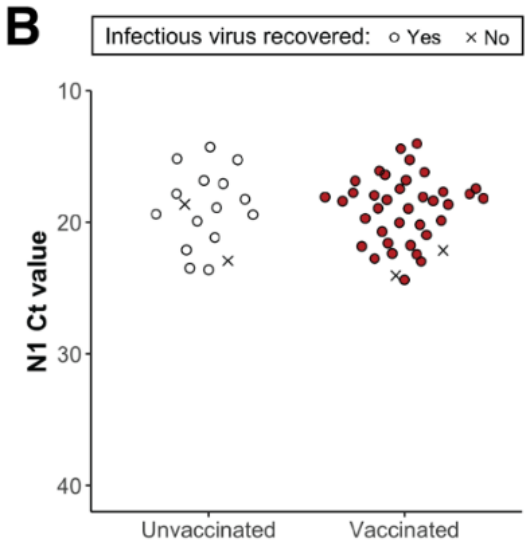
Figure 1, A



1, B. Infectiousness was determined for a subset of N1 Ct-matched specimens with Ct <25 by inoculation onto Vero E6 TMPRSS2 cells and determining presence of cytopathic effects (CPE) after 5 days in culture. Specimens were selected by N1 Ct-matching between fully vaccinated and not fully vaccinated persons, then specimens from persons with unknown vaccination status were excluded from the analysis. Circles indicate presence of CPE; 'X' indicates no CPE detected.

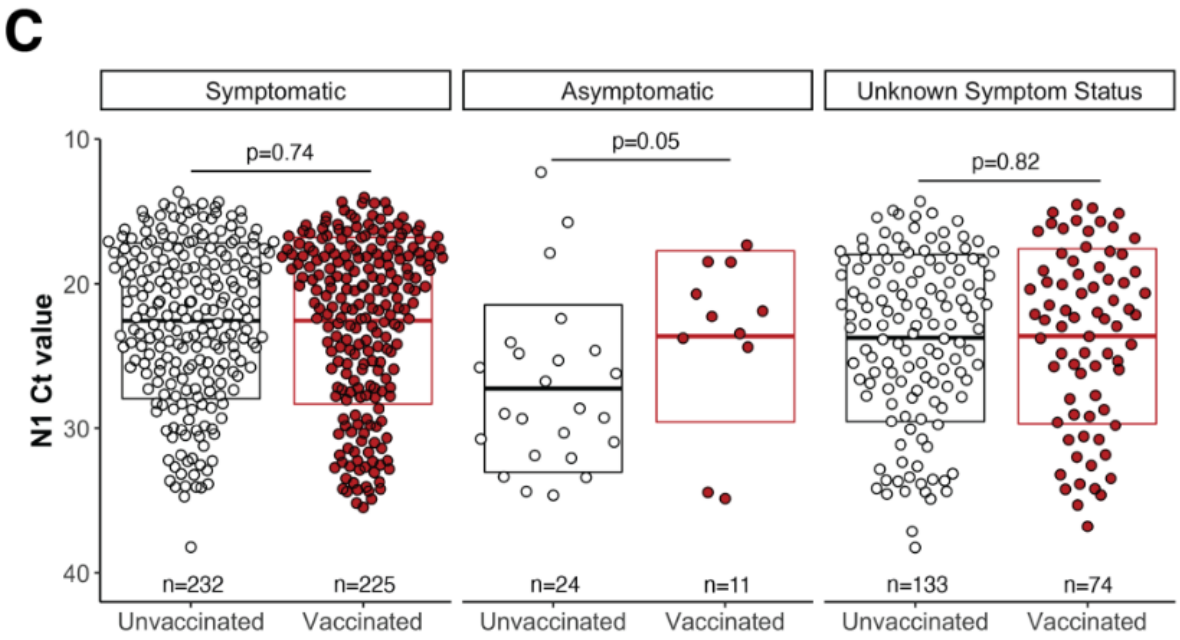
Testing a subset of low-Ct samples revealed infectious SARS-CoV-2 in 15 of 17 specimens (88%) from unvaccinated individuals and 37 of 39 (95%) from vaccinated people.

Figure 1, B



1, C. N1 Ct values for SARS-CoV-2-positive specimens grouped by vaccination status for individuals who were symptomatic or asymptomatic, or those whose symptom status was not determined, at the time of testing.

Figure 1, C



https://www.medrxiv.org/content/10.1101/2021.07.31.21261387v4.full.pdf

Let's consider the implications of this study in the real world. This next story seems to corroborate the findings of this study and should be the death nail to vaccine mandates worldwide.

Massive study across 68 countries and nearly 3,000 counties in the U.S. finds that high vaccination levels of the population seem to correlate with higher infection transmission and case rates

A study published September 30th, 2021, in the ***European Journal of Epidemiology*** titled, **Increases in COVID-19 are unrelated to levels of vaccination across 68 countries and 2947 counties in the United States**, exposes the lie that the vaccination program is working and that these gene therapy prophylactics will be able to move the needle on ending the pandemic.

Findings

At the country-level, there appears to be no discernable relationship between percentage of population fully vaccinated and new COVID-19 cases in the last 7 days (Fig. 1). In fact, the trend line suggests a marginally positive association such that countries with higher percentage of population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days. The lack of a meaningful association between percentage population fully vaccinated and new COVID-19 cases is further exemplified, for instance, by comparison of Iceland and Portugal. Both countries have over 75% of their population fully vaccinated and have more COVID-19 cases per 1 million people than countries such as Vietnam and South Africa that have around 10% of their population fully vaccinated.

Across the US counties too, the median new COVID-19 cases per 100,000 people in the last 7 days is largely similar across the categories of percent population fully vaccinated (Fig. 2). Notably there is also substantial county variation in new COVID-19 cases *within* categories of percentage population fully vaccinated. There also appears to be no significant signaling of COVID-19 cases decreasing with higher percentages of population fully vaccinated (Fig. 3).

Of the top 5 counties that have the highest percentage of population fully vaccinated (99.9–84.3%), the US Centers for Disease Control and Prevention (CDC) identifies 4 of them as "High" Transmission counties. Chattahoochee (Georgia), McKinley (New Mexico), and Arecibo (Puerto Rico) counties have above 90% of their population fully vaccinated with all three being classified as "High" transmission.

Conversely, of the 57 counties that have been classified as "low" transmission counties by the CDC, 26.3% (15) have percentage of population fully vaccinated below 20%. Since full immunity from the vaccine is believed to take about 2 weeks after the second dose, we conducted sensitivity analyses by using a 1-month lag on the percentage population fully vaccinated for countries and US counties. The above findings of no discernable association between COVID-19 cases and levels of fully vaccinated was also observed when we considered a 1-month lag on the levels of fully vaccinated (Supplementary Figure 1, Supplementary Figure 2).

In summary, even as efforts should be made to encourage populations to get vaccinated it should be done so with humility and respect. Stigmatizing populations can do more harm than good. Importantly, other non-pharmacological prevention efforts (e.g., the importance of basic public health hygiene with regards to maintaining safe distance or handwashing, promoting better frequent and cheaper forms of testing) needs to be renewed in order to strike the balance of learning to live with COVID-19 in the same manner we continue to live a 100 years later with various seasonal alterations of the 1918 Influenza virus.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8481107/
My comment: There are a couple of very important things missing from the last summary paragraph. It would be nice to see these journals discuss the role of optimizing vitamin D levels in the population, as well as promoting the early use of antiviral treatments that are proving to be so very valuable in preventing hospitalizations and deaths. Those would include hydroxychloroquine with zinc, Ivermectin and Budesonide used appropriately. There is literally well over 100 studies now that show tremendous benefit with these medications used as early treatment for COVID-19.

That leads me to this next story and pharma's attempt to cash in on that early treatment market.

A report from a hospital in Israel showing 39 of 42 cases in an outbreak were in people that were fully vaccinated

A report published September 26th, 2021, in the ***Euro Surveillance*** the European communicable disease bulletin, **Nosocomial outbreak caused by the SARS-CoV-2 Delta variant in a highly vaccinated population, Israel, July 2021**

The abstract

A nosocomial outbreak of SARS-CoV-2 Delta variant infected 42 patients, staff and family members; 39 were fully vaccinated. The attack rate was 10.6% (16/151) among exposed staff and reached 23.7% (23/97) among

exposed patients in a highly vaccinated population, 16–26 weeks after vaccination (median: 25 weeks). All cases were linked and traced to one patient. Several transmissions occurred between individuals wearing face masks. Fourteen of 23 patients became severely sick or died, raising a question about possible waning immunity. https://pubmed.ncbi.nlm.nih.gov/34596015/

New study from Sweden shows how rapidly the three leading vaccines against COVID-19 decrease in effectiveness

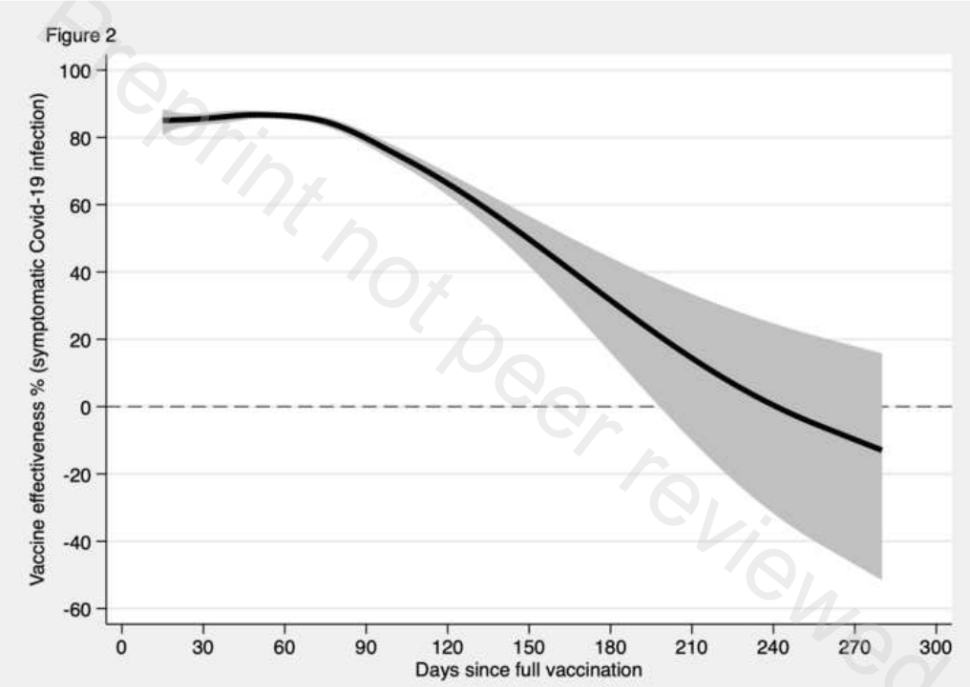
The study is a preprint posted October 25th 2021 titled, **Effectiveness of COVID-19 vaccination against risk of symptomatic infection, hospitalization, and death up to nine months: a Swedish total population cohort study.** The findings mirror other studies and reports from all over the world showing the dramatic decline in effectiveness of the vaccines within a few months.

Findings of vaccine effectiveness against infection:

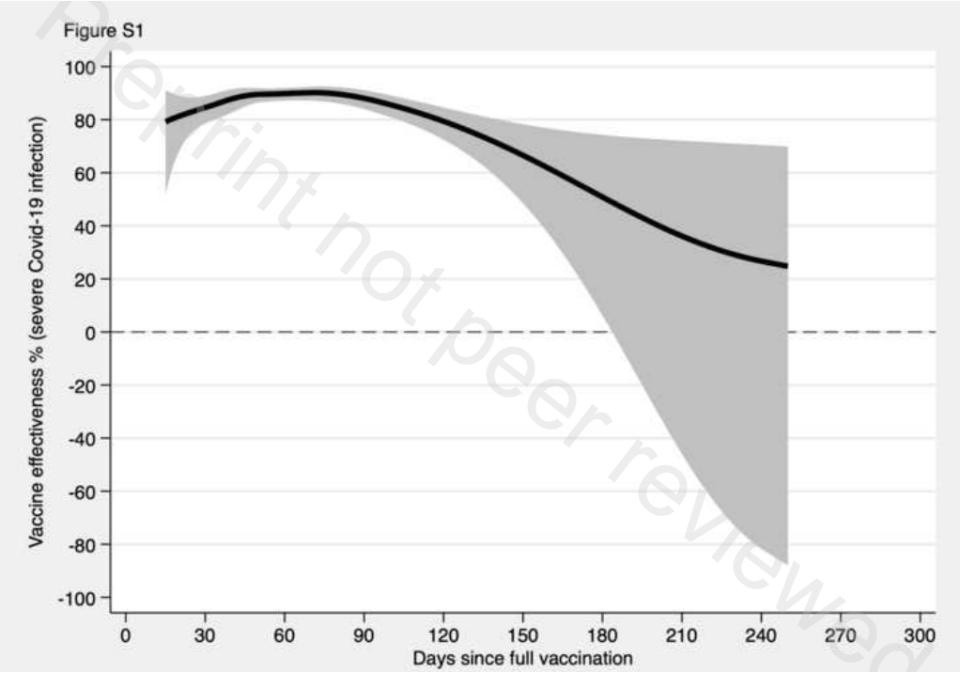
- Pfizer waned progressively from 92% at day 15-30 to 47%, and from day 211 and onwards no effectiveness could be detected.
- Moderna waned to 59% from day 181 and onwards.
- AstraZeneca's effectiveness was generally lower and waned faster, with no effectiveness detected from day 121 and onwards.

As You can see, vaccine effectiveness decreases below zero at about nine months.

Figure 2. Adjusted vaccine effectiveness (any vaccine) against symptomatic Covid-19 infection among 842,974 vaccinated individuals matched to equally number of unvaccinated individuals through 9 months of follow-up. To model the association between vaccine effectiveness during follow-up, restricted cubic splines were used with 5 degrees of freedom



Supplemental Figure 1. Adjusted vaccine effectiveness (any vaccine) against Covid-19 hospitalization or death among 842,974 vaccinated individuals matched to equally number of unvaccinated individuals through 9 months of follow-up. To model the association between vaccine effectiveness during follow-up, restricted cubic splines were used with 5 degrees of



"Overall, vaccine effectiveness was lower and waned faster among men and older individuals.
For the outcome severe Covid-19, effectiveness waned from 89% at day 15-30 to 42% from day 181 and onwards, with sensitivity analyses showing notable waning among men, older frail individuals, and individuals with comorbidities."

https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3949410

My comments:

1. In looking at the graphs above you can see the dark line representing the average decrease flanked by a shaded gray area that tends to widen as time goes on. That represents the full spectrum of individuals studied participating in the study. Look at how far below the zero line that shaded area goes in both graphs. That means that the vaccine effectiveness is in the negative, meaning that in that percentage of the population, the vaccine is making people more susceptible to contracting COVID-19, becoming hospitalized and dying. The quote below the second graph describes those individuals that are most likely to fall within that negative shaded area. Could this represent cases of severe disease and deaths due to Antibody Dependent Enhancement (ADE)? Concerns over the potential for ADE have been worrying experts in the medical and scientific community since prior to the release of the vaccines. The development of ADE in animals in clinical trials of vaccine development after the SARS-CoV-1 outbreak in 2002-2003 is what prevented those vaccines from ever making it to human trials. It was simply too risky. The omission of animal trials in the rush to get the COVID-19 vaccines to market is in my opinion a huge mistake. With the increase over time of COVID related hospitalizations and deaths in vaccinated individuals around the world, we may be seeing the predicted outcome of those shortcuts becoming realized.

2. Some people may look at the graph above and say that even some protection against hospitalization and death is worth taking the vaccine. What those people don't realize or in some may choose to ignore, is that optimal levels of vitamin D will do the same thing with zero risk of side effects. This has been shown in dozens of studies that I have posted on my web site HERE. Plus many other benefits of optimizing vitamin D in overall health. The other thing that will reduce hospitalizations and death significantly, (as studies have shown up to an 85% reduction), are the early treatment medications I have presented repeatedly over the last 18 months.

Is it even possible to reach herd immunity with the vaccines? Many experts from the most vaccinated countries don't seem to think so

White House spokespersons and public health officials continue to tell the American people that the vaccines have the capability of ending the pandemic. This rationale has been used to justify the mandates and now to justify going after extremely low risk children with these experimental gene therapy products. So, what do some of the experts around the world who have seen first-hand the vaccine's inability to slow the pandemic feel about this overly optimistic viewpoint. Jefferey Jaxen, the ***Highwire's*** investigative journalist wrote an editorial piece that contained a couple of those stunning admissions.

Sir Andrew Pollard, a professor of pediatric infection and immunity at the ***University of Oxford*** and the Director of the ***Oxford Vaccine Group*** has now admitted that in the light of the vaccine failure, any chance of reaching herd immunity as a result of high vaccination levels is virtually impossible. He even called the idea mythical. Pollard was quoted as saying "We don't have anything that will stop transmission, so I think we are in a situation here with this current variant where herd immunity is not a possibility because it still infects vaccinated individuals."

Iceland's Chief Epidemiologist Þórólfur echoed Pollard's views for his own country as Iceland's visir.is website reports:

"… it is disappointing that herd immunity has not been achieved with vaccination." He says that only one other way is able to achieve herd immunity, to allow the virus to spread through the community.

"We really cannot do anything else," says Þórólfur when asked whether the nation of 70 to 80 [percent] must be allowed to become infected to achieve herd immunity.

Even our CDC's very own Rochelle Walensky has had to publicly admit that the vaccines do not stop infection or transmission. Therefore, the notion that they could contribute to stopping the spread of the virus is irrational.

The mRNA vaccines may inhibit the innate immune system which could reduce effectiveness against viral infection and lead to increased risk of cancer

Last month I covered a story about Dr. Ryan Cole, an Idaho Pathologist that reported that he and many colleagues are seeing an explosion of new and recurrent cancers in vaccinated people. It also discussed the possible mechanisms for how this may be possible.

Here is a short excerpt from that article. I though it would add context for this month's story.

Explaining his findings at the March 18 event, Cole told Idahoans that the vaccines seem to be causing serious autoimmune issues, in a way he described as a "reverse HIV" response.

Cole explained that two types of cells are required for adequate immune system function: "Helper T-cells," also called "CD4 cells," and "killer T-cells," often known as "CD8 cells."

According to Cole, in patients with HIV, there is a massive suppression of "helper T-cells" which cause immune system functions to plummet, and leave the patient susceptible to a variety of illnesses.

Similarly, Cole describes, "post-vaccine, what we are seeing is a drop in your killer T-cells, in your CD8 cells," "And what do CD8 cells do? They keep all other viruses in check," he continued.

Much like HIV causes immune system disruption by suppressing CD4 "helper" cells, the same thing happens when CD8 "killer" cells are suppressed. In Dr. Cole's expert view, this is what seems to be the case with the COVID-19 jabs.

Cole goes on to state that as a result of this vaccine-induced "killer T-cell" suppression, he is seeing an "uptick" of not only endometrial cancer, but also melanomas, as well as herpes, shingles, mono, and a "huge uptick" in HPV when "looking at the cervical biopsies of women."

https://www.lifesitenews.com/news/idaho-doctor-reports-a-20-times-increase-of-cancer-in-vaccinated-patients/

If you want to see a great and revealing interview with Dr. Cole about this very topic, check out ***The Highwire.com*** **Episode 234- Rise of the Resistance** https://thehighwire.com/**videos/is-there-a-covid-vaccine-cancer-connection/**

Introducing the two scientists being touted as heroes for helping mRNA evade the body's immune system. But will history remember them as villains?

Drs. Drew Weissman and Katalin Kariko from the University of Pennsylvania discovered a way of sneaking lipid nanoparticles past the immune system's defense are being heralded in the scientific community as heroes. Some are even calling for the award of a Nobel Prize for discovering how to uncouple the immune system's first line of attack so the carrier molecules can get to their intended targets.

But…Will there be unintended consequences like unchecked cancer?

Their 2005 study published in the journal *Immunity*

- **Suppression of RNA recognition by Toll-Like Receptors: the impact of nucleoside modification and the evolutionary origin of RNA-**

From the summary

DNA and RNA stimulate the mammalian innate immune system through activation of toll like receptors (TLRs).

We show that RNA signals through human TLR 3, TLR 7, and TRL 8, but incorporation of modified nucleosides M5C, M6A, M5U, S2U, or pseudouridine ablates activity. Dendritic cells exposed to such modified RNA express significantly less cytokines and activation markers than those treated with unmodified RNA. We conclude that nucleoside modifications suppress the potential of RNA to activate dendritic cells.

https://pubmed.ncbi.nlm.nih.gov/16111635/

My comment: Dendritic cells are a key player in the immune system. Dendritic cells are antigen-presenting cells. Their main function is to process antigen material and present it on the cell surface to the T cells of the immune system. They act as messengers between the innate and the adaptive immune systems as they can differentiate into various cells that can attack invading organisms or cancer.

This study identified ways to modify RNA in such a way as to trick the immune system and reduce the immune system's response to the foreign RNA. On one hand, it sounds like a good idea to the people developing drugs and biologics wanting to use lipid nanoparticles and genetically modified RNA strands as therapeutics. But on the other hand, like has happened so many times in science and medicine, the unintended consequences can have dire results.

A contemporary study describes how this same mechanism used in the Pfizer vaccine negatively impacts the body's innate immune response

Now, on to another study that presents concerns about the vaccines interfering with the innate immune system. The article is a medRxiv preprint titled, **The BNT162b2 mRNA vaccine against SARS-CoV-2 reprograms both adaptive and innate immune responses.**

From the summary

Interestingly, however, the BNT162b2 vaccine also modulated the production of inflammatory cytokines by innate immune cells upon stimulation with both specific (SARS-CoV-2) and non-specific (viral, fungal and bacterial) stimuli. The response of innate immune cells to TLR4 and TLR7/8 ligands was lower after BNT162b2 vaccination, while fungi-induced cytokine responses were stronger. In conclusion, the mRNA BNT162b2 vaccine induces complex functional reprogramming of innate immune responses, which should be considered in the development and use of this new class of vaccines.

….**inhibition of innate immune responses may diminish anti-viral responses. Type I interferons also play a central role in the pathogenesis and response against viral infections, including COVID-19** (Hadjadj et al., 2020). With this in mind, we also assessed the production of IFN-α by immune cells of the volunteers after vaccination. Although the concentrations of IFN-α were below the detection limit of the assay for most of the stimuli, **we observed a significant reduction in the production if IFN-α secreted after stimulation with poly I:C and R848 after the administration of the second dose of the vaccine** (Figure 1H, 1I). **This may hamper the initial innate immune response against the virus, as defects in TLR7 have been shown to result in and increased susceptibility to COVID-19 in young males** (Van Der Made et al., 2020). These results collectively demonstrate that the effects of the BNT162b2 vaccine go beyond the adaptive immune system and can also modulate innate immune responses.

The effect of the BNT162b2 vaccination on innate immune responses may also indicate a potential to interfere with the responses to other vaccinations, as known for other vaccines to be as 'vaccine interference' (Lum et al., 2010; Nolan et al., 2008; Vajo, Tamas, Sinka, & Jankovics, 2010). Future studies are therefore needed to investigate this possibility, especially the potential interaction with the influenza vaccine: **in the coming years (including the autumn of 2021) COVID-19 vaccination programs will probably overlap with the seasonal Influenza vaccination, so it is crucial to perform additional studies to elucidate the potential interactions and effects of the COVID-19 vaccines with the current vaccination schedules, especially for immunosuppressed and elderly individuals.**

https://www.medrxiv.org/content/10.1101/2021.05.03.21256520v1.full.pdf

A couple key takeaways are, that the vaccines appear to:

Reduce production of Type 1 Interferon, a crucial compound produced by immune cells that are a first line of defense against viral infection, as it regulates an immune response by activating multiple cell types, including dendritic cells, cytotoxic T cells, and natural killer cells. Reduction of Type 1 Interferon and also derail an important part of the immune system's control over cancer (see #1 and #2 below).

#1. **Interferon-alpha and cancer: mechanisms of action and new perspectives of clinical use** - ***Journal Biochimie-*** 2007

From the study

Early studies in mouse tumor models showed the importance of host immune mechanisms in the generation of a long-lasting antitumor response after treatment of the animals with IFN-alpha/beta. Subsequently, an ensemble of studies based on the use of genetically modified tumor cells expressing specific IFN molecules provided important information on the host-mediated antitumor mechanisms induced by the local production of IFN-alpha. Of note, several studies have then underscored new immunomodulatory effects of IFN-alpha, including activities on T cells and dendritic cells, which may lead to IFN-induced antitumor immunity. In addition, recent reports on new immune correlates in cancer patients responding to IFN-alpha represent additional evidence on the importance of the interactions of IFN-alpha with the immune system for the generation of a durable antitumor response.

https://pubmed.ncbi.nlm.nih.gov/17532550/

#2. **Interferons α and β in cancer: therapeutic opportunities from new insights** - ***Nature Reviews Drug Discovery-*** 2019

The abstract- (I have added the bolded words)

Over the past decade, preclinical and clinical research have confirmed the essential role of interferons for effective host immunological responses to malignant cells. Type I interferons (IFNα and IFNβ) directly regulate transcription of >100 downstream genes, which results in a myriad of direct (on cancer cells) and indirect (through immune effector cells and vasculature) effects on the tumour. New insights into endogenous (**interferon made by the immune system)** and exogenous **(from the outside)** activation of type I interferons in the tumour and its microenvironment have given impetus to drug discovery and patient evaluation of

interferon-directed strategies. When combined with prior observations or with other effective modalities for cancer treatment, modulation of the interferon system could contribute to further reductions in cancer morbidity and mortality.

https://pubmed.ncbi.nlm.nih.gov/30679806/

A 2021 study explains how the mRNA vaccines are designed to escape the innate immune system

A 2021 study published in the ***International Journal of Biological Sciences*** titled, **mRNA vaccines for COVID-19: what, why and how** describes mechanisms that are designed into the vaccines to help them illude the body's immune system.

From the article

RNA degradation
mRNA vaccines took the vaccine development stage by storm mainly due to their rapid development and versatility of design. However, as described above there are two significant intrinsic limitations of mRNA as a vaccine: 1) the instability of mRNA molecules **and 2) the activation of the innate immune response.** Appropriate purification of IVT-synthesized mRNA is critical to avoid the cellular immune response against the exogenous mRNA and maximize the protein yield. **Moreover, the incorporation of chemically modified nucleosides such as pseudouridine and 1-methylpseudouridine allows mRNA molecules to escape the recognition by TLR7 and -8 as well as other innate immune sensors** [62, 111]. Surprisingly, pseudouridine in mRNA molecules enhances the translation efficiency from ssRNA by reducing the PKR activity [112]. Moreover, pseudouridine-modified mRNA can be translated in primary dendritic cells **and even in mice by evading innate immune surveillance** and increasing the protein yield

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8071766/

This next story may reflect a trend of gradual immune compromise in vaccinated people as time goes on.

A disturbing trend for vaccinated individuals noted from Public Health England's updates- Cases, hospitalizations and deaths rising in the fully vaccinated

A series of articles posted on ***The Expose*** paint a dire picture for the health of the immune systems in those that are vaccinated with the experimental COVID-19 gene therapy products.

I will only show a few of the charts in an effort to conserve space for this newsletter. The links are provided if you would like to look at everything in more detail.

The first article posted October 10th, 2021 titled, **A comparison of official Government reports suggest the Fully Vaccinated are developing Acquired Immunodeficiency Syndrome**, shows ***Public Health England*** charts which reflect a decline in vaccinated individuals protection. This is something that I have been reporting on

over the last several months from Public Health England. But in these articles, they have cleverly strung together the various charts in sequence allowing us to see the changes from month to month.
From the article

The 5 PHE tables below from their excellent Vaccine Surveillance Report, separated by 4 weeks, clearly show the progressive damage that the vaccines are doing to the immune system's response.

People aged 40-69 have already lost 40% of their immune system capability and are losing it progressively at 3.3% to 6.4% per week.

My comment: In all fairness, I am not sure if this trend is due to a gradual decline in the immune systems of people that have had the vaccines, the fact that the antibody protection from the vaccines wane as time goes on, antibody dependent enhancement in those who are vaccinated, or that the vaccines are driving further mutations in the spike and hence the development of variance that are escaping whatever vaccine protection there may be left..., or a combination of the above.

I am going to show you the first table (weeks 32-35) and the last (weeks 36-39) in the article. They have added the far-right column to the *PHE* table from their report.

Table 2. COVID-19 cases by vaccination status…

Cases reported by specimen date between week 32 and week 35 2021 –
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1016465/Vaccine_surveillance_report_-_week_36.pdf

Age group	Total Cases	Vax Status unknown	Unvaccinated	1 dose 1-20 days before specimen date	1 dose ≥21 days before specimen date	2nd dose ≥14 days before specimen date	Rates per 100k in double vaxxed (V)	Rates per 100k in unvaxxed (U)	Immune system boost or degradation % (U-V)/U when positive (pfizer's formula) (U-V)/V when negative
Under 18	167,832	15,901	141,676	8,132	1,368	757	476.0	1,192.9	+60.1% (excludes 12-15)
18-29	176,392	19,529	53,187	4,598	66,545	32,533	711.1	1,520.8	+53.2%
30-39	113,373	12,452	33,986	1,497	22,434	43,004	782.2	1,143.9	+31.6%
40-49	97,881	8,930	15,106	496	6,000	67,349	1,116.2	880.4	-21.1%
50-59	84,488	6,868	7,552	168	2,248	67,652	962.0	729.7	-24.1%
60-69	45,252	3,657	2,650	54	772	38,119	672.3	487.5	-27.5%
70-79	25,499	2,034	910	12	273	22,270	480.5	367.5	-23.5%
80+	12,011	1,124	545	9	246	10,087	391.1	427.4	+8.5%

Cases reported by specimen date between week 36 and week 39 2021 – https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1023849/Vaccine_surveillance_report_-_week_40.pdf

Age group	Total Cases	Vax status unknown	Unvaccinated	1 dose 1-20 days before specimen date	1 dose ≥21 days before specimen date	2nd dose ≥14 days before specimen date	Rates per 100k in double vaxxed (V)	Rates per 100k in unvaxxed (U)	Immune system boost or degradation % (U-V)/U when positive (pfizer's formula) (U-V)/V when negative	Weekly Decline
Under 18	305,428	20,967	272,981	4,073	5,898	609	278.8	2,325.7	+88.0% (includes 135k 12-15 cases)	+4.3%
18-29	67,820	8,556	23,440	1,119	12,593	22,112	409.6	688.1	+40.5%	-4.3%
30-39	81,532	7,534	21,449	690	7,468	44,391	763.6	738.4	-3.3%	-11.4%
40-49	101,094	6,839	11,662	297	3,653	78,643	1,291.8	690.2	-46.6%	-6.9%
50-59	70,731	4,668	5,144	88	1,464	59,366	839.5	502.5	-40.1%	-5.7%
60-69	36,953	2,585	1,798	26	546	31,998	563.1	332.9	-40.9%	-2.1%
70-79	22,142	1,367	693	6	207	19,869	428.9	281.4	-34.4%	-3.6%
80+	10,581	863	403	4	199	9,106	354.4	319.5	-9.8%	-2.5%

Weekly Decline in doubly vaccinated immune system performance compared to unvaccinated people…

Age group	Week36 Decline	Week37 Decline	Week38 Decline	Week39 Decline	Week40 Position	Average Weekly Decline	Weeks before total immune system failure (100% degradation)
18-29	-2.5%	-1.9%	-4.0%	-4.3%	+40.5%	-3.2%	**44** weeks (140.5/3.2)
30-39	-6.0%	-7.0%	-10.5%	-11.4%	-3.3%	-8.7%	**12** weeks (96.7/8.7)
40-49	-5.2%	-5.3%	-8.1%	-6.9%	-46.6%	-6.4%	**9** weeks (53.4/6.4)
50-59	-4.0%	-2.4%	-3.9%	-5.7%	-40.1%	-4.0%	**15** weeks (59.9/4)
60-69	-4.2%	-2.9%	-4.2%	-2.1%	-40.9%	-3.35%	**18** weeks (59.1/3.35)
70-79	-4.1%	+0.7%	-3.9%	-3.6%	-34.4%	-2.7%	**25** weeks (65.6/2.7)
80+	-5.6%	-7.1%	-3.1%	-2.5%	-9.8%	-4.6%	**20** weeks (90.2/4.6)

https://theexpose.uk/2021/10/10/comparison-reports-proves-vaccinated-developing-ade/

The second article titled, **It gets worse – A comparison of official Government reports suggest the Fully Vaccinated are developing Acquired Immunodeficiency Syndrome much faster than anticipated** reflects an update posted approximately a week later and adds another dimension to the analysis.

From the article

A Vaccine efficacy of **50%** means that doubly vaxxed people are 50% more protected from Covid than unvaxxed people. It means that the delta case rate in the vaxxed is half the delta case rate in the unvaxxed.
A Vaccine efficacy of **-50%** means that unvaxxed people are 50% more protected from Covid than doubly vaxxed people. It means that the delta case rate in the vaxxed is double the delta case rate in the unvaxxed.
A Vaccine efficacy of **0%** means that doubly vaccinated people are 0% more protected from Covid than

unvaxxed people. It means that the delta case rate in the vaxxed equals the delta case rate in the unvaxxed. It means the vaccines have lost all their effectiveness.

Age group	Week35 Vax Efficacy	Week36 Vax Efficacy	Week37 Vax Efficacy	Week38 Vax Efficacy	Week39 Vax Efficacy	Week40 Vax Efficacy
18-29	+53.2%	+50.7%	+48.8%	+44.8%	+40.5%	+33.5%
30-39	+31.6%	+25.6%	+18.6%	+8.1%	-3.3%	-13.8%
40-49	-21.1%	-26.3%	-31.6%	-39.7%	-46.6%	-52.2%
50-59	-24.1%	-28.1%	-30.5%	-34.4%	-40.1%	-45.8%
60-69	-27.5%	-31.7%	-34.6%	-38.8%	-40.9%	-46.7%
70-79	-23.5%	-27.6%	-26.9%	-30.8%	-34.4%	-44.0%
80+	+8.5%	+2.9%	-4.2%	-7.3%	-9.8%	-18.1%

https://theexpose.uk/2021/10/15/its-worse-than-we-thought-fully-covid-vaccinated-ade/

Public Health England numbers continuing to deteriorate month by month for the vaccinated

Representing September 06th through October 02nd 2021

COVID-19 vaccine surveillance report – week 40

Table 2. COVID-19 cases by vaccination status between week 36 and week 39 2021

Rates higher in all vaccinated age groups over 30

Cases reported by specimen date between week 36 and week 39 2021	Total	Unlinked*	Not vaccinated	Received one dose (1-20 days before specimen date)	Received one dose, ≥21 days before specimen date	Second dose ≥14 days before specimen date	Rates among persons vaccinated with 2 doses (per 100,000)	Rates among persons not vaccinated (per 100,000)
Under 18	305,428	20,967	272,981	4,973	5,898	609	278.8	2,325.7
18-29	67,820	8,556	23,440	1,119	12,593	22,112	409.6	688.1
30-39	81,532	7,534	21,449	690	7,468	44,391	763.6	738.4
40-49	101,094	6,839	11,662	297	3,653	78,643	1,281.8	690.2
50-59	70,731	4,668	5,144	89	1,464	59,366	839.5	502.5
60-69	36,953	2,585	1,798	26	546	31,998	563.1	332.9
70-79	22,142	1,367	693	6	207	19,869	428.9	281.4
80+	10,581	869	403	4	199	9,106	354.4	319.5

I've been reporting on this in previous newsletters since June. Every month the numbers continue to be skewed higher in the vaccinated group.

Scroll to next page…

And this is the latest report, ***Public Health England's*** Technical Briefing week number 43, looking at the emergency room visits resulting in person being admitted.

Table 3. COVID-19 cases presenting to emergency care (within 28 days of a positive specimen) resulting in an overnight inpatient admission by vaccination status between week 39 and week 42 2021

Cases presenting to emergency care (within 28 days of a positive test) resulting in overnight inpatient admission, by specimen date between week 39 and week 42 2021	Total	Unlinked*	Not vaccinated	Received one dose (1-20 days before specimen date)	Received one dose, ≥21 days before specimen date	Second dose ≥14 days before specimen date[1]
Under 18	633	17	592	12	11	1
18-29	324	8	212	2	28	74
30-39	708	10	446	2	47	203
40-49	991	14	495	5	40	437
50-59	1,139	13	447	1	46	632
60-69	1,177	12	288	3	33	841
70-79	1,642	1	195	3	34	1,409
≥80	1,724	2	157	0	38	1,527

And the death rates in the vaccinated and the unvaccinated. Shocking, especially for those over 60 years of age.

Death within 60 days of positive COVID-19 test by date of death between week 39 and week 42 2021	Total**	Unlinked*	Not vaccinated	Received one dose (1-20 days before specimen date)	Received one dose, ≥21 days before specimen date	Second dose ≥14 days before specimen date[1]
Under 18	5	0	4	1	0	0
18-29	19	1	11	0	0	7
30-39	42	1	27	0	2	12
40-49	100	3	55	0	6	36
50-59	224	3	100	0	9	112
60-69	490	4	143	0	23	320
70-79	904	4	121	0	27	752
≥80	1,717	5	167	0	53	1,492

Israeli hospital outbreak, with 39 of 41 people being fully vaccinated and highly masked

A study titled, **Nosocomial outbreak caused by the SARS-CoV-2 Delta variant in a highly vaccinated population, Israel, July 2021**, shows just how much vaccines and masking are failing.

It describes a SARS-CoV-2 outbreak among 42 patients in a hospital setting of which "39 were fully vaccinated," the "index case was … fully vaccinated," "all transmission between patients and staff occurred between masked and vaccinated individuals, as experienced in an outbreak from Finland," and that this

"outbreak exemplifies the high transmissibility of the SARS-CoV-2 Delta variant among twice vaccinated and masked individuals."

The abstract

A nosocomial outbreak of SARS-CoV-2 Delta variant infected 42 patients, staff and family members; 39 were fully vaccinated. The attack rate was 10.6% (16/151) among exposed staff and reached 23.7% (23/97) among exposed patients in a highly vaccinated population, 16–26 weeks after vaccination (median: 25 weeks). All cases were linked and traced to one patient. Several transmissions occurred between individuals wearing face masks. Fourteen of 23 patients became severely sick or died, raising a question about possible waning immunity.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8485578/

Why is the virus evading the vaccines so rapidly and efficiently?

An October 25th 2021 article published in ***Nature Cellular and Molecular Immunology*** titled, **The spike protein of SARS-CoV-2 variant A.30 is heavily mutated and evades vaccine induced antibodies with high efficiency**, does a good job of explaining why the vaccines are failing so miserably.

***Note:** ChAdOx1 nCoV-19 is the AstraZeneca/Oxford vaccine. BNT162b2 is the Pfizer vaccine.

From the article

Compared to the S protein of SARS-CoV-2 B.1, which circulated in the early phase of the pandemic, the S protein of the A.30 variant contains 10 amino acid substitutions and five deletions. All deletions along with four substitutions are found in the N-terminal domain of the surface unit S1, which harbors an antigenic supersite that is targeted by most neutralizing antibodies not directed against the receptor-binding domain (RBD). In addition, three mutations are located inside the RBD, which binds to the cellular receptor ACE2 and constitutes the main target of neutralizing antibodies. Two of these mutations, T478R and E484K, are located close to the ACE2 binding site, and E484K is known to reduce susceptibility to antibody-mediated neutralization. Finally, two mutations are located close to the S1/S2 cleavage site, and one mutation is found in the transmembrane unit S2, which facilitates fusion of the viral envelope with cellular membranes.

In summary, A.30 exhibits a cell line preference not observed for other viral variants and efficiently evades neutralization by antibodies elicited by ChAdOx1 nCoV-19 or BNT162b2 vaccination. SARS-CoV-2 entry into cell lines depends on S protein activation by the cellular proteases cathepsin L or TMPRSS2, and activation by the latter is thought to support viral spread in the lung.

Collectively, our results suggest that the SARS-CoV-2 variant A.30 can evade control by vaccine-induced antibodies and might show an increased capacity to enter cells in a cathepsin L-dependent manner, which might particularly aid in the extrapulmonary spread. As a consequence, the potential spread of the A.30 variant warrants close monitoring and rapid installment of countermeasures.
https://www.nature.com/articles/s41423-021-00779-5

Breakthrough infections transmit as efficiently as unvaccinated infections

An article posted on a ***medRxiv preprint*** August 25th, 2021, titled, **Predominance of antibody-resistant SARS-CoV-2 variants in vaccine breakthrough cases from the San Francisco Bay Area, California**,
The abstract

Associations between vaccine breakthrough cases and infection by SARS coronavirus 2 (SARS-CoV-2) variants have remained largely unexplored. Here we analyzed SARS-CoV-2 whole-genome sequences and viral loads from 1,373 persons with COVID-19 from the San Francisco Bay Area from February 1 to June 30, 2021, of which 125 (9.1%) were vaccine breakthrough infections. **Fully vaccinated were more likely than unvaccinated persons to be infected by variants carrying mutations associated with decreased antibody neutralization (L452R, L452Q, E484K, and/or F490S) (78% versus 48%, p = 1.96e-08), but not by those associated with increased infectivity (L452R and/or N501Y) (85% versus 77%, p = 0.092)**. **Differences in viral loads were non-significant between unvaccinated and fully vaccinated persons overall (p = 0.99) and according to lineage (p = 0.09 – 0.78). Viral loads were significantly higher in symptomatic as compared to asymptomatic vaccine breakthrough cases (p < 0.0001), and symptomatic vaccine breakthrough infections had similar viral loads to unvaccinated infections (p = 0.64)**. In 5 cases with available longitudinal samples for serologic analyses, vaccine breakthrough infections were found to be associated with low or undetectable neutralizing antibody levels attributable to immunocompromised state or infection by an antibody-resistant lineage. **These findings suggest that vaccine breakthrough cases are preferentially caused by circulating antibody-resistant SARS-CoV-2 variants, and that symptomatic breakthrough infections may potentially transmit COVID-19 as efficiently as unvaccinated infections, regardless of the infecting lineage.**

My comment: To me this clearly says that vaccinated individuals have no advantage when it comes to protection against infection, level of viral load and therefore also transmissibility. Not only that, but vaccinated persons were more likely (78% vs. 48%) to be infected by variants containing mutations. Well, this makes perfect sense, because the virus even though it is not an intelligent organism (if it is actually an organism- See my article of the month), microbes have learned how to evolve to survive over millennia. And this virus has learned how to beat the vaccine induced antibody production. That's what organisms do. A perfect example is with antibiotic resistant bacteria. This is a health crisis around the world because of the indiscriminate use of antibiotics unnecessarily or inappropriately. In the United States alone, there are over 100,000 people who die due to hospital acquired antibiotic resistant infections.

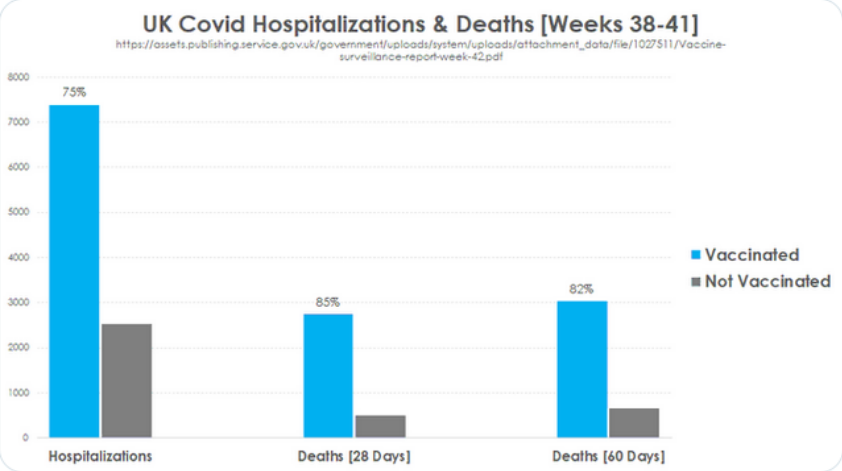
Scroll to the next page…

The U.K. continues its downhill slide for the vaccinated

PLC
@Humble_Analysis

In the UK, the vaccinated now account for 75% of covid hospitalizations and more than 80% of covid deaths reported.

assets.publishing.service.gov.uk/government/upl...



12:13 PM · Oct 28, 2021 · Twitter Web App

PLC
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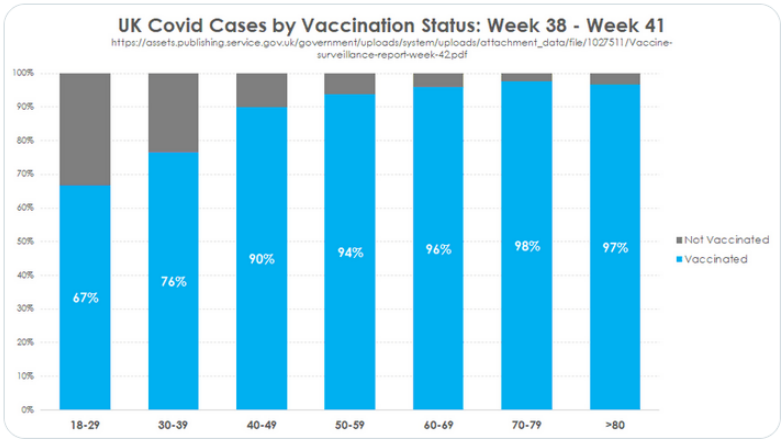
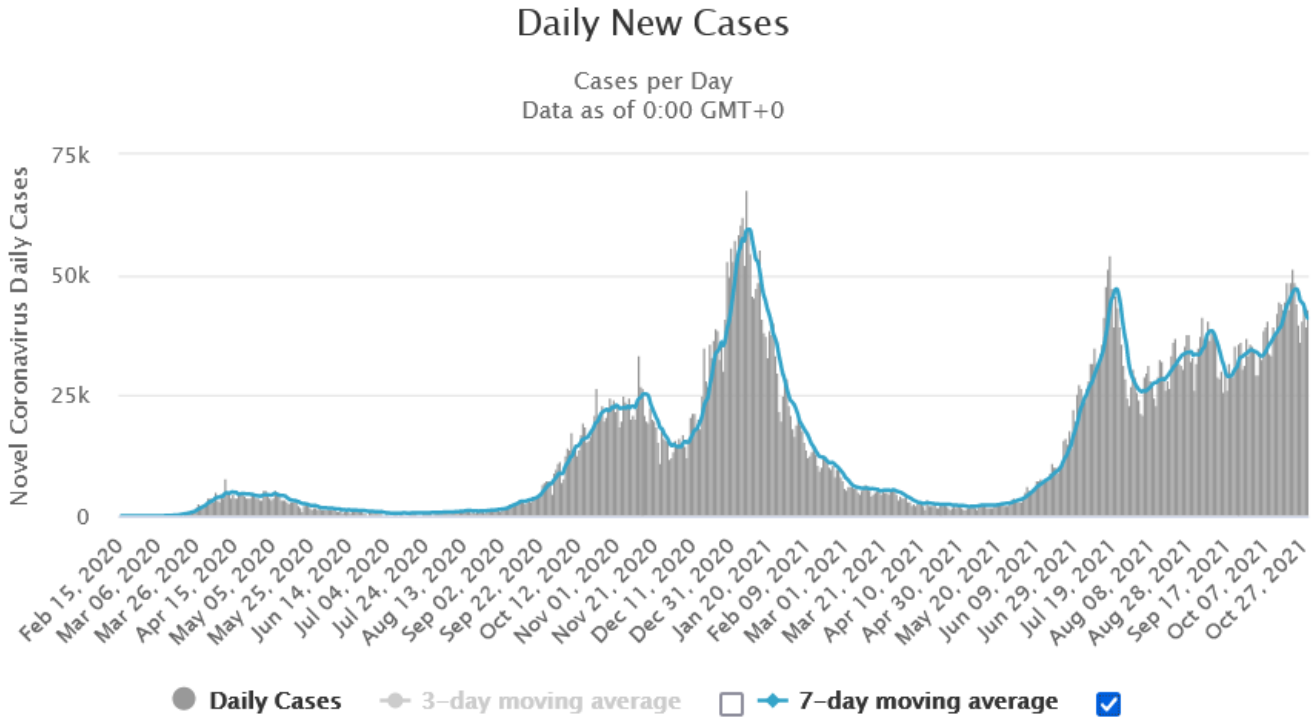
For all ages >18, the vast majority of covid infections reported by the NHS in UK are vaccinated. For those over 40, more than 90% of cases are vaccinated.

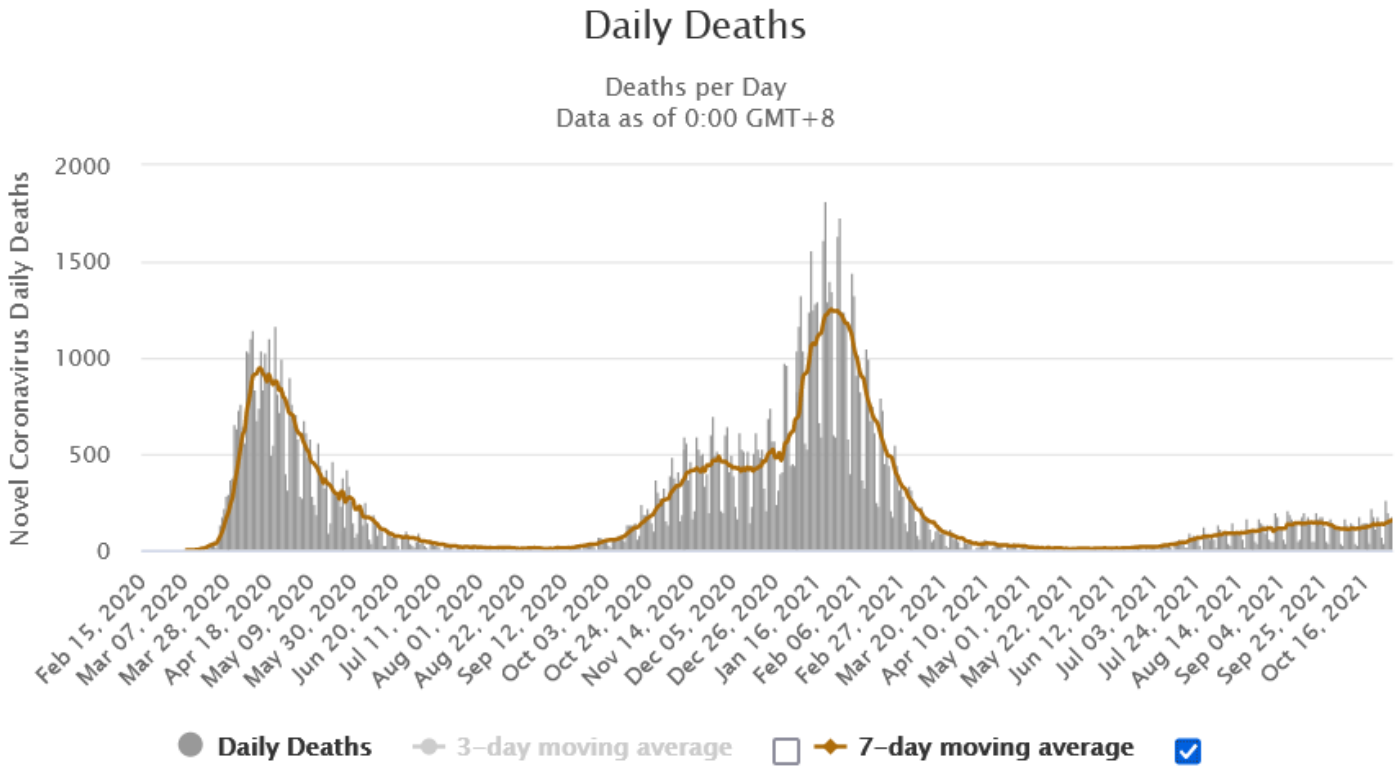
assets.publishing.service.gov.uk/government/upl...



4:09 AM · Oct 27, 2021 · Twitter Web App

Daily New Cases in the United Kingdom



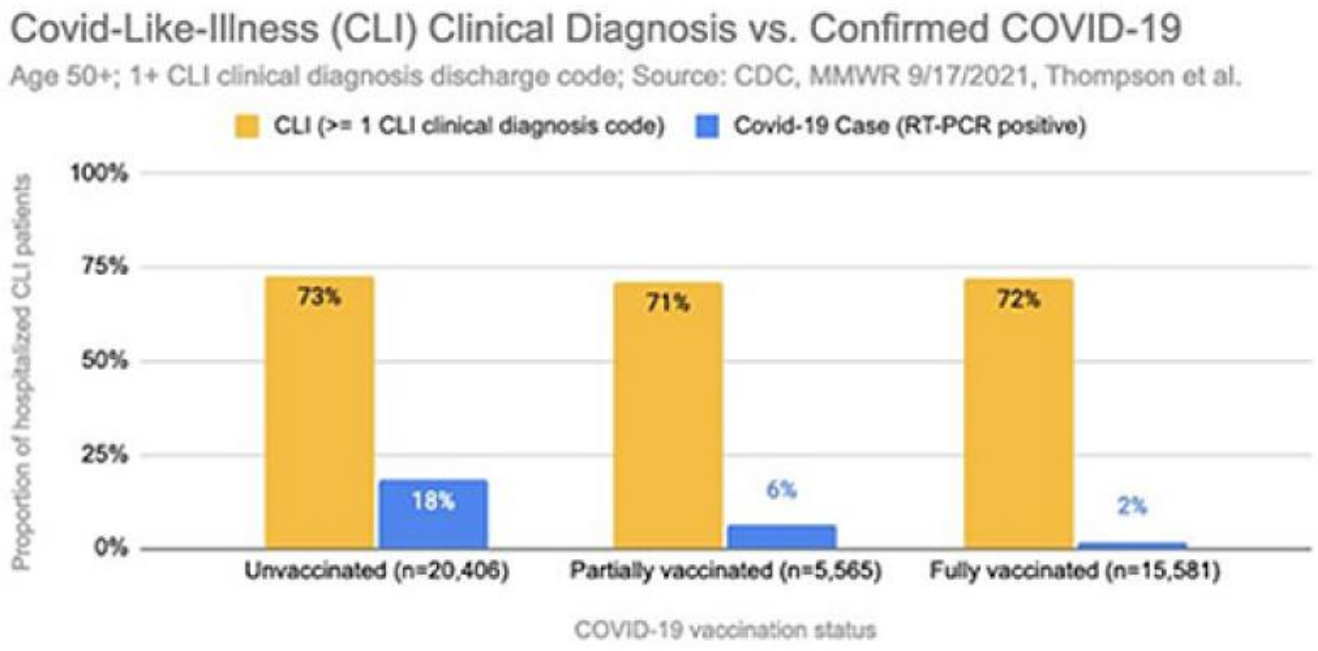


More statistics on the failure of the vaccines

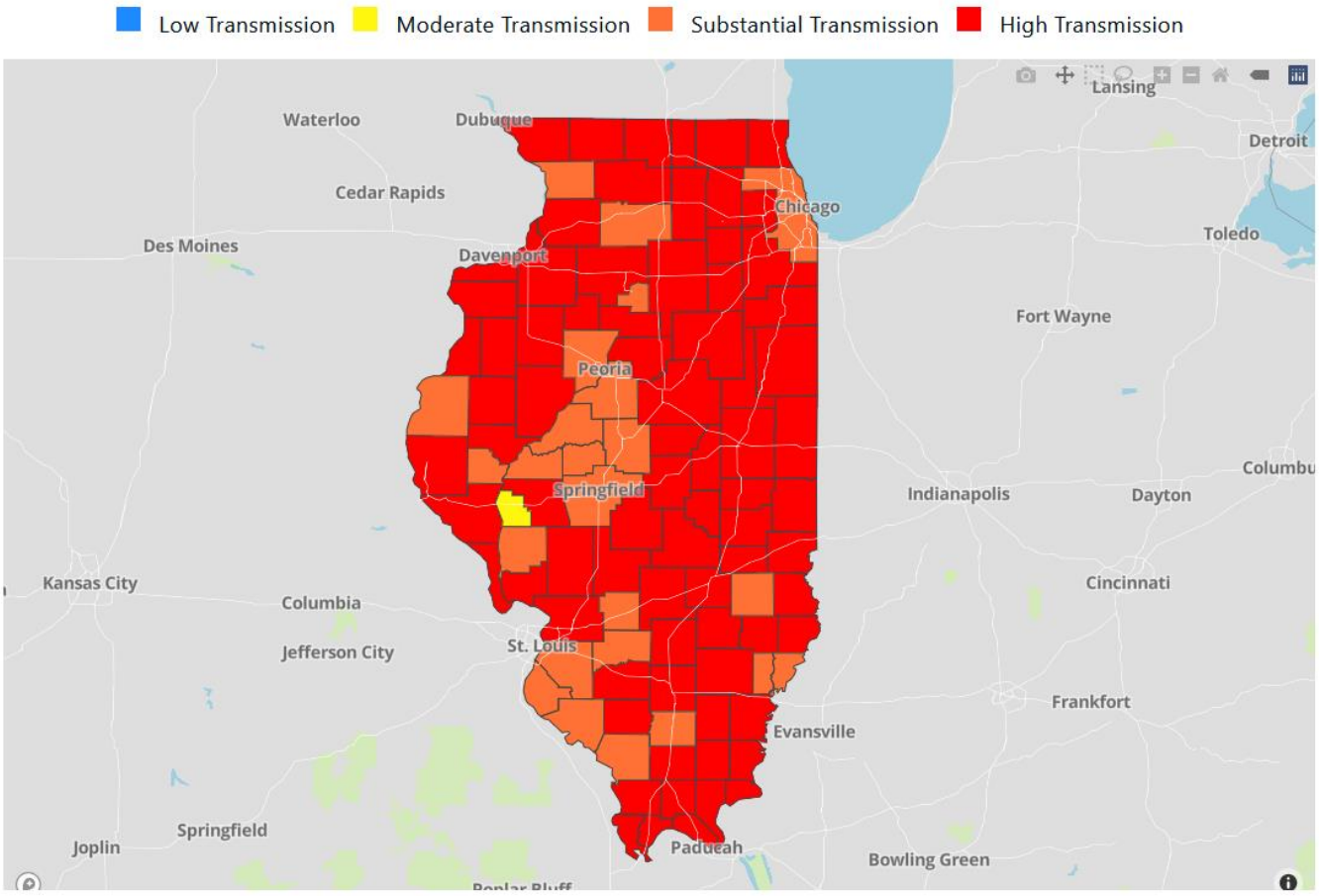
An article published by ***Dr. Mercola*** titled, **Are the COVID Shots Working?**, highlights some lowlights of the statistics comparing case numbers and degree of illness of vaccinated vs. unvaccinated individuals.

STORY AT-A-GLANCE

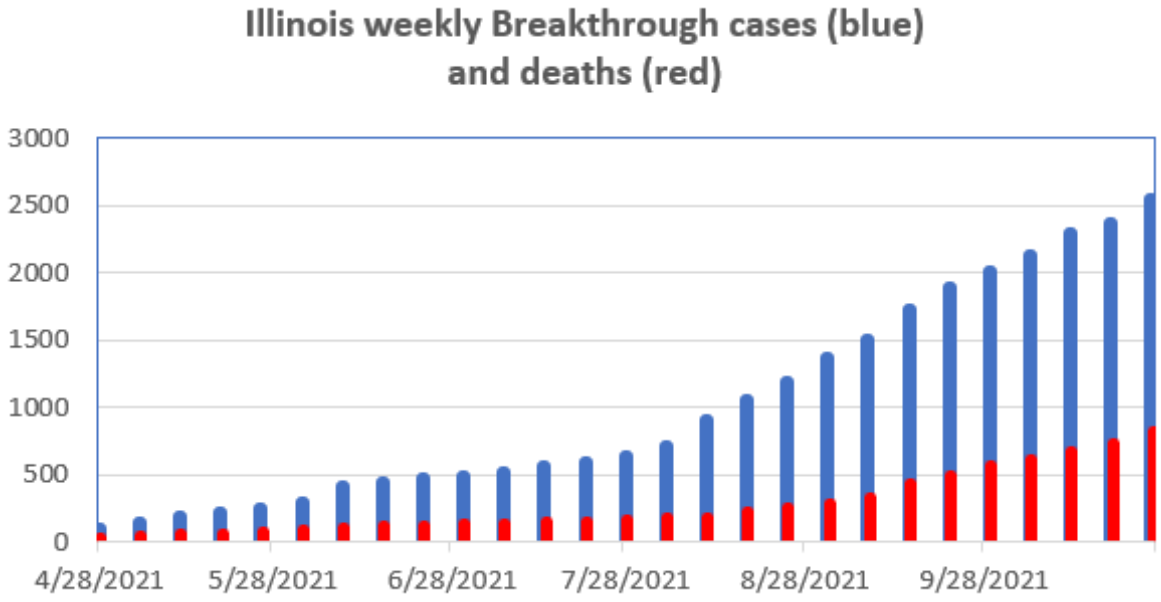
- A recent report details a SARS-CoV-2 Delta outbreak in an Israeli hospital where 238 out of 248 (96%) of the exposed patients and staff had been fully vaccinated with Pfizer's mRNA vaccine
- Of the 238 fully vaccinated individuals, 39 (16%) were infected, as were three of the 10unvaccinated individuals who got exposed
- While all of the sickened staff recovered, five infected patients died and nine turned into severe or critical cases. All of the dead and severe/critical cases were fully vaccinated. Two unvaccinated patients that got infected only had mild illness
- This outbreak tells us that the COVID shots cannot create herd immunity. It also suggests vaccinated people may be more prone to serious and lethal infection than the unvaccinated
- Of 41,552 hospitalized patients in the U.S., 73% of the unvaccinated, 71% of the partially vaccinated and 72% of the fully vaccinated received a diagnosis of COVID-like illness (CLI) between January 1, 2021, and June 22, 2021



The state of Illinois is 68% fully vaccinated, but transmission rates are high across the state



Data from this map is provided by the Centers for Disease control **data source is available here**. Data Last Updated 10/28/2021



Illinois reported that 77% of the deaths the week of October 20th were fully vaccinated (91 out of 117).
https://dph.illinois.gov/covid19/vaccine/vaccine-breakthrough.html

Waterford Ireland has the highest vaccination rate in the country and also an out-of-control COVID-19 surge

An article titled, **Covid is surging in Waterford, Ireland where 99.7 percent of adults are Fully Vaccinated** appeared in ***Citizen Free Press*** October 17th, 2021.

From the article

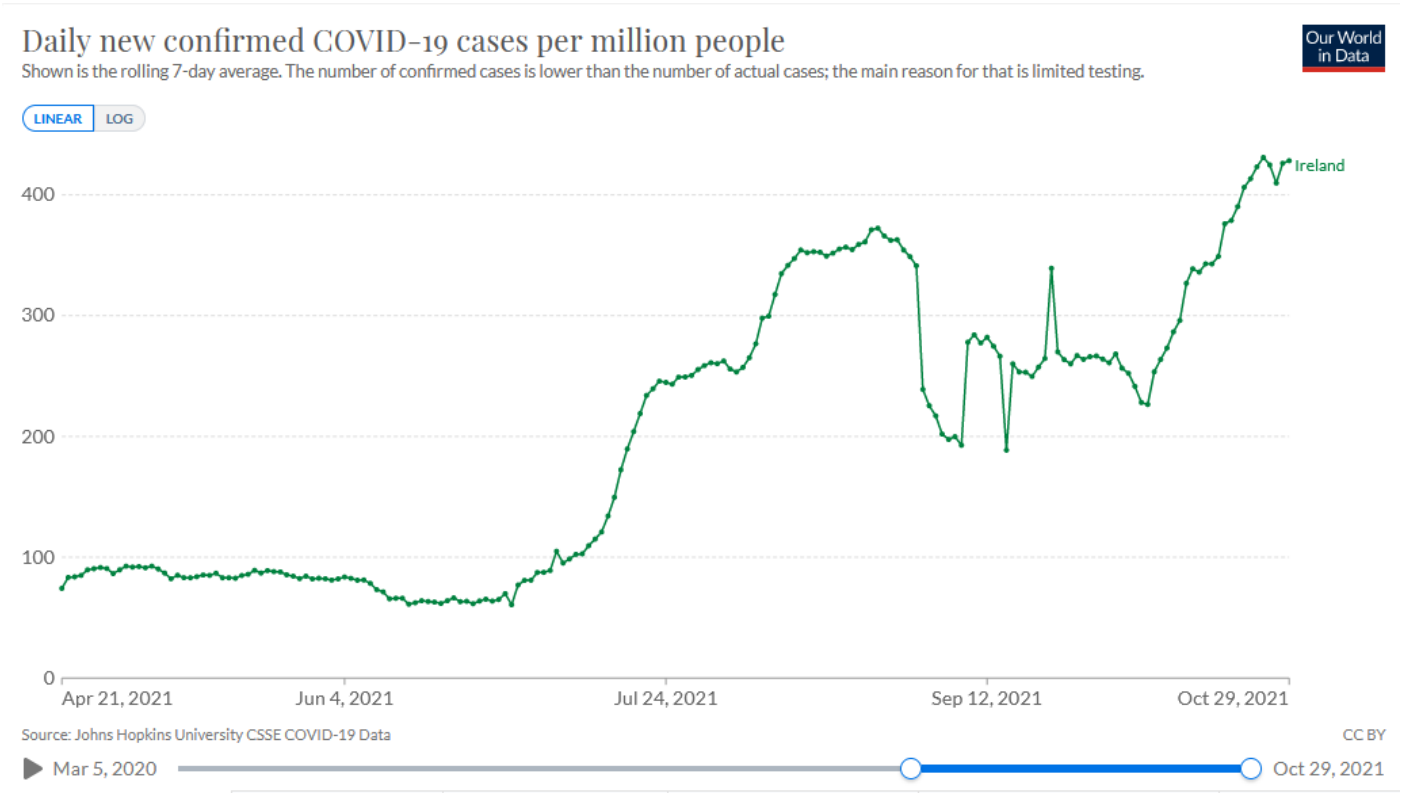
Waterford, once the crown jewel of Ireland's Vaccination program, now has the highest rate of infection in the country. For the first time since March, the number of patients in hospital with Covid in Ireland is over 400. This in a country where 92% of adults have been Vaccinated against the CCP Virus.

It's worse for County Waterford where almost every single person over the age of 18 has been double jabbed and yet case numbers are surging with more than 700 new cases documented in the last 2 weeks.

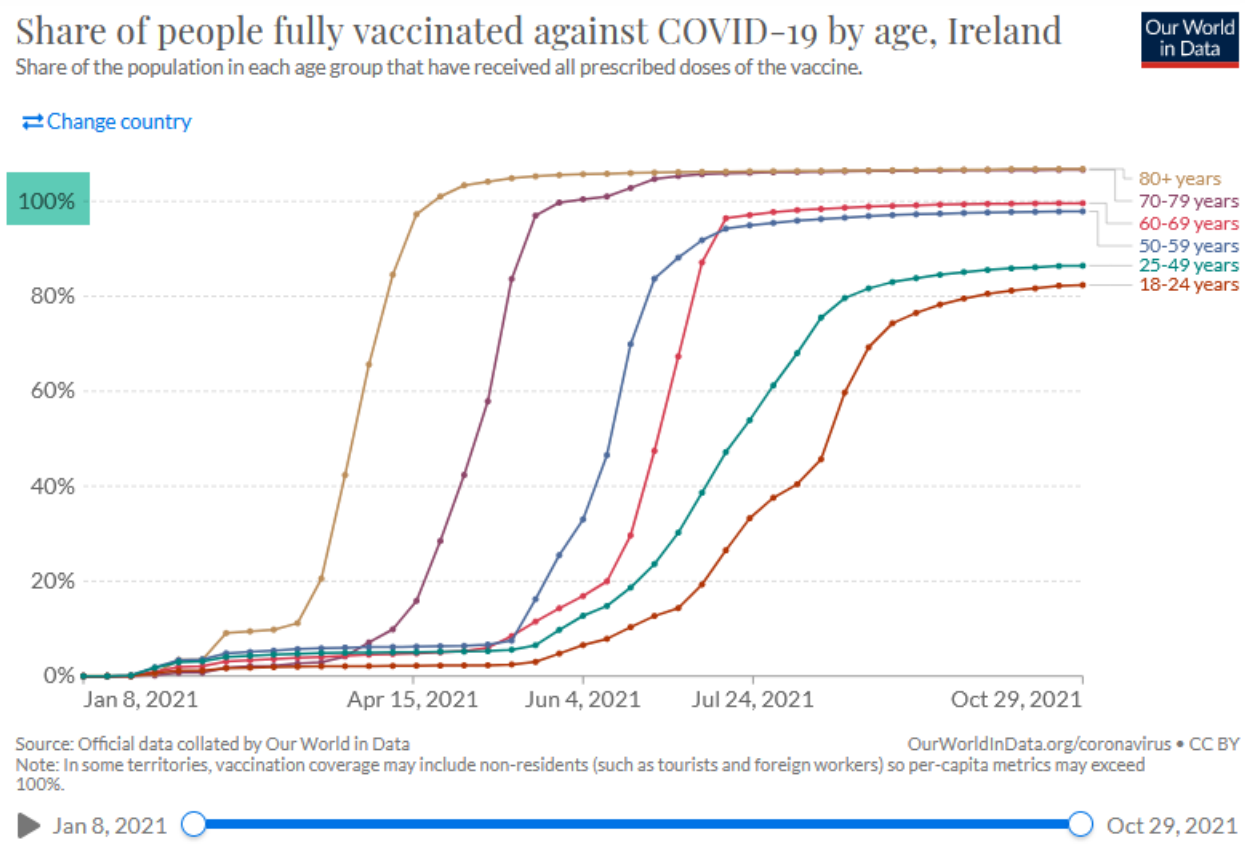
The number of vaccinated patients in ICU now is almost as high as the entire number of Covid patients in ICU a year ago. HSE chief clinical officer Dr Colm Henry admitted the figures were "higher than we would like" but added they would be even higher but for the impact of vaccination.

https://citizenfreepress.com/column-3/covid-is-surging-in-waterford-ireland-where-99-7-percent-are-double-vaccinated/

Daily cases on the rise in Ireland

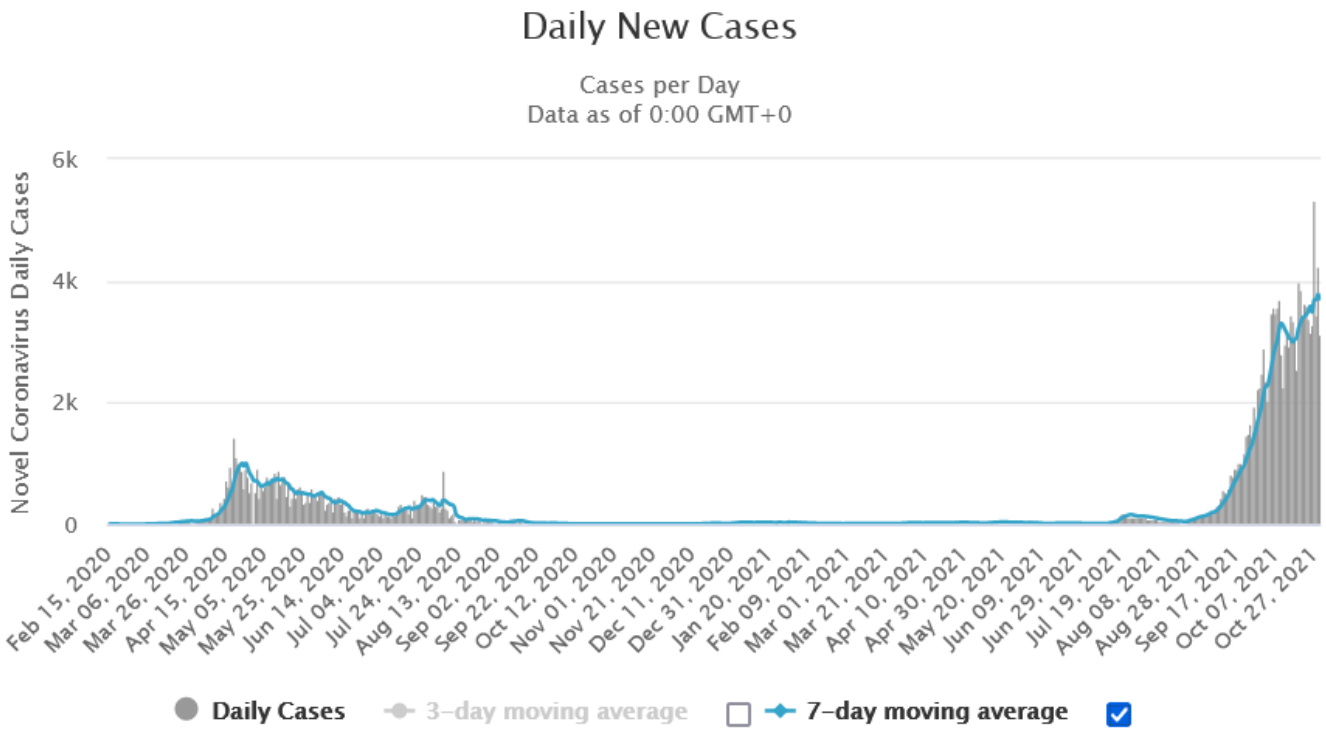


Yet nearly 100% of the population over the age of 50 are vaccinated

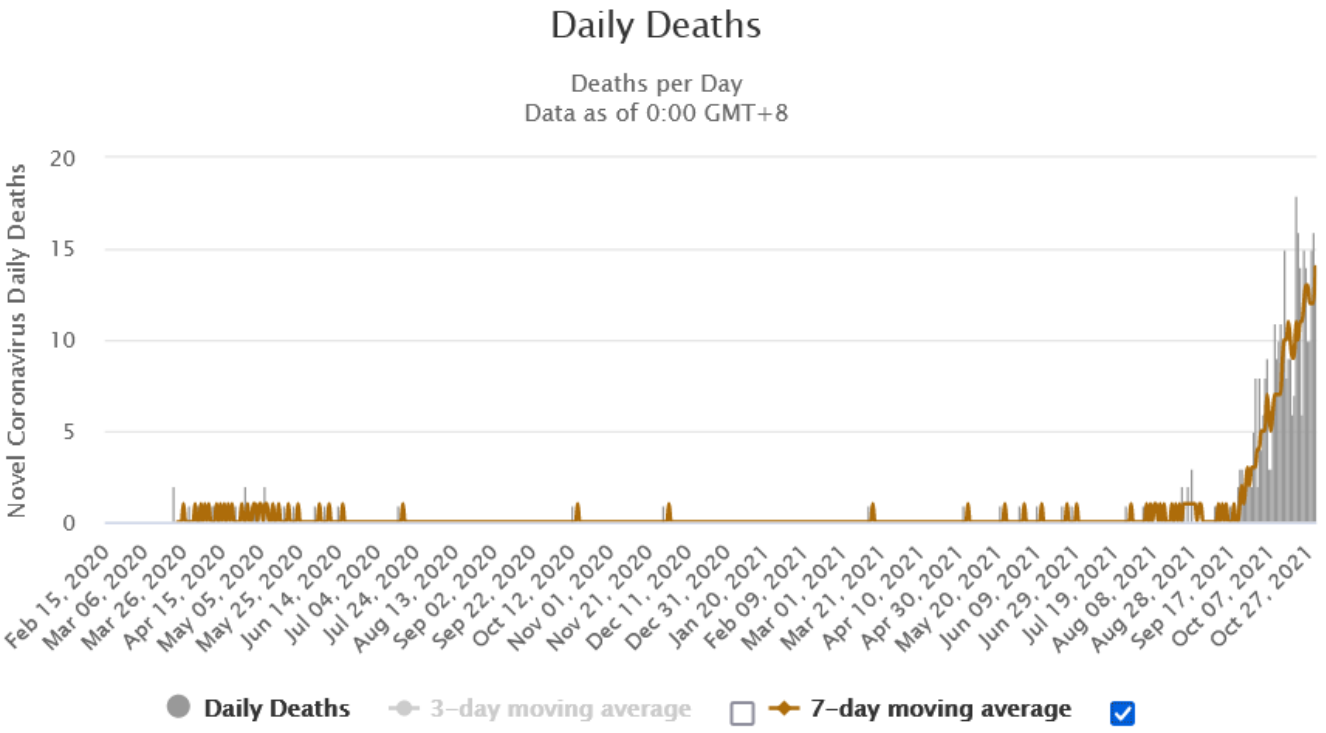


Singapore, a country then has fully vaccinated 80% of their population is experiencing soaring case rates

Daily New Cases in Singapore



Daily New Deaths in Singapore



Despite the tidal wave of evidence against the safety and effectiveness of the COVID-19 shots, the FDA plan to move forward with full approval of 5-11 year-olds. Here are 10 reasons why that is a terrible idea.

In an article published in ***The Defender*** on the ***Children's Health defense*** website by Toby Rogers, ten very good reasons are laid out as to why approving these "vaccines" for children would be a terrible idea. (And I could think of at least 10 more, many of which I have laid out in my free download about the risk of COVID to children versus the risks of the vaccines. You can download that **HERE**.

From the article- I'm just giving you a teaser here, only the 10 reasons without the details. But the devil's in the details as they say. I highly recommend reading the whole excellent article.

1. COVID-19 rates in children ages 5 to 11 are so low that there were ZERO cases of severe COVID-19 and ZERO cases of death from COVID in either the treatment (n= 1,518) or control group (n= 750).
2. Pfizer's clinical trial in kids was intentionally undersized to hide harm.
3. Pfizer only enrolled 'participants 5-11 years of age without evidence of prior SARS-CoV-2 infection.'
4. **Did Pfizer LOSE CONTACT with 4.9% of their clinical trial participants?**
5. **The follow-up period was intentionally too short.**
6. **The risk-benefit model created by the FDA only looks at one known harm from the Pfizer mRNA shot — myocarditis.**
7. **Pfizer intentionally wipes out the control group as soon as they can by vaccinating all of the kids who initially got the placebo.**
8. **Given all of the above, how on earth did the FDA claim any benefits at all from this shot?**
9. **The FDA model only assesses the benefits of vaccine protection in a six-month period after the completion of two doses**.
10. **The FDA/Pfizer play fast and loose with their estimates of myocarditis**.

https://childrenshealthdefense.org/defender/fda-risk-benefit-analysis-pfizer-children-covid-vaccine/

Guidance for obtaining religious exemptions

Here is an example of an email that I have been sending people that are wanting to apply for a religious exemption. I'm not presenting this the be all/end all, but I'm hoping that it can give some ideas and guidance in the process.

I think that it is to a person's advantage if they don't belong to a particular denomination like the Catholic Church or the episcopalian church, etc., unless they have come out against the COVID-19 vaccines. That is because many of those official church denominations have come out in support of vaccines in the past and in some cases this vaccine in particular, stating that it does not violate their religious "code" or church doctrine,

or because the vaccine is for “the greater good”. That is unfortunate because that is really going to work against people of those faiths and denominations who stand on Biblical principles and have a sincerely held religious belief that it would be wrong for them to violate. This is especially egregious because of the use of aborted fetal tissue in the manufacture and production of many vaccines including these COVID-19 gene therapy products. Depending on the fetal cell line, dozens of babies were sacrificed to find the perfect match to use tissue from their organs that can be grown in perpetuity and used in the production of vaccines. Even more tragically the vaccines that use fetal cell lines could be produced using other methodology in animal tissues. But much more on that in a minute.

I've heard some commentators and even attorneys on podcasts say that you don't need to even tell them what's your religion is. They say that you can just say that “it's between me and God”, and that they cannot ask you or confront you about that, because that would be subjecting you to a religious test which goes against the Bill of Rights. However, if you defend yourself using your constitutional position, it is possible that it may lead to a more confrontational issue with an employer. Unfortunately, it would be difficult to predict if one would get that pushback and each employee should measure that themselves based on their own personal knowledge of the makeup of and history with management or administration. If you know someone that has been successful in their religious exemption appeal, it may be helpful to ask them what position they took and how they constructed it.

Unfortunately, there just doesn't seem to be 100% clear cut consensus on how to approach this issue. These principles may apply for many different religions, but because I am not familiar with the core beliefs of any other than Christianity, I will comment on what I know and believe. For a person that is a non-denominational Christ follower or lives their life on the basis of Scripture as their final authority on all matters of conscience and morality, I would take the approach that you must hold to your firmly held religious beliefs. And then if they push for an explanation further, I recommend that you say that you view your body as the ***Temple of the Holy Spirit*** (as Scripture clearly states in 1 Cor 6:19), and taking the shot would defile it. That may induce questions from them like, do you take other vaccines? Or what is it about these vaccines that you oppose as compared to other vaccines you have taken in the past? You may then have to argue the use of aborted fetal tissue in the development and production of the vaccines. If you have taken other vaccines that may have contained components grown in fetal tissue in the past, but was unaware of that fact, you could then also say that you were not aware that other vaccines taken in the past used aborted babies and contained their DNA in those shots. Further, knowing that now, I am in complete objection to having them injected into my body because it would violate my sincerely held religious beliefs.

More on fetal Cell lines used in the making of the vaccines

There is an obvious moral dilemma for people of faith that don’t support the use of abortion to produce medical products or having them injected into their bodies. Importantly and of additional concern is that when vaccines are produced by growing the virus or bacteria in aborted fetal tissue, there are DNA strands that make it through in the manufacturing process. There are in fact hundreds of thousands of DNA fragments that are allowed by the FDA in every dose. So, that human DNA is injected into your body and potentially may combine with your own DNA in a process called homologous recombination. There is a scientist named Theresa Deisher that has done extensive research and writing about this. I have a section of my eBook ***1200 Studies- Truth Will Prevail*** on this found on https://wellnessdoc.com . I know that's probably too much information, but for making decisions about other vaccines for children or yourself that would definitely be a consideration.

A couple points that might clarify the objection to the use of aborted fetal cells. Pfizer and Moderna did not use the HEK293 fetal cells in production, but did in the research, testing and development phase. J & J used the PER.C6 in the production. Therefore, you would have to say that your sincerely held religious beliefs would prohibit using any product that used an aborted baby in any phase of the making of the product. **ALTHOUGH…**The second week of October ***Project Veritas*** came out with a video showing emails from top officials at Pfizer talking about the use of fetal tissue in their vaccines and their desire to cover it up from the public. https://www.projectveritas.com/news/pfizer-leaks-whistleblower-goes-on-record-reveals-internal-emails-from-chief/

The source for the information below is ***Children of God for Life***. It is a great website on this topic, and I've used it as a source for many of my articles in the past. https://cogforlife.org/

Moderna

Fetal cell line: The **HEK293** cell line (info here) originated from a healthy aborted child in the 1970s, age unknown.

Did Moderna use the HEK293 fetal cell line in research? Yes, they did in the research and development of the vaccine.

- In March 2020, researchers explained in *Science* journal that they expressed the 2019-nCoV spike in the prefusion conformation using HEK293 cells. That means they made the spike protein so they could study it, and they used HEK293 cells as the medium to express it in.
- In this preliminary report from July 2020, researchers explain in the supplementary appendix that ACE-2-overexpressing 293T cells were used in a neutralization assay to detect the presence of antibodies, a test to make sure the vaccine works as it should.
- This August 2020 preclinical trial report in *Nature* journal also explains that researchers transfected HEK293 cells to test expression. That means they added the vaccine in each step of development to the cells to see if they produced the protein as expected. This is the *in vitro* (in the lab) mRNA expression test.
- This U.S. patent for the *in vivo* (in the body) production of proteins explains a similar test, including testing the mRNA encapsulated in the lipid for delivery into the body. Again, they needed to see if the vaccine was stable and worked as expected.

Pfizer

Fetal cell line: The **HEK293** cell line (info here) originated from a healthy aborted child in the 1970s, age unknown.

Did Pfizer/BioNTech use the HEK293 fetal cell line in research? Yes, they did in the research and development of the vaccine, similar to the way Moderna (above) did. They used the HEK293 cell line for testing the vaccine. And as mentioned above, the Project Veritas video seem to reveal that they may also have been used in the manufacturing process as a result of their scheming to prevent the public from finding out how these fetal cell lines were used.

- In September 2020, researchers explained that they used HEK293 in a neutralization assay to detect the presence of antibodies, a test to make sure the vaccine works as it should, and they transfected HEK293 cells to test expression. That means they added the vaccine in each step of development to the

cells to see if they produced the protein as expected. This is the *in vitro* (in the lab) mRNA expression test.
- This U.S. patent describes how they made RNA molecules encoding fusion proteins (like the spike protein) and tested them in development. They used a variety of cell lines, HEK293 among them, but do not specifify which cell line they used for the COVID-19 vaccine. Again, they needed to see if the vaccine was stable and worked as expected.

J & J

Fetal cell line: AdVac® technology uses **PER.C6®** cell line (info here) originating from a healthy 18-week-old aborted child.

Did Johnson & Johnson use the PER.C6 fetal cell line in research and production? Yes, they did in the research and development of the vaccine, as explained in this scientific report from July 2020 in *Nature* journal and in this scientific report from September 2020 also in *Nature* journal. To propagate the virus in the PER.C6 cells means to grow it in them. They will need to do this in ongoing manufacturing.

Another consideration is ***Title VII of the Civil Rights Act of 1964***. This comes into play in employment discrimination. Title VII makes it unlawful for public or private employers, employment agencies, licensing agencies, and unions to refuse to hire, to fire, or otherwise discriminate against any individual in compensation or the terms or conditions of his/her employment based on certain protected classes. It further prohibits harassment in the workplace based on those same protected classes.
Under Title VII, employment discrimination or harassment based on any of the following protected categories is unlawful:
- Color
- **Creed/Religion**
- Gender (Sex)
- National Origin
- Pregnancy (included in Sex Discrimination)
- Race

How did we even get to this ridiculous point of absurdity?

This whole scenario should never have come to this point for anybody, because nobody should ever be forced to take a medicine or medical product that they don't feel they want or need. Also, the infection survival rate for people under age 60 is 99.73%. The infection survival rate for people under the age of 30 is 99.986%. And for children and teens under the age of 20, the survival rate is 99.9973%. Individuals should be allowed to do their own risk reward stratification. And based upon their level of health and age, they should be able to do a calculation as to whether the risk of the side effects from the vaccines is worth the benefit for them. Besides that, the vaccines are failing on such a massive scale in countries that are slightly ahead of us on their vaccination programs, signifying that it will only continue to get worse here in the U.S. The Pfizer vaccine has been found to only be 39% effective in Israel according to data as August 2021 and has continued to decline since then. That is in part because of the waning of the antibodies, but also the variants like Delta are defeating the vaccine by mutating along points of the spike protein, which is the only thing that vaccinated people's antibodies are trained to identify. And moreover, the antibodies produced from the vaccines are trained to identify the spike from the original virus. Now, because of the mutations in these variants especially along the spike protein changing its configuration, the antibodies are becoming increasingly ineffective.

In addition, immunity for people who have recovered from the infection is so much more durable and robust than what the vaccines have been shown to provide. The immune system recognizes the totality of the virus, which is 29 different protein sequences rather than just the one protein sequence of the spike protein. It's literally criminal that the CDC is not recognizing that scientific fact showing the long-term and effectiveness of natural immunity (no longer disputable with nearly 3 dozen studies that I am aware of). And yet, the coercion of forcing people through the use of mandates they dictate by using businesses and entities to do their dirty work for them.

In addition:

This is a link to an article that has some great ideas and suggestions in it. The article also has some recommendations as to what you should and should not put on the form requesting the religious exemption. https://thenewamerican.com/covid-vaccine-mandates-if-i-dont-want-the-jab-what-are-my-options/. Remember, these are all only suggestions. Ultimately you have to decide what your particular employer is looking for and how best to address it.

The **Informed Consent Action Network (ICAN)**- Help with university exemptions
This link https://www.icandecide.org/covid-19-vaccine-exemptions/ will take you to information regarding religious and medical exemptions for select universities' COVID-19 vaccination requirements. The list was taken from the Siri & Glimstad LLP website. They cannot guarantee the accuracy of this information as this was last updated on June 23, 2021.

Also, ***America's Frontline Doctors*** has a whole legal team dedicated to medical freedom issues and especially surrounding the vaccine. You could probably find some good information there as well. https://americasfrontlinedoctors.org/ . I believe that they have some forms that you can use with your efforts with employers.

Do the adenovirus vaccines like J & J and AstraZeneca integrate into DNA of the person getting the shots?

A 2002 study published in ***Current Gene Therapy*** titled, **Adenovirus as an Integrating Vector** raises concerns about the effect they may have on the chromosomes of the recipient of the vaccine.

The Johnson and Johnson and the AstraZeneca-Oxford vaccines are adenovirus vector vaccines. They have taken an adenovirus and rendered it unable to replicate. They then splice the genetically modified spike protein from the SARS-CoV-2 virus into the adenovirus. The adenovirus gains access into the recipient's cells and then is replicated by the ribosomes (like little copy machines) inside the cell to be released, thus stimulating the immune system to create antibodies.

Abstract:

Recombinant adenoviral vectors have served as one of the most efficient gene delivery vehicles in vivo thus far. Multiply attenuated or completely gutless adenoviral vectors have been developed to achieve long-term gene expression in animal models by overcoming cellular immunity against de novo synthesized adenoviral

proteins. However, since adenovirus lacks native integration machinery, the goal of gene therapy obtaining permanent expression cannot be realized with current adenoviral vector systems. **Recent studies have shown that replication-incompetent adenoviral vectors randomly integrate into host chromosomes at frequencies of 0.001-1% of infected cells.** To improve the integration frequencies of adenoviral vectors, a variety of hybrid vectors combining the highly efficient DNA delivery of adenovirus with the integrating machinery of retroviruses, adeno-associated viruses, and transposons, have been emerging. These hybrid vectors have shown promise, at least in in vitro systems. Furthermore, a denoviral vectors have shown potential as gene targeting vectors. These developments should eventually lead to more effective gene therapy vectors that can transduce a myriad of cell types stably in vivo.

https://pubmed.ncbi.nlm.nih.gov/12109211/

This study was from 2002. What I don't know is if they have fixed that glitch prior to the development of the most recent adenovirus virus vector vaccines.

There is a lack of correlation between percentage of population vaccinated and rates of COVID-19 across a broad swath of countries

This table is from a ***Dr. Mercola*** article titled, **Ivermectin vs. Merck's New Antiviral, Molnupiravir**

While the table does not have anything to do with the two medications, I thought it was a stark example of the lack of correlation between percentage of the population vaccinated and the percentage of the population that have had cases of COVID-19.

From the article

And yet, data show that the number of confirmed cases of COVID in countries where much of the population is unvaccinated is not higher than in countries where nearly100% have been given the jab. For example, as of October 13, 2021, according to the CNN COVID-19 vaccination tracker and the Johns Hopkins Coronavirus Resource Center

Country	Vaccination Rate	Infections	Population	% Population Infected
Portugal	86.4%	1,075,639	10,196,709	10.5%
United Arab Emirates	84.3%	737,890	9,890,402	7.4%
Spain	79%	4,977,448	46,754,778	10.6%
Ireland	74.6%	404,514	4,937,786	8.1%
United States	55.8%	44,455,949	331,002,651	13.4%
Russia	39.9%	7,687,559	145,934,462	5.2%
Romania	29%	1,365,788	19,237,691	7%

Indonesia	21.1%	4,228,552	273,523,615	1.5%
India	19.6%	33,985,920	1,380,004,385	2.4%
Vietnam	16.4%	843,281	97,338,579	0.86%
Bangladesh	11.1%	1,562,958	164,689,383	0.9%

Since this data was derived from Dr. Mercola's article comparing Ivermectin and Molnupiravir, I thought I would include the key takeaways that Dr. Mercola led that article with: ***(Emphasis mine)***

- One paper compared Merck's data on molnupiravir against peer-reviewed data on ivermectin and found ivermectin has a low side effect profile, costs less than molnupiravir and is more effective against SARS-CoV-2. ***(Ivermectin costs between $30 and $60 for a treatment series, whereas molnupiravir costs just over $700).***

- Clinical Trials data show Merck gathered 1,850 participants but released data on only762 in the non-hospitalized arm of the study. The study with hospitalized patients anticipated 1,300 participants, but enrolled 304 before terminating for "business reasons" ***(One can only imagine what "business reasons" is actually code for).***

- Merck has applied for emergency use authorization for molnupiravir against COVID-19. Some are excited about an antiviral that may be effective against the virus, but the exclusion criteria for participants in the study may mean few will qualify to take the drug. ***(Once again, an example of drug companies using certain exclusion criteria In their trials, such as accepting only extremely healthy people for a study that will determine whether a drug may be used in a population consisting of a high percentage of sick people, many with multiple comorbidities and many that are very elderly. But why should that be a surprise?).***

Doctor Mercola has come under so much fire and threats from our government, that he has conceded to delete his articles 48 hours after he posts them. Therefore, this article is no longer available on his website. Unfortunately, another victory for censorship and cancel culture.

Is the approval of Pfizer's vaccines a bait and switch, when the version that will not be available until sometime next year was the one FDA approved and the original one being used until then is still under EUA?

An article published on American Greatness titled, **Defense Department Pulls a Bait and Switch on Vaccines**
If a soldier goes to a military hospital or a private provider to receive an approved Pfizer COVID vaccine, he will be administered the unapproved Pfizer-BioNTech vaccine. Coerced, it's illegal.
Excerpts from the article

On August 24, Secretary of Defense Lloyd Austin issued a memo to senior Pentagon leadership announcing that he was implementing a mandatory COVID-19 vaccination policy for all military service members. The day before, the FDA had issued full authorization to Pfizer for their Comirnaty COVID-19 vaccine product (the nomenclature of which is meant to be a mashup of the words "COVID", "mRNA", and "community") . At first

glance it would seem that the mandatory vaccination policy, while scientifically unsound and strategically foolish, was at least a policy being implemented according to both the letter of the directive and in accordance with the law. But a further examination of the facts and the manner in which this order is being implemented makes clear that the military's implementation of this order is illegal and highly unethical.

In the memo, Secretary Austin issued a directive and a promise, that "Mandatory vaccination against COVID-19 will only use COVID-19 vaccines that receive full licensure from the Food and Drug Administration (FDA), in accordance with FDA-approved labeling and guidance." The problem with this is that the Comirnaty vaccine product that was approved by the FDA is not available anywhere in the Military Health System. It is not even in production, according to the military's TRICARE healthcare providers. If a soldier goes to a military hospital or a private provider to receive an approved Pfizer COVID vaccine, he will be administered the unapproved Pfizer-BioNTech vaccine which is a vaccine that is not approved but has been administered under an Emergency Use Authorization (EUA). We are told that this is but a brand name difference, that the formulation is the same, and they can be used interchangeably. But as the FDA was approving the Comirnaty product, they were renewing the authorization for the Pfizer-BioNTech product. If it's just a matter of brand name, why issue an approval for one brand name and an EUA renewal for the other? This is because they are not actually the same.

According to the formulation comparison sheet, the Comirnaty vaccine product has a very different formulation than the Pfizer BioNTech product—on a per 30 µg dose basis for instance, it contains 25 percent more SARS-CoV-2 spike glycoprotein mRNA, 34 percent more polyethylene glycol, 1070 percent more potassium chloride, as well as an ingredient listed only as "Redacted Ingredient." That last item is alarming. Informed consent is required by both federal and international law under the Nuremberg Code. It is impossible to give informed consent to receive a medical ingredient that is shrouded in secrecy behind a *redacted* label.

There is a difference between Pfizer's BioNTech and Comirnaty products that may even be more profound: the legal one. According to the FDA's own vaccine fact sheet for the two Pfizer vaccines, "*The products are legally distinct . . .*". That legal distinction may mean that any service member who is coerced into taking the vaccine and suffers adverse effects—which is already happening, with case rates of vaccine-induced myocarditis soaring among service members—will have *no legal recourse* because the vaccine they took was only given Emergency Use Authorization, not full approval, which means that there is no legal liability whatsoever for Pfizer if and when vaccine injury occurs. Not only is the manufacturer not liable for damages incurred, neither are governments or employers. And under the Public Readiness and Emergency Preparedness Act (PREP), their families would also be barred from legal recourse as well.

These facts were brought to my attention by a group of fighter pilots who are standing up to a corrupt military leadership who seek to impose a dangerous and unnecessary experimental gene therapy on them, taking no responsibility for their welfare or health care if and when this experimental therapy causes serious injury or death. They provided me with internal emails confirming that the FDA-approved Pfizer vaccine product is not available to anyone in the United States Military. From the director of a Military Treatment Facility:
Per the memo attached, On September 13, 2021, the National Library of Medicine within the National Institutes of Health (NIH), reported, '[a]t present, Pfizer does not plan to produce any product with these new [Comirnaty National Drug Codes] and labels over the next few months while EUA authorized product is still available and being made available for U.S. distribution.' Therefore, Pfizer has not made any Comirnaty. There is no expected date when we will receive Comirnaty.

Read the rest of the article here…. https://amgreatness.com/2021/10/19/defense-department-pulls-a-bait-and-switch-on-vaccines/

It appears that the spike protein toxin may circulate up to four months after injection with the mRNA shots

An October 15th 2021 article published in ***The Journal of Immunology*** titled, **Cutting edge: circulating exosomes with COVID spike protein are induced by BNT162b2 (Pfizer-BioNTech) vaccination prior to development of antibodies: a novel mechanism for immune activation by mRNA vaccines**, appears to reveal that the spike protein generated from the mRNA vaccines continue to circulate in the body far longer than the developers and many experts had believed.

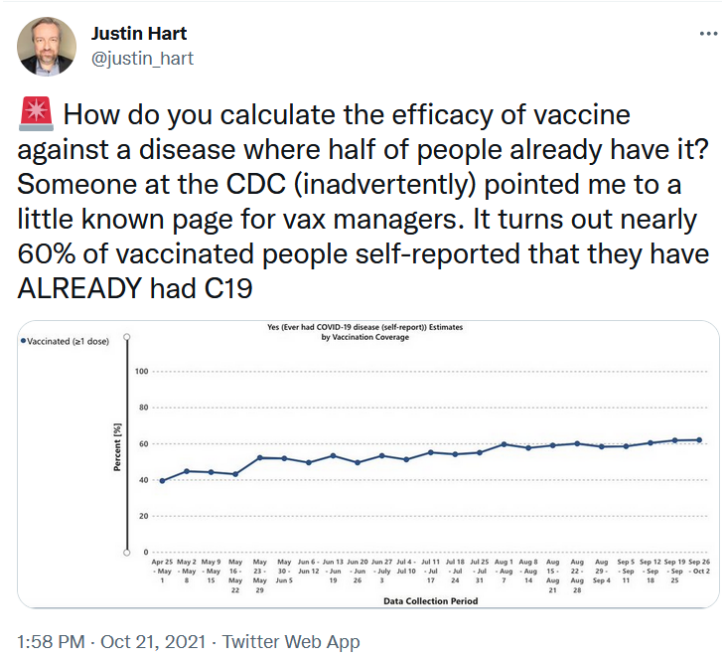
The Abstract

Severe acute respiratory syndrome corona virus 2 (SARS-CoV-2) causes severe acute respiratory syndrome. mRNA vaccines directed at the SARS-CoV-2 spike protein resulted in development of Abs and protective immunity. To determine the mechanism, we analyzed the kinetics of induction of circulating exosomes with SARS-CoV-2 spike protein and Ab following vaccination of healthy individuals. Results demonstrated induction of circulating exosomes expressing spike protein on day 14 after vaccination followed by Abs 14 d after the second dose. Exosomes with spike protein, Abs to SARS-CoV-2 spike, and T cells secreting IFN-γ and TNF-α increased following the booster dose. Transmission electron microscopy of exosomes also demonstrated spike protein Ags on their surface. **Exosomes with spike protein and Abs decreased in parallel after four months.** These results demonstrate an important role of circulating exosomes with spike protein for effective immunization following mRNA-based vaccination. This is further documented by induction of humoral and cellular immune responses in mice immunized with exosomes carrying spike protein.

https://www.jimmunol.org/content/early/2021/10/11/jimmunol.2100637

Speaking of vaccine effectiveness, if greater than 60% of people who are vaccinated have already had COVID and have natural immunity isn't that going to make the vaccine look more effective than it really is?

Food for thought…



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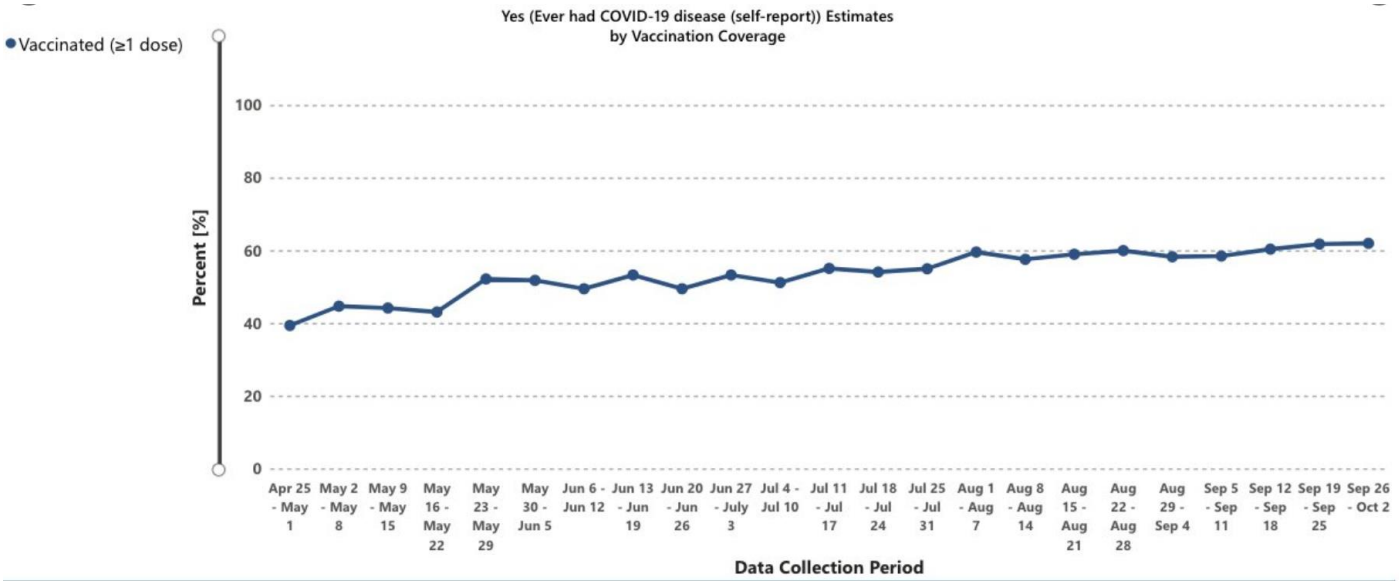


VAERS Red Box COVID-19 monthly casualty comparisons over time

VAERS COVID REPORTS

44,606 Reports Through March 19, 2021*

jump to browse reports

2050	4450	7485
DEATHS	HOSPITALIZATIONS	URGENT CARE
6759	**354**	**421**
OFFICE VISITS	ANAPHYLAXIS	BELL'S PALSY

Total Heart Attacks	Total Miscarriages	Total Severe Allergic Reaction	Total Thrombocytopenia
434	76	2550	134

VAERS COVID REPORTS

(Vaccine Adverse Events Reporting System, USA)

157,277 Reports
Through April 30, 2021
*

jump to browse reports

3837	10715	21623
DEATHS	HOSPITALIZATIONS	URGENT CARE
26046	**834**	**942**
OFFICE VISITS	ANAPHYLAXIS	BELL'S PALSY

Heart Attacks	Miscarriages	Severe Allergic Reaction	Thrombocytopenia/Low Platelet
1132	213	7463	822

VAERS COVID REPORTS

(Vaccine Adverse Events Reporting System, USA)

262,521 Reports
Through May 21, 2021
*

jump to browse highlighted reports

4,406 DEATHS	**14,986** HOSPITALIZATIONS	**34,474** URGENT CARE
45,006 OFFICE VISITS	**1,214** ANAPHYLAXIS	**1,411** BELL'S PALSY

Heart Attacks 1,598	Miscarriages 511	Severe Allergic Reaction 12,219	Thrombocytopenia/Low Platelet 1222

VAERS COVID Vaccine Data

(Vaccine Adverse Events Reporting System, USA)

387,288 Reports
Through June 18, 2021
*

jump to browse highlighted reports

6,136 DEATHS	**21,806** HOSPITALIZATIONS	**51,575** Urgent Care
72,588 OFFICE VISITS	**1,624** ANAPHYLAXIS	**1,977** BELL'S PALSY

6,450 Life Threatening	2,483 Heart Attacks	1,644 Myocarditis/Pericarditis	1,776 Thrombocytopenia/Low Platelet
720 Miscarriages	17,408 Severe Allergic Reaction	5,194 Disabled	4,447 Tinnitus

VAERS COVID Vaccine Data

Reports from the Vaccine Adverse Events Reporting System.
Our data reflects all VAERS data including the "nondomestic" reports.

518,769 Reports
through July 23, 2021*

jump to browse highlighted reports

11,940 DEATHS	40,991 HOSPITALIZATIONS	65,067 URGENT CARE
88,920 OFFICE VISITS	4,110 ANAPHYLAXIS	3,714 BELL'S PALSY

1,272 Miscarriages	4,799 Heart Attacks	3,201 Myocarditis/Pericarditis	12,808 Permanently Disabled
1,932 Thrombocytopenia/ Low Platelet	11,199 Life Threatening	22,286 Severe Allergic Reaction	6,123 Tinnitus

VAERS COVID Vaccine Data

Reports from the Vaccine Adverse Events Reporting System.
Our data reflects all VAERS data including the "nondomestic" reports.
read the VAERS disclaimer

623,341 Reports
through August 20, 2021*

jump to browse highlighted reports

13,627 DEATHS	55,821 HOSPITALIZATIONS	74,368 URGENT CARE
100,966 OFFICE VISITS	5,721 ANAPHYLAXIS	4,785 BELL'S PALSY

1,671 Miscarriages	6,071 Heart Attacks	5,093 Myocarditis/ Pericarditis	17,794 Permanently Disabled
2,831 Thrombocytopenia/ Low Platelet	14,105 Life Threatening	25,921 Severe Allergic Reaction	7,324 Shingles

VAERS COVID Vaccine Adverse Event Reports

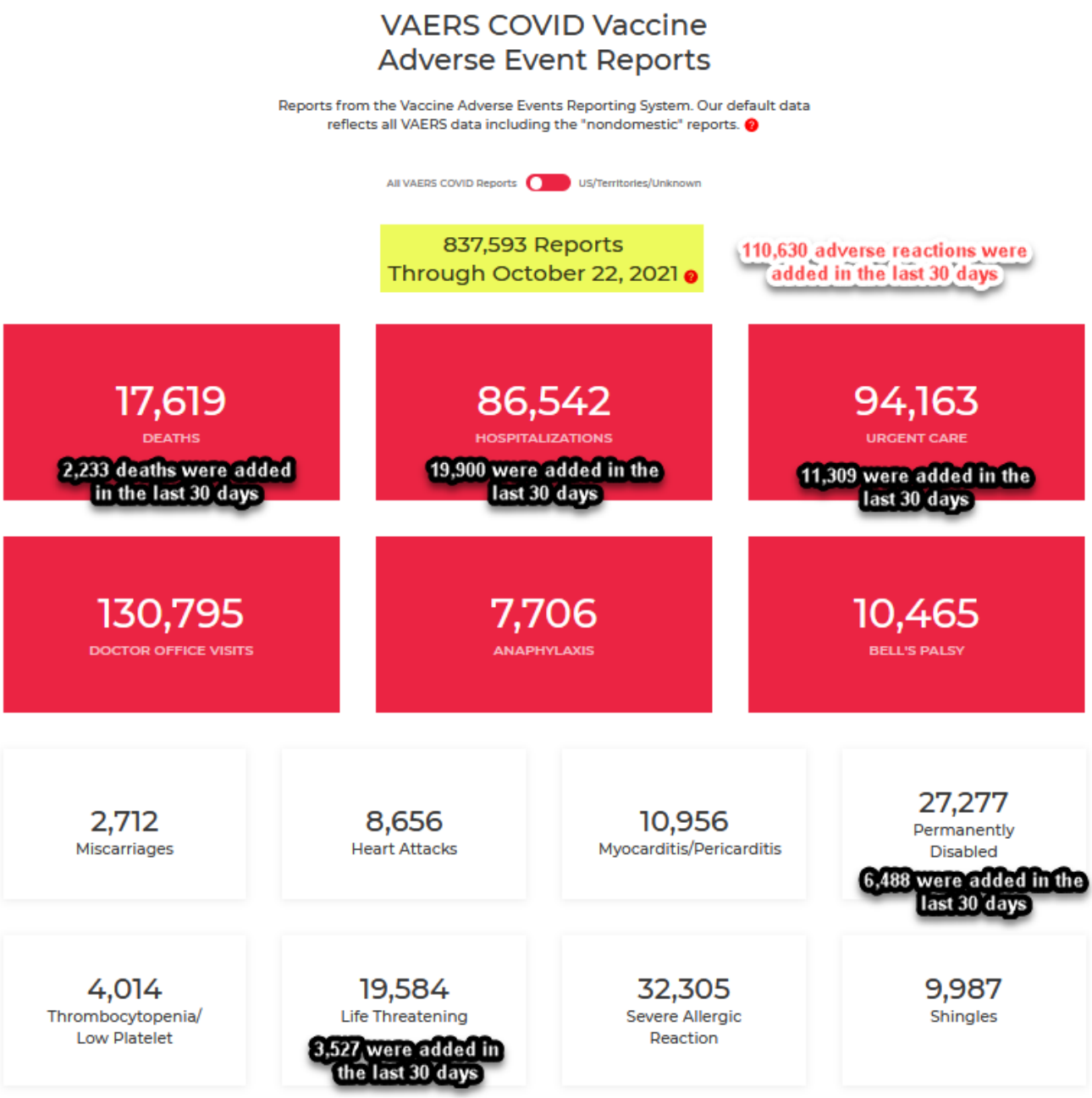
Reports from the Vaccine Adverse Events Reporting System. Our default data reflects all VAERS data including the "nondomestic" reports.

All VAERS COVID Reports — US/Territories/Unknown

726,963 Reports
Through September 17, 2021

15,386 DEATHS	**66,642** HOSPITALIZATIONS	**82,854** URGENT CARE
114,127 DOCTOR OFFICE VISITS	**6,378** ANAPHYLAXIS	**8,626** BELL'S PALSY

2,122 Miscarriages	**7,267** Heart Attacks	**6,812** Myocarditis/Pericarditis	**20,789** Permanently Disabled
3,231 Thrombocytopenia/ Low Platelet	**16,057** Life Threatening	**28,168** Severe Allergic Reaction	**8,153** Shingles



Other valuable resources from Dr. Palmer:

Many other COVID-19 related resources as well as helpful health resources can be found on Dr. Alan Palmer's website at https://wellnessdoc.com

Dr. Palmer's highly acclaimed eBook

Check out Dr. Palmer's downloadable eBook called ***1200 Studies- Truth Will Prevail***. It is the most comprehensive exposé on vaccines ever produced. Dr. Palmer took on this project and mission because of his intense desire to educate people about the potential risks of vaccines and the troubling changes we have seen in the health of our children, coinciding with the significant increase in vaccine doses added to the schedule in the last 30 years (72 doses by age 18).

1200 Studies is updated periodically, and now contains 950 pages of excerpts and summaries from over 1,500 studies, published in journals representing 45 different medical and scientific disciplines and authored by thousands of scientists, contradicting what we are and have been told about vaccines. These are unbiased, objective studies by researchers who are not funded by vaccine manufacturers. The most recent update added 150 pages on the COVID-19 vaccines.

And it is designed it as a PDF with easy-to-use navigation tools, search capability and links directly to the studies on PubMed. The entire Table of Contents are links directly to the page in the book on that topic. And every page has the links directly to the study on PubMed or the source journal. It is available at https://1200studies.com or https://www.wellnessdoc.com/1200studies/

Want to learn information about all things COVID-19 that you'll never hear from the mainstream media?

Consider subscribing to Dr. Palmer's ***Monthly 1200 Studies COVID-19 newsletter***. It will provide you with the stories, the research, the data and what the top experts from all over the world are saying about the virus, the lockdowns, the vaccines and the real numbers. You will learn information that doesn't fit the mainstream media's narrative and the information that certain factions do not want you to know. Now with all things COVID-19, as the 24/7 media drives hysteria and fear mongering, a new push for public compliance or even mandated vaccines is on. If you don't have time to do all that homework yourself, let him do it for you. **Subscribe at** https://www.wellnessdoc.com/science-and-news-monthly-newsletter/

Other eBooks on all things COVID

Check out Dr. Palmer's **eBooks on the many different controversial topics surrounding the COVID-19 pandemic** and the public health responses countries have implemented and, in some cases, hang onto today.

Current and future release topics include:

- The ineffectiveness and harms of lockdowns
- The PCR testing debacle
- The ineffectiveness and harms of face masks
- Sweden- the world's control group
- Natural anti-viral prevention and treatment nutrients
- Safe and effective repurposed medications for COVID-19
- Natural infection and lasting immunity
- The origins of the SARS-CoV-2 virus
- Germ vs. Terrain Theory
- Cytokine and bradykinin storm

Check them out at https://www.wellnessdoc.com/ebooks-and-publications/

https://Wellnessdoc.com - My website has lots of free educational resources on health, diet, nutrition and healthy lifestyle habits.