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

By Dr. Alan Palmer- Updated May 1st, 2022 (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 1,350-page eBook with excerpts and summaries from over 1,600 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 May 1st, 2022.

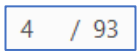
Continue to tips for easy navigation of this extensive document on the next page

You may notice that this document is quite massive. It contains many charts and graphs that I've included to make your understanding and enjoyment of the topics much better.

And as the title would indicate, it is a chronological history of the valid issues and concerns over the of development, deployment, contrasting evidence to the public narratives and of the suppressed data and research regarding the serious problems that have occurred.

Tips for easy navigating

Like my eBook, it is not necessarily meant to be read cover-to-cover (although you could if you have the time). It is really meant to be used as an information and reference tool. Scan the table of contents and click on the link to the topics that interest you.

To return to the previous page click on the  **(previous view) button on the toolbar (Adobe Acrobat). If you don't see it, right click on the tool bar…go to navigation tools drop-down and select it and it will appear on your toolbar. Each time you click it, it will take you to the previous page you were on even if that page was 60 pages back. If you read 3 pages after navigating from the table of contents and want to return back there, click it 3 times. Another way to return to the table of content page (other than scrolling), is to change the page displayed on the left in this window on the toolbar to the page your navigated from in the table of contents** 

and hit the enter key. Hope that helps make your experience better 😊

You can also do key word and phrase searches in Adobe Acrobat to make it easier to find certain topics in the document.

Table of Contents with active links directly to that topic in the article

- Trials were designed to use chemical cocktails instead of inert saline placebos in the control (placebo) groups
- Clinical trials fraught with even more problems and adverse reactions
- Other vaccine adverse reactions and long-term concerns
- Many prestigious scientists and doctors call for a halt to the approval due to serious safety concerns around immune enhancement, infertility and brain injury
- Erasing the placebo group
- Pharma insiders are the foxes watching the henhouse in the vaccine clinical trials
- 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 1st, 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

June 1st, 2021 Update

- ACTION ALERT! We are facing an unprecedented crisis of injury and deaths from the COVID-19 vaccines. It must be stopped! Read this Citizen's Petition to the FDA from *Children's Health Defense* and comment on the FDA's web site.
- It's looking more and more like the SARS-CoV-2 virus was engineered to be more infective to human epithelial cells. And the Wuhan lab origin with funding from the NIH looks almost certain.
- Latest VAERS COVID vaccine injury reports and the incredibly more likely astronomical numbers
- Another example of under-reporting: A recent analysis of anaphylactic reactions from COVID-19 vaccines find that they are significantly under-reported
- New report out of Israel reveals shocking levels of adverse reactions from the Pfizer vaccine
- Time to blow your mind- This is how they do it – how they lie with statistics from study results to sell more drugs/vaccines
- How effective are the COVID-19 vaccines- REALLY?
- Another reason the reported "effectiveness" of the vaccines is all smoke and mirrors as this article from the medical journal *Lancet Microbe* reveals

- How effective are the COVID-19 vaccines- REALLY?
- Another reason the reported "effectiveness" of the vaccines is all smoke and mirrors as this article from the medical journal *Lancet Microbe* reveals
- Pharma can lie with statistics to deceive people and the World Health Organization continues to suppress proven effective treatments
- Tucker Carlson is the fearless leader of the counter-narrative to the mainstream media's steady diet of fear, hysteria and misinformation!
- How deadly are the COVID-19 vaccines compared to the flu vaccine this year?
- How does the number of reported deaths in the U.S. from the COVID-19 vaccines compare to all deaths from all vaccines in the last 30 years?
- Video showing the rise in COVID-19 cases and deaths after countries implemented their mass vaccination program
- More evidence that cases and deaths have risen dramatically after mass vaccination efforts begin
- How are the states with the lowest percentage of their population vaccinated faring?
- The coming Nuremberg style trials
- Did Pfizer know people taking their vaccine could shed the spike protein to others? And is that what is happening?
- The evidence shows that the spike protein by itself can cause disease in the body

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?

December 1st, 2021 Update

- Study concludes that mRNA vaccines cause inflammation of the endothelium and vascular changes that may explain the various types of cardiovascular complications after vaccination
- Study finds no need for children to be vaccinated against COVID-19 and shocking finds that at least 5 times as many people over 65 die from the vaccines than from COVID.
- Study shows another mechanism for the way that the spike protein alone causes cardiovascular damage
- Pfizer under-reported the number of deaths in the vaccinated cohort in their clinical trial. The numbers extrapolated to all vaccinated individuals is massive
- What about the most vulnerable to COVID-19, the elderly?
- Now that we have seen how miniscule the risk from COVID-19 is for children and teens, how about the risk from the vaccines?
- Brilliant presentation by Steve Kirsch at the October VRBPAC Meeting October 26th, 2021 on considering the COVID-19 shots for 5-11 year old children
- Does the vaccine efficacy study from Sweden I highlighted last month disclose an increased rise in deaths after the vaccines?
- Increase in all-cause deaths in the UK by vaccination status shows significant increase after the second dose
- Reporting of vaccine effectiveness uses a deceptive tactic to make it sound better than it really is
- More trouble for the credibility of the vaccine trials as a whistleblower's accounts including emails, documents and recordings of violations are disclosed in a *British Medical Journal* Investigative Report
- Why is the FDA trying to hide the Pfizer trial data from the public for 55 years?

- In typical fashion, the people on the committee deciding whether children are exposed to these shots and parent's right to protect their children's bodily autonomy all have ties to Big Pharma

- An attorney's op-ed in the Wall Street Journal explains why it is illegal to mandate these shots on children

- Article exposes false narratives about the origins of SARS-CoV-2 variants and the failure of Dr. Fauci and his cohorts to allow doctors to treat patients early

- The latest variant fear-porn, the omicron variant. Is there a reason for concern?

- Just in time for the new variant, Pfizer to the rescue with a new vaccine. Couldn't have seen that one coming!

- Vermont, with the highest vaccination rate in the country is reeling from all-time high cases, hospitalizations and deaths, especially in the fully vaccinated

- Now consider West Virginia, the state with the lowest vaccination rate in the country

- Israeli news reporting serious concerns about the trends in rise of vaccinated hospitalizations and deaths

- Several studies warning of enhanced or fatal disease in animals vaccinated for SARS-CoV-1 when later exposed to the wild virus, may be what we are seeing now in highly vaccinated countries

- Portugal, the 4th most highly vaccinated country in the world and having delivered over 900,000 booster shots is seeing a large uptick in cases and new restrictions.

- Gibraltar, the most highly vaccinated country in the world at 121% has been seeing an uptick in cases as of late

- Shocking graph shows CDC data of obscure cause of death diagnosis code titled "Symptoms signs and abnormal clinical and laboratory findings not elsewhere classified", cross-referenced and following COVID-19 vaccine doses administered

- New England Journal of Medicine reports on a mechanism for spike protein driven antibody reaction that may lead to adverse reactions including immune-suppression, myocarditis and autoimmune disease…a possible explanation for some vaccine caused reactions and disease

January 1st, 2022 Update

- Omicron- The latest excuse for more endless fear-mongering. What are the FACTS?
- Omicron sweeps across the world in record time
- A December 17th study theorizes why Omicron is less lethal even though it is much less more transmissible
- Current status of Omicron in South Africa
- Omicron's mutations have not only escaped the "vaccines", they may have also escaped the previously effective monoclonal antibody treatments
- A December 23rd, 2021 article in *Nature* discusses the implications of the Omicron regarding vaccine, monoclonal antibody treatment and immune escape
- How early into the vaccination program was it discovered that the variants were significantly evading the vaccines? This study may surprise you.
- Denmark, a country that is over 80% vaccinated locking down amidst record high cases
- Another study, this time out of Germany shows that children are at extremely low risk from COVID-19
- A molecular biologist/toxicologist warns of possible fertility issues from the COVID-19 shots
- What is the true number of COVID vaccine related deaths? Is the CDC altering the figures?
- Former World Health Organization's European Advisory Group on Immunization vice president warns about wave of serious illness and deaths in vaccinated people over the winter
- Fully vaccinated Cruise ships are experiencing SARS-CoV-2-CoV-2 infection outbreaks
- International scientists and doctors convene in Rome Italy to declare the efficacy of early treatment options and other measures to return once again to a normal society

- An excellent paper on the problems with the development of, the ingredients contained and the many adverse consequences from the COVID-19 shots we are now seeing and may very well see in the future

- Study identifies mechanisms for delayed chronic adverse responses related to autoimmunity after COVID-19 infection or shots

- An excellent British Medical Journal Rapid Response lays out very good reasons against mandatory COVID-19 shots

- A review of the Pfizer Clinical Trial database revels that a high percentage of the trial participants did NOT continue beyond 4 months of the trial. The question is why?

- The FDA has petitioned a judge to allow 75 years for the release of the Pfizer clinical trial data. What could they possibly be trying to hide?

- Small wins pile up as Governor Hochul of New York drops the vaccine mandate for New York transportation workers

- An important warning for seniors by an expert on vaccine injuries

- Excellent resource for building your case for legal exemptions from the experimental shots

- CDC's reporting system VAERS -"Red Box" casualty counts month by month

February 1st, 2022 Update

- The evidence shows that the spike protein by itself can cause disease in the body

- New Lancet paper confirms that Omicron escapes the 2-dose and booster regimen

- Breaking news- CDC study posted January 19th finds natural immunity to be far superior to vaccine immunity for the Delta variant

- Another study confirms that both vaccinated and boosted individuals are more likely to be infected with Omicron

- Not only are the shots incapable of preventing infection or transmission, but are making people MORE susceptible to becoming infected

- And hospitalizations are rising faster in vaccinated and even vaxxed-and-boosted than in the unvaccinated with Omicron

- Nobel Prize winning scientist blows up the current effectiveness of the vaccines and the irrationality of the mandates

- The data shows the cases, hospitalizations and death per 100K are MUCH higher in the vaccinated than the unvaccinated

- Third shot added to children aged birth-4 years old in Pfizer study, because two shots didn't produce sufficient antibody response. Here's another compelling reason for parents to say H ___ NO!

- The CDC was asked what the magic number of deaths or disabled people that will signal the stopping point for the jabs is? You may or may not be surprised at the answer.

- Reports surface about the large unreported numbers of injuries to U.S. military personnel from the shots

- A bombshell study from the journal Cardiology exposes the real risks of myocarditis from the shots

- Check out this shocking list of 291 recorded athlete heart attacks and heart related deaths in 2021

- UChicago students write one of the best and most well-referenced letters against vaccine mandates I have ever read. This can be a model template for other student and employment appeal letters

- What about the rationale for vaccinating children? A World-renowned vaccine developer/expert weighs in

- Understand how vaccine induced pressure drives more infectious variants

- Internationally, the highest vaxxed countries are seeing MASSIVE record high case counts

- Fauci said three shots will be the 'optimal regimen for vaccination'. The poor guy just can't get anything right.

- **And now data from the U.S., published in the *Journal of the American Medical Association* reveals a start reality about hospitalizations and deaths in fully vaccinated individuals**

- **COVID-19 deaths have always BEEN LOW VAXXED OR NOT**

- **Countries that are investigating all-cause mortality are noticing a significant increase of NON-Covid related deaths since the advent of the vaccine programs**

- **PANDA, a group of international doctors and scientists cite 10 reasons why mandatory vaccination must be rejected**

- **CDC gets it wrong again as they continue to push boosters for everyone**

- **CDC, U. of Cal. Berkeley and So. Cal. Kaiser Permanente authored article finds that Omicron is much less dangerous than Delta, so much so that there was only one death out of 52,297 omicron cases**

- **Look at Austria, fully vaxxed, boostered, vaccine passport policies and some of the harshest restrictions in the world**

- **And, in the U.S., states with the highest percentage of boosted individuals are seeing record numbers of deaths, despite Fauci's June 3rd, 2021 assertion that with 50% of people vaccinated we won't see the "surges" we've seen in the past**

- **CDC continues to ignore the evidence**

- **Israel finding second booster to be ineffective**

- **The claims that vaccination prevents serious outcomes and death are proving to be increasingly false**

- **Mysterious surge in non-COVID mortality among 18-49 year olds**

- **The latest Omicron variant (BA.2) which is gaining steam, has 7 NEW mutations of the S-protein. This is predicted to make the "ancient" vax formula made to mimic the original Wuhan strain that is still being pushed, even more useless.**

- FDA revokes the EUA for the two monoclonal antibodies because they are a mismatch for Omicron. YET, Fauci, Walensky and their minions in the media continue to push the completely mismatched vaccines.

- **March 1st, 2022 Update**

- Vaccine effectiveness hit an all-time low. U.K. data shows a NEGATIVE efficacy of 206% in ages 40-49, -171% in ages 30-39 and -120% in ages 18-29 in fully vaccinated and boosted individuals.

- Israeli Ministry of Health (MOH) posts Facebook survey asking about vaccine adverse reactions. They quickly freaked out after tens of thousands of comments flooded the post about adverse events

- Physicians for Informed Consent: CDC Data Show COVID-19 Mass Vaccination Has Had No Measurable Impact on COVID-19 Mortality in the U.S.

- A sophisticated analysis of the COVID-19 mortality data reveals SHOCKING data that the risk of death from the "vaccines" is greater than the risk from COVID-19 itself for all age groups under 80 years of age

- No relationship in mortality trend line with higher vaccination rates in 35 countries. Interpretation: The vaccines are not saving lives.

- The continent of Africa, with four times the population of the U.S. (1.4 billion) and only 13% fully vaccinated, has only 25% of the COVID-19 deaths

- Iceland, with 78% fully vaccinated and 67% boosted has the highest case rate in the world per million population

- Let's check in on Israel. 4-shots and the highest case rates in the world on January 17th, 2022.

- Three ways the CDC skews the "unvaccinated" numbers

- New evidence supporting that the genetically engineered spike protein from the shots can rapidly integrate into the DNA of the person who is injected

- Toxicologist warns about the COVID jabs having the potential to affect fertility

- Department of Defense data shows a significantly higher rate of miscarriages in female personnel who received the COVID-19 injections.

- Widespread and significant data changes appear on the DOD database after questions were raised about spikes in reports of adverse events after COVID injections to military personnel

- A new Lancet Journal article documents cases of Multisystem Inflammatory Syndrome in teens after receiving the COVID-19 shots

- Other valuable resources from Dr. Palmer

April 1st, 2022 Update

- How has each new vaccine campaign impacted deaths in Israel?

- South Korea is making the headlines for their explosion of cases and deaths, in a population that is 87% fully vaccinated, nearly 100% masked, distanced and contact traced

- U.S. Millennials aged 25-40 saw a historic spike in excess deaths in the fall of 2021 coinciding with governmental vaccine mandates and the booster campaign. What is the real cause?

- Adverse events from the Pfizer document data dump are off the charts

- Pfizer documents reveal an extraordinarily high number of deaths compared to the number of people vaccinated

- The Pfizer clinical trial was not double-blinded as is the gold-standard leading to biased and potentially manipulated results

- Whistleblower reveals numerous instances of deviation from trial protocols and in her words “fraud” that occurred right under her nose.

- Pfizer study results on children shows rapidly declining efficacy and are determined ineffective after two shots

- Staunch vaccine advocate/proponent suffers tinnitus from COVID-19 shots
- Journal of Pediatrics posts a study showing that the majority of participants ages 12-17 suffering from myocarditis after their COVID-19 injections were still having structural and functional adverse effects of their hearts 8 months later
- Study looks at spike protein in the blood from infection compared to that from COVID-19 injections
- The Washington Times publishes an opinion piece that asks tough questions about excess deaths that spike after COVID-19 shots
- Iceland, 79% fully vaccinated and in the top 10 most vaccinated countries in the world seeing huge uptick in COVID cases and deaths since the boosters rolled out
- Spain, one of the highest vaccinated countries of the world is seeing a major percentage of cases, hospitalizations and deaths in the fully vaccinated
- Dr. Geert Vanden Bossche makes a dire prediction that highly contagious variants will continue to develop in the most highly vaccinated countries and escalate into more severe disease and death in vaccinees
- Study in mainstream journal cites: "Vaccine escape mutation" viral strains caused by "vaccine induced evolutionary pressure" leading to high rates of infections "among highly vaccinated populations"
- Study on brain cells exposed to Pfizer's injection show several aberrations that can cause multiple issues in the nervous system including ones similar to that seen in brain cancer
- HIV gene sequences are in the spike protein of the SARS-CoV-2 virus AND the vaccines seem to impair the innate immune system of those getting the shots
- New research confirms that a patented 19-nucleotide gene sequence not found in nature was inserted precisely in the position of the spike protein of the SARS-CoV-2 virus, that would make it more likely to infect human cells
- An eye-opening, jaw dropping editorial opinion in the *British Medical Journal* pulls back the curtain on the out-of-control corruption that occurs between Big Pharma, regulatory agencies and researchers as business as usual

- Project Veritas captures undercover video of an FDA regulator spilling the beans
- Pharmaceutical companies and the fines they've paid 1991-2017. Guess who's the #2 worst offender?
- The federal government paid $1,000,000,000 (one billion) dollars to news agencies to promote the COVID-19 injections

May 1st, 2022 Update

- The failure of the vaccines to prevent COVID-19 deaths in some of the highest vaccinated countries in one screen capture
- What's next in the COVID Controller's playbook as the narrative shifts away from the failed vaccine?
- Nordic study shows myocarditis is 28X higher in vaccinated than in those infected with SARS-CoV-2
- A study in the Journal of the American Medical Association reveals just how devastating the number of cases of myocarditis after the injection really are
- Speaking of myocarditis and worse- Professional soccer players dropping dead from heart attacks at meteoric rates since COVID shot requirements
- Mysterious cases of hepatitis in children- What's the real cause?
- COVID-19 vaccine induced hepatitis can be serious and leave long-lasting effects
- S1 portion of the vaccine spike protein circulates freely in the bloodstream and causes numerous problems, some of them outlined here in these studies
- One example of the danger of this is that the S1 segment can enter the brain
- Another problem is that S1 can react with platelets and fibrin and cause hypercoagulability or blood clots
- The spike proteins can bind with ACE-2 receptors on cell surfaces and shift the body to a pro-inflammatory state

- Atypical white blood cells pick up S1 proteins and cause inflammatory reactions throughout the body
- Spike protein from the COVID-19 shots circulate within exosomes throughout the body
- Now that we've demonstrated that the toxic spike protein can cross the blood brain barrier into the brain, check out this study that gets into more detail about how that causes damaging effects in brain cells
- Another serious and even life-threatening potential mechanism for injury from the COVID-19 shots
- The genetically modified mRNA in the COVID-19 shots induce suppression of the innate immune system which leads to a higher risk of a variety of serious health problems including cancer
- Despite all of these serious potential complications from the shots and the incredibly low risk to children from the virus, these maniacs are still coming for your children
- British children up to 52 times more likely to die following a COVID shot according to government data
- Israeli study shows that 4th booster protection from infection wanes after just 4-weeks
- All-cause mortality strikingly higher in the vaccinated
- All-cause mortality in excess deaths are also escalating in Canada also as of summer of 2021
- More evidence that boosters are not getting the job done in elderly people
- How are the vaccinated doing in New Zealand compared to the unvaccinated?
- Hard to believe - Stanford kicks out and even deports students that will not keep up with the never-ending vax schedule
- VAERS Red Box COVID-19 vaccine monthly injury and death report - comparisons over time

Ready for a wild ride? You are about to embark on a chronological journey looking at a critical review of the development, rollout and aftermath of the riskiest human experiment of all-time.

Here we go!...

March 1st, 2021

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.

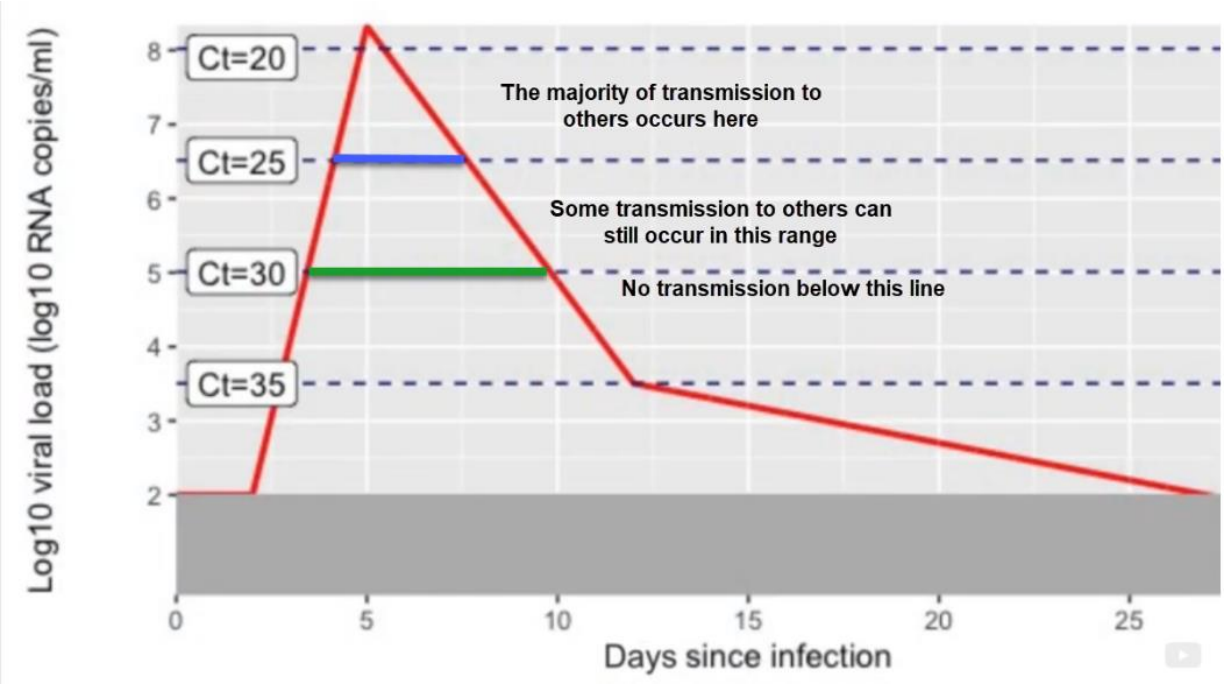
Story continued next page…

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.

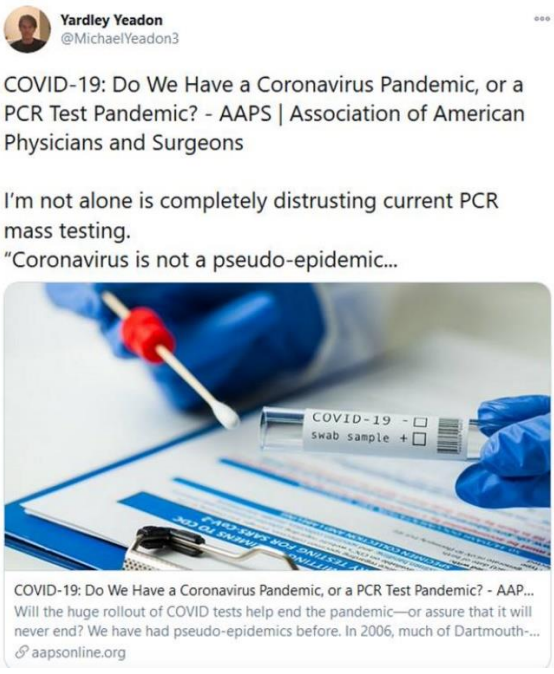
Because the respiratory disease lab had fewer entrenched systems than Lindstrom's previous lab, the review also found that basic mistakes were made. "The absence or failure of document control to ensure the use of a single verified correct test quality control procedure matching [Emergency Use Authorization]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

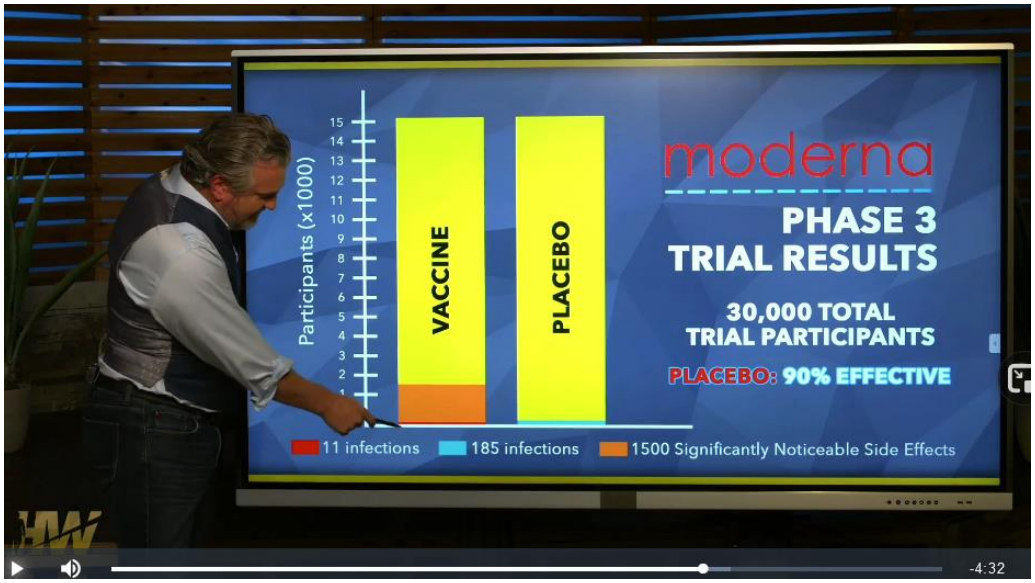
Well, that quote from Dr. Slaoui is a real smoke screen. Autoimmune disease, cancer or other chronic metabolic diseases take much longer to rear their ugly head, typically months or even years, not just the short 2 to 3 months since participants were injected. And, I would have to assume that someone 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.

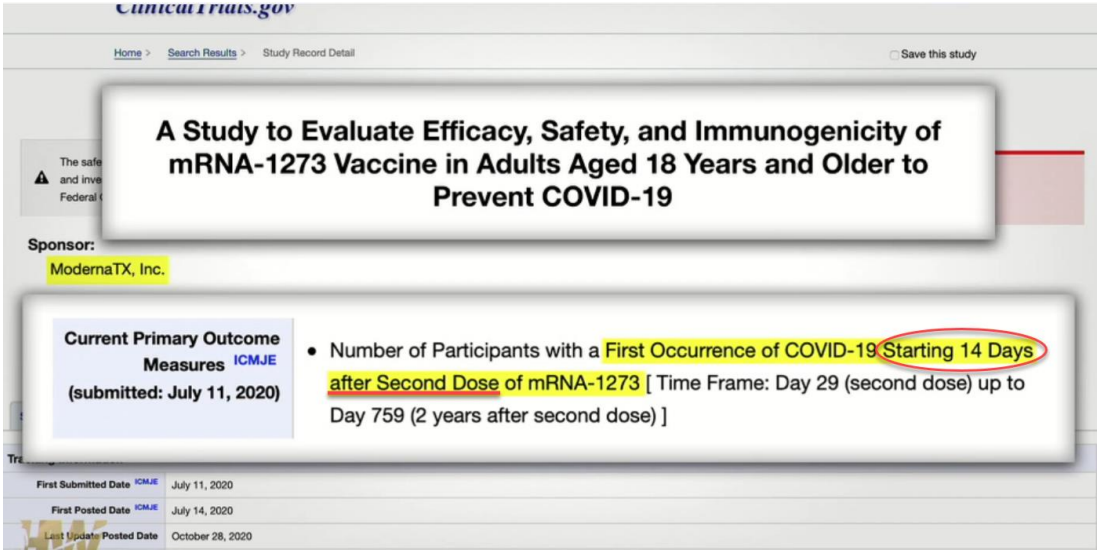
In the graphic below looking at the Moderna vaccine and using the 10-15% range of people experiencing significant side effects, Del shows that if just 10% (1,500 of 15,000 getting the shots) experienced those types of symptoms, the number of people experiencing those significant side effects from the 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."

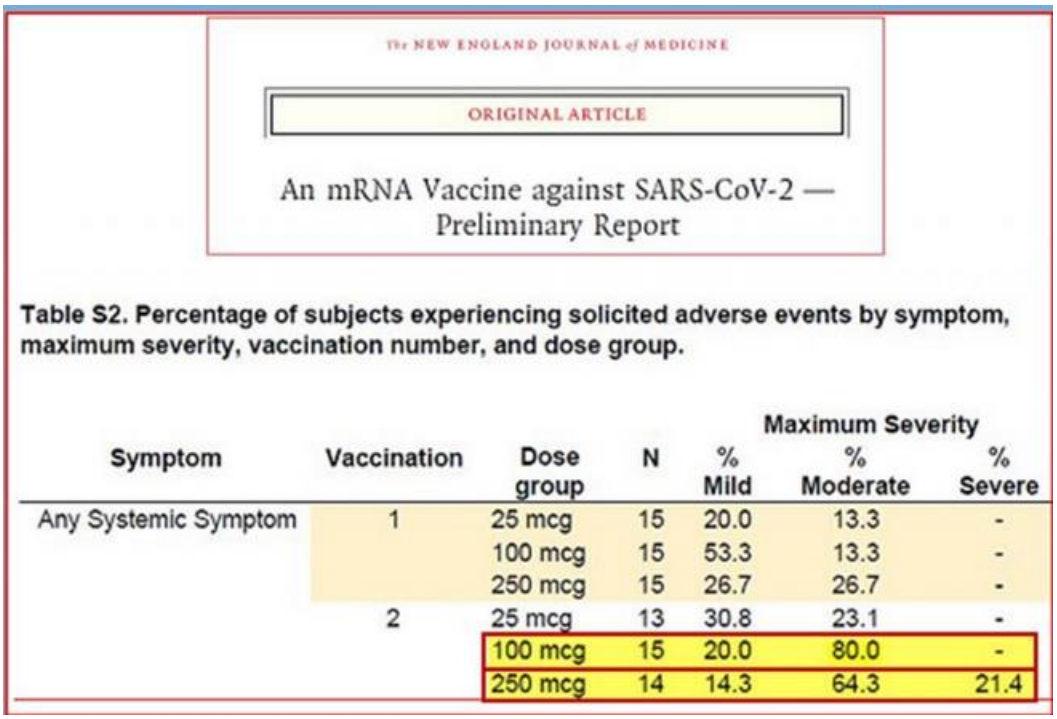
"**Their trick is to only capture adverse reactions that occur more than 28 days after injection *if* the participant withdraws from the clinical trial.** This is nonsensical, since there is little for a participant to withdraw from after getting two doses during the first 28 days of the clinical trial. 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

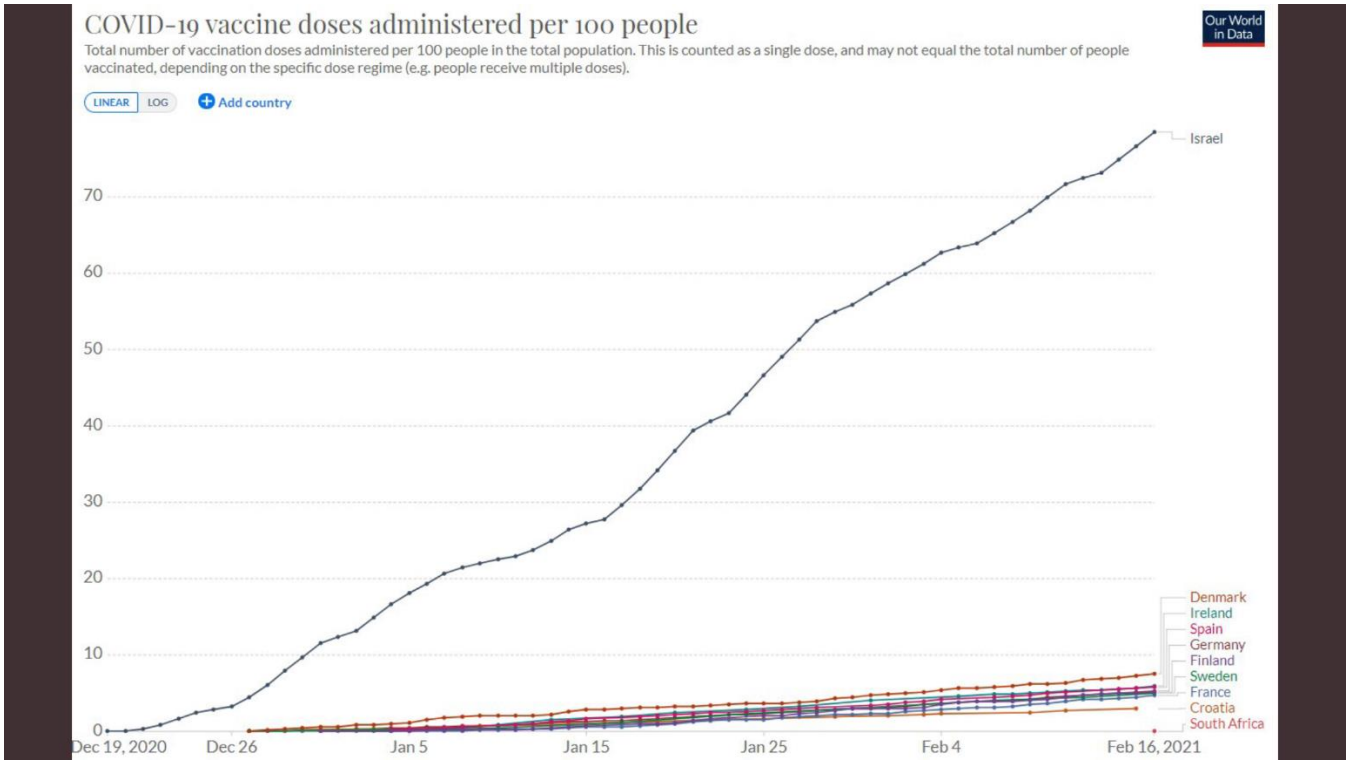
Spain halts vaccine in nursing home after 46 residents die shortly after the first Pfizer shot

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.

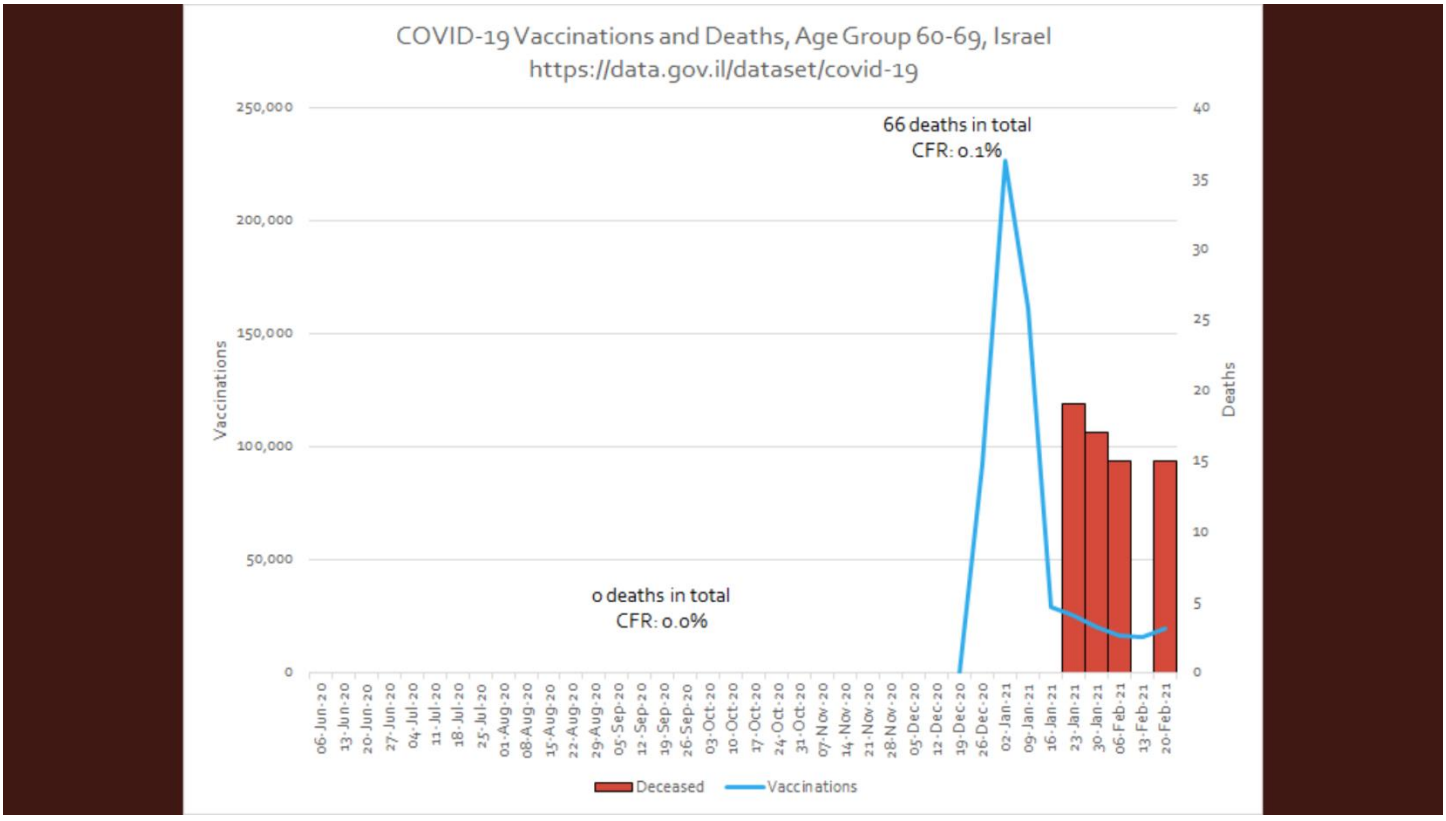
https://europerenaissance.com/2021/02/19/spain-second-pfizer-shots-halted-after-46-nursing-home-residents-die-after-the-first-shot/

Continued next page…

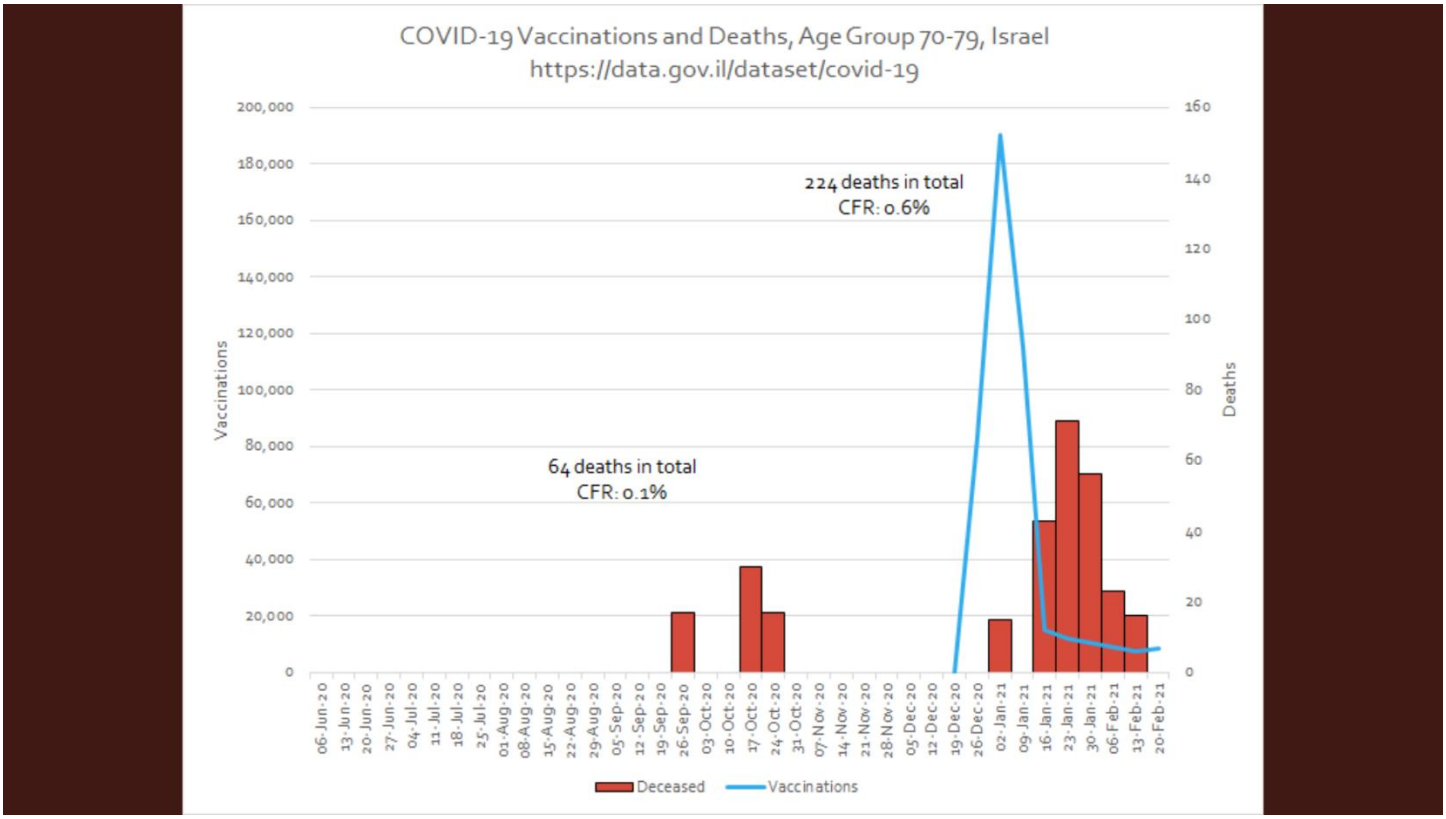
Israel has the highest rate of COVID-19 vaccine distribution in the world, but it seems to correlate with a large increase in deaths in their elderly



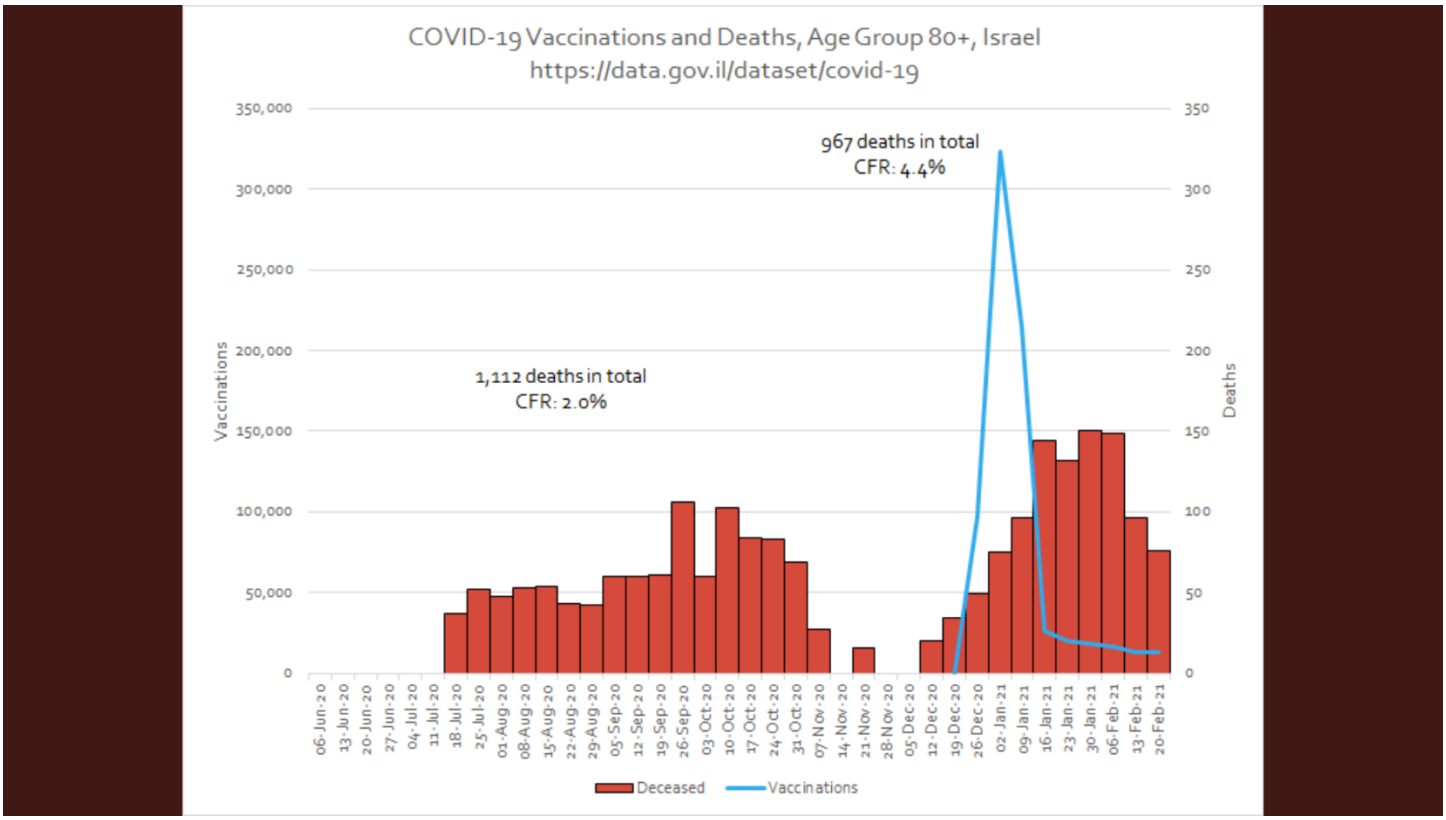
Deaths in the 60 to 69 year-old age group- Vaccination campaign is the blue line



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/

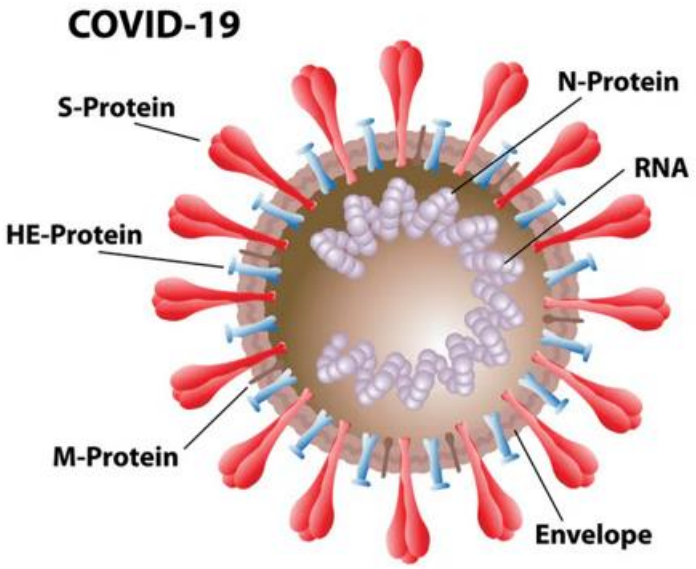
   This article reinforces that doctors have a poor level of awareness of the scope of the risk of allergic reactions to PEG. This is especially concerning since we are seeing a large uptick in allergic reactions from the COVID-19 vaccines, some fatal. Doctors need to know that this risk exists, how to 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?

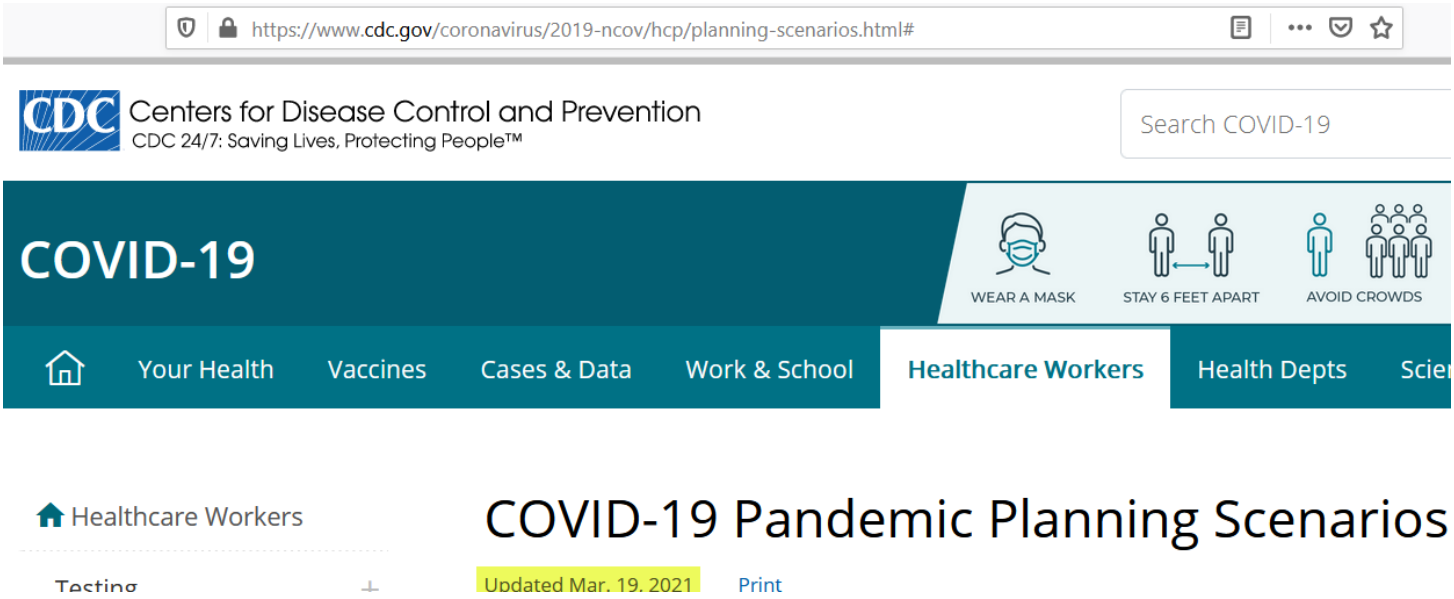
https://www.rt.com/news/516069-pfizer-covid19-vaccine-refrigerator-cold/

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:

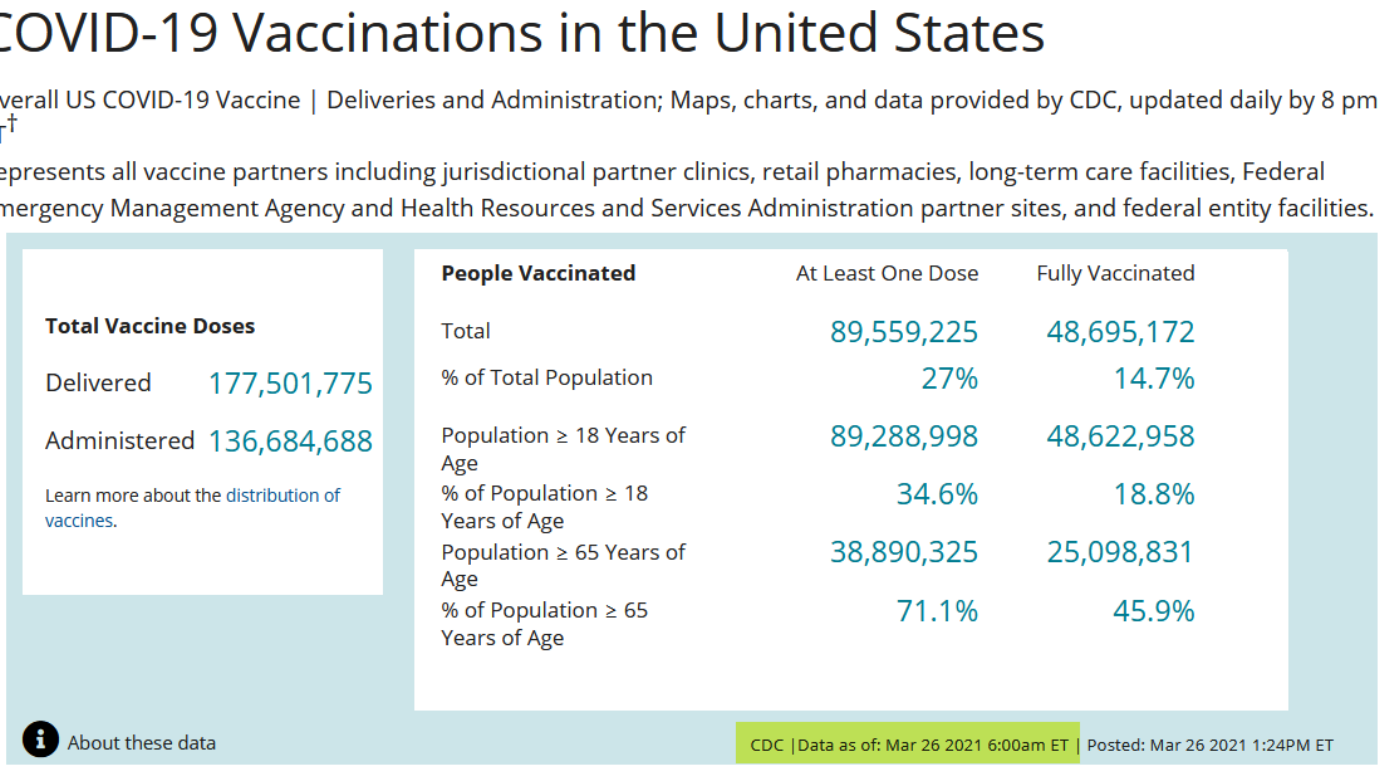
- In the 0-17 year-old age group, the Infection Fatality Rate is 0.002% (20 deaths per million infections, or 1 death in every 50,000 infections)

- 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

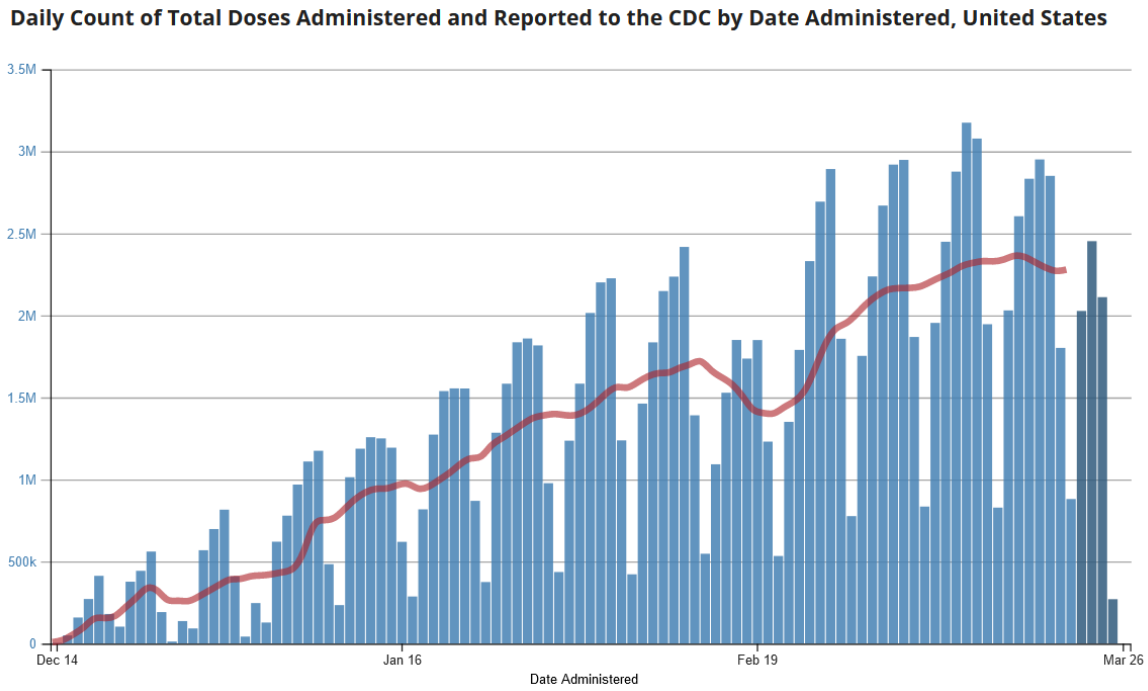
https://covid.cdc.gov/covid-data-tracker/#vaccinations

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



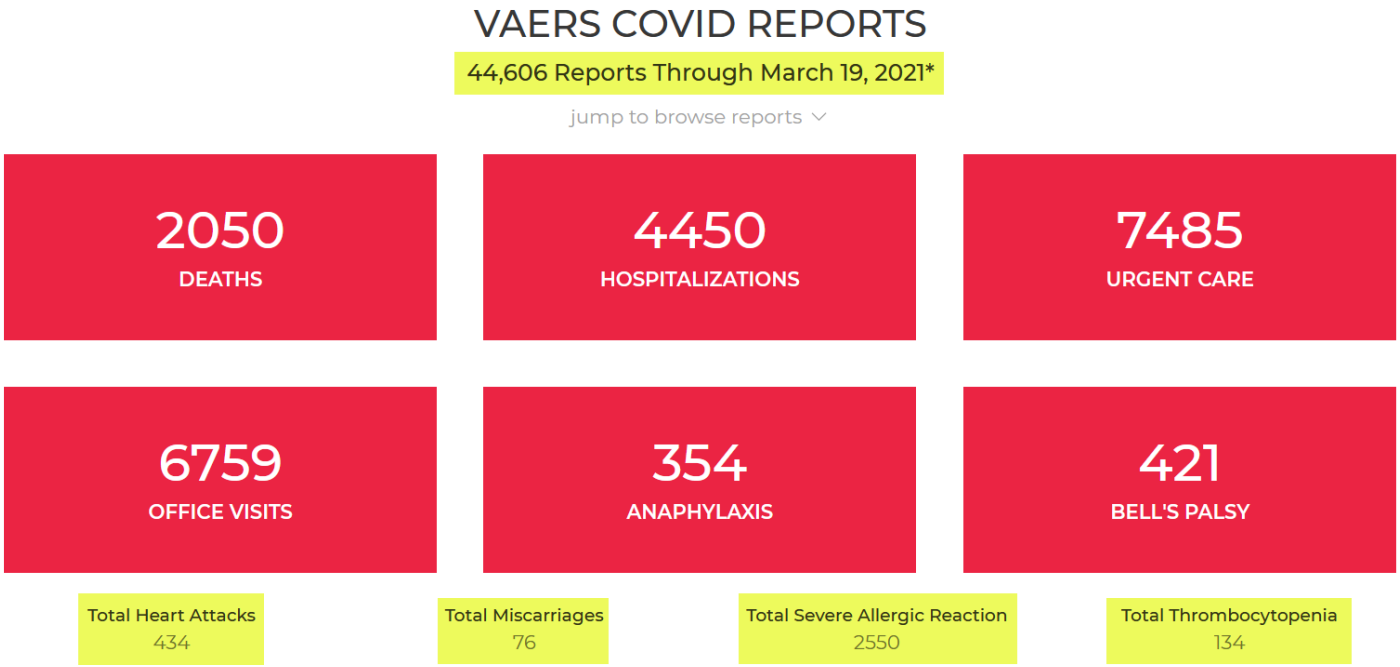
My calculation resulted in 14,123,487 doses March 19th (last VAERS death total available) through the 25th, the last full day reported for vaccines doses administered. Since I am calculating the number of people fully vaccinated and Pfizer and Moderna require 2 doses, I will divide the 14,123,487 does 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) X 100 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%)

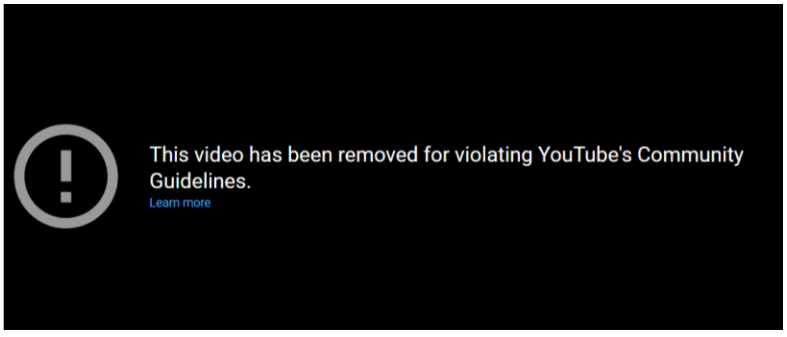
And remember, according to the ***Annals of Internal Medicine*** article above, the Infection Fatality Rate for the under 40 age group is only 0.01%. So according to their statistics the risk of death from the vaccines are nearly 5 times higher!

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.

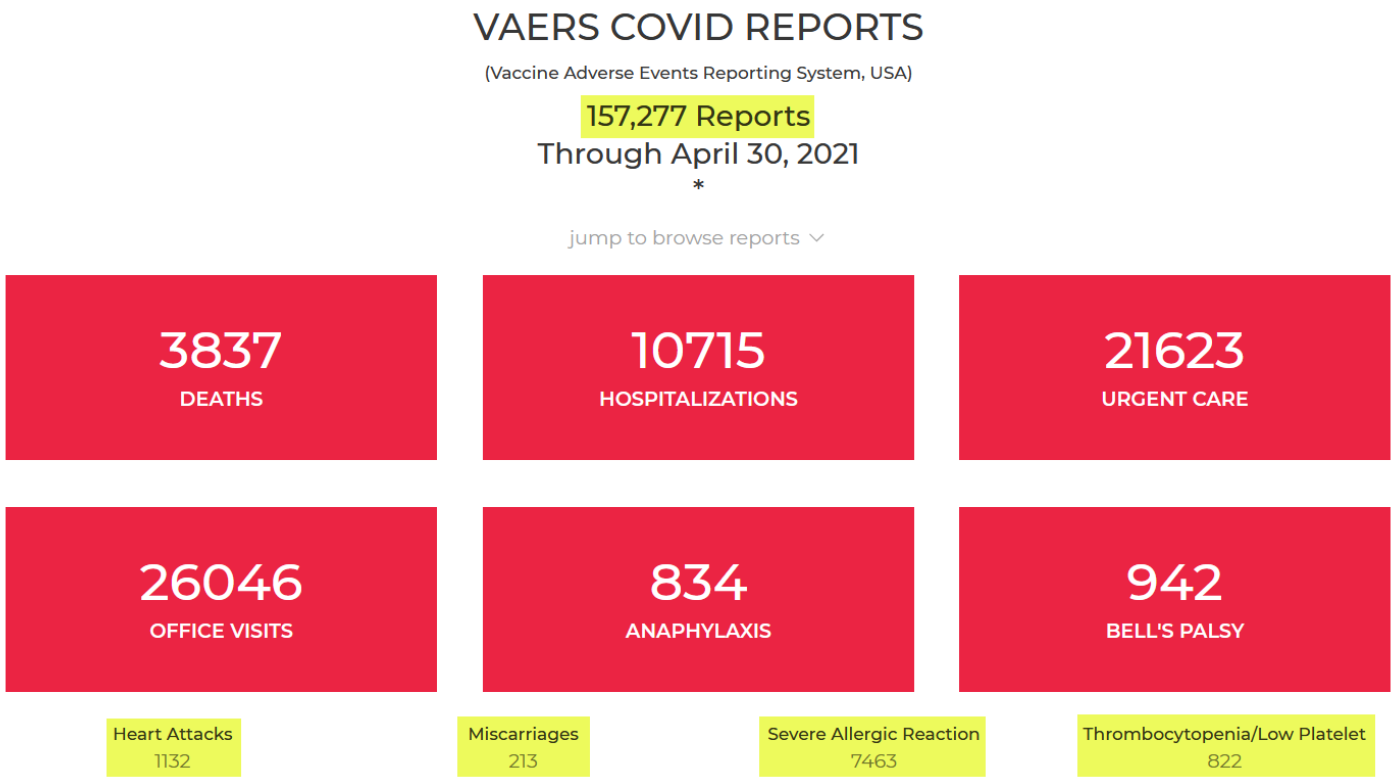
These are three events that were completely preventable. The shocking and maddening thing is that this is happening all over our country and the world, yet the media is silent. Doctors are either afraid or unwilling to report them because of being criticized for doing the right thing, or in some warped 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, 2021 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}.

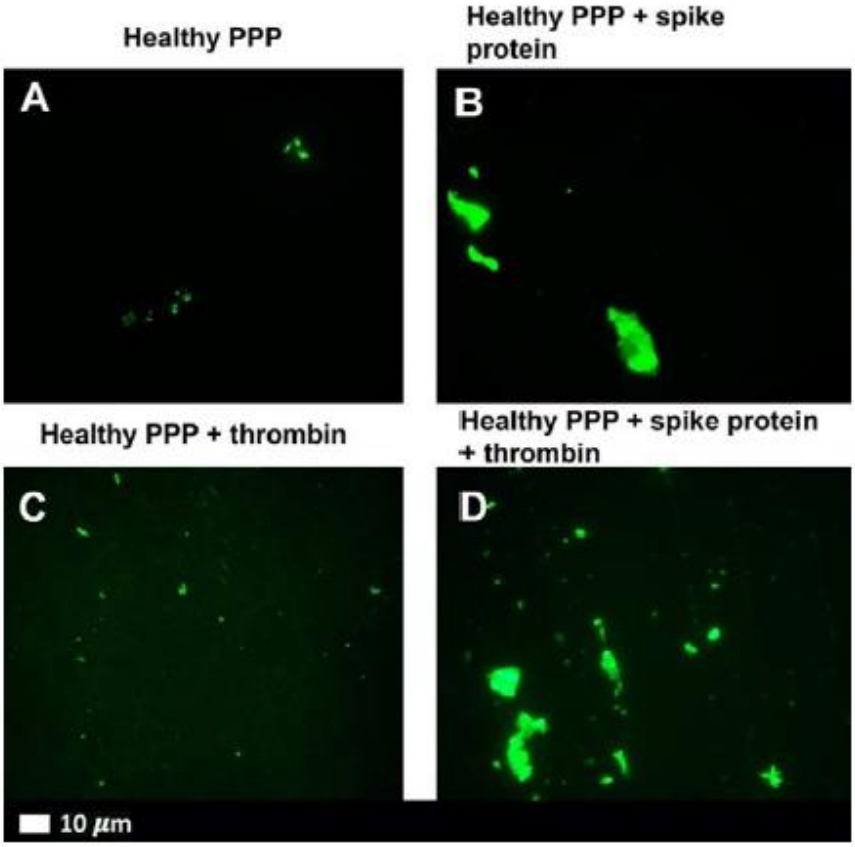


Figure 5A: Fluorescence microscopy micrographs of representative naïve whole blood (WB), where platelets were incubated with fluorescent marker, CD62P-PE. **B)** WB after exposure to spike protein. The white arrows point to hyperactivated activated platelets.

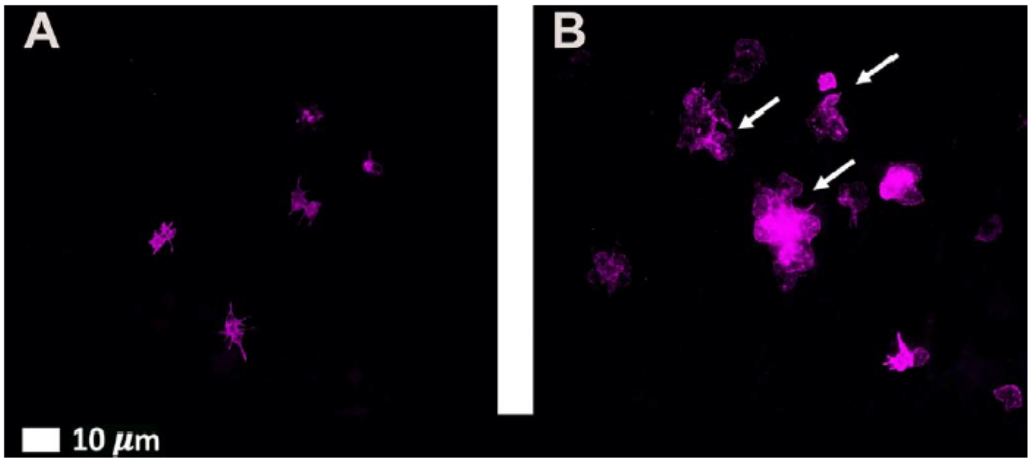


Figure 6A to H: Representative scanning electron micrographs of healthy control whole blood (WB), with and without spike protein. **A and B)** Healthy WB smears, with arrow indicating normal erythrocyte ultrastructure. **C to H)** Healthy WB exposed to spike protein (1 $ng.mL^{-1}$ final concentration), 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).

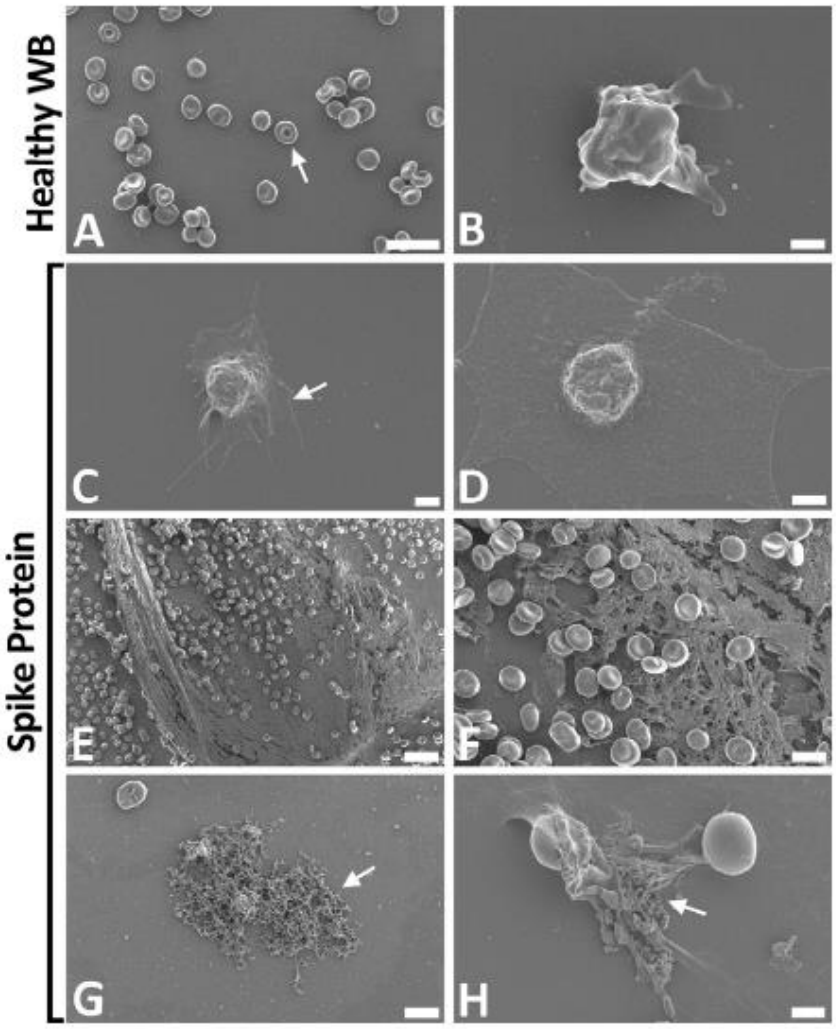
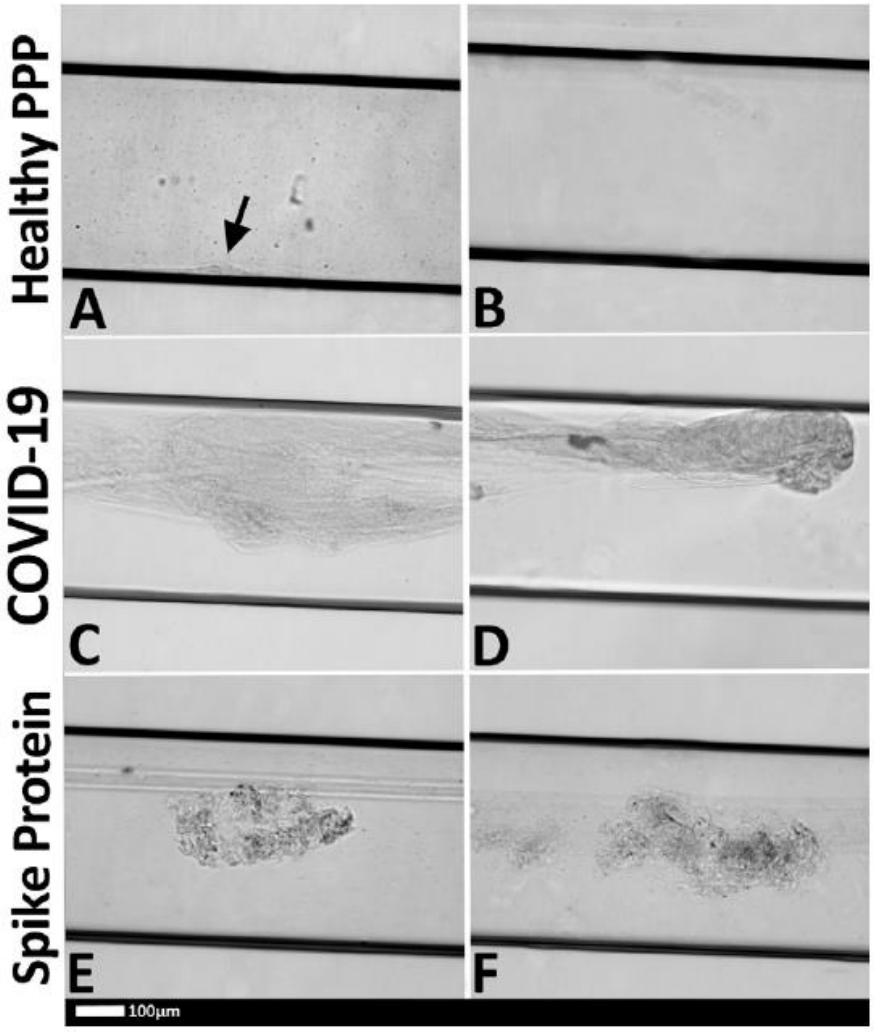


Figure 7: Representative micrographs of PPP clots in the microfluidic chambers (black horizontal lines are the outlines of the chambers) that were coated with thrombin. **A)** Healthy PPP clot, with small clot formation (arrow), with **B)** no clot formed in the healthy PPP sample; **C and D)** examples 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

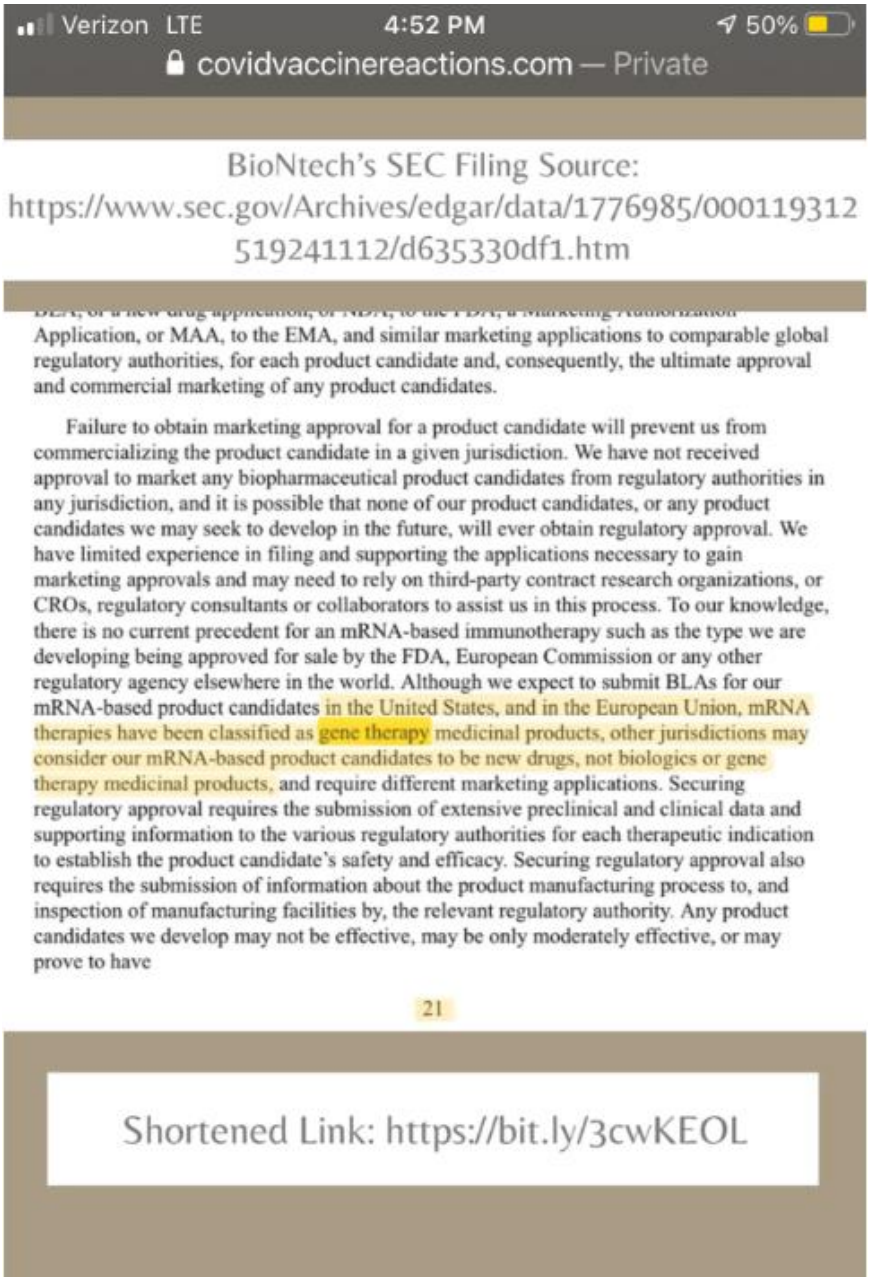
BioNTech SE
(Exact Name of Registrant as Specified in Its Charter)

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)

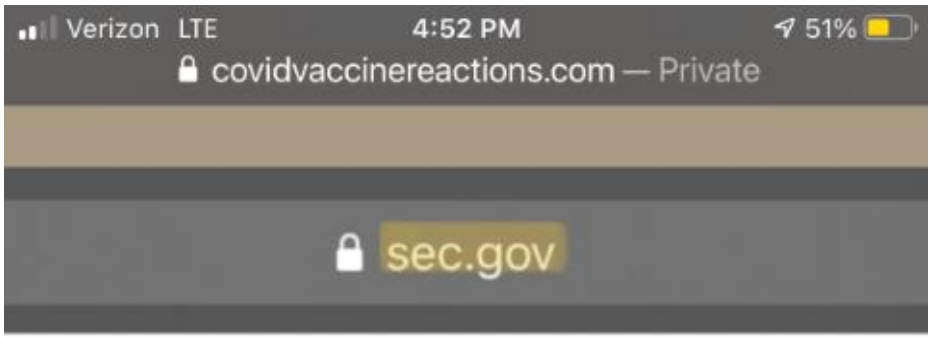
Prof. Ugur Sahin, M.D.
An der Goldgrube 12
D-55131 Mainz
Germany
Tel: +49 6131-9084-0
(Address, Including Zip Code, and Telephone Number, Including Area Code, of Registrant's Principal Executive Offices)

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

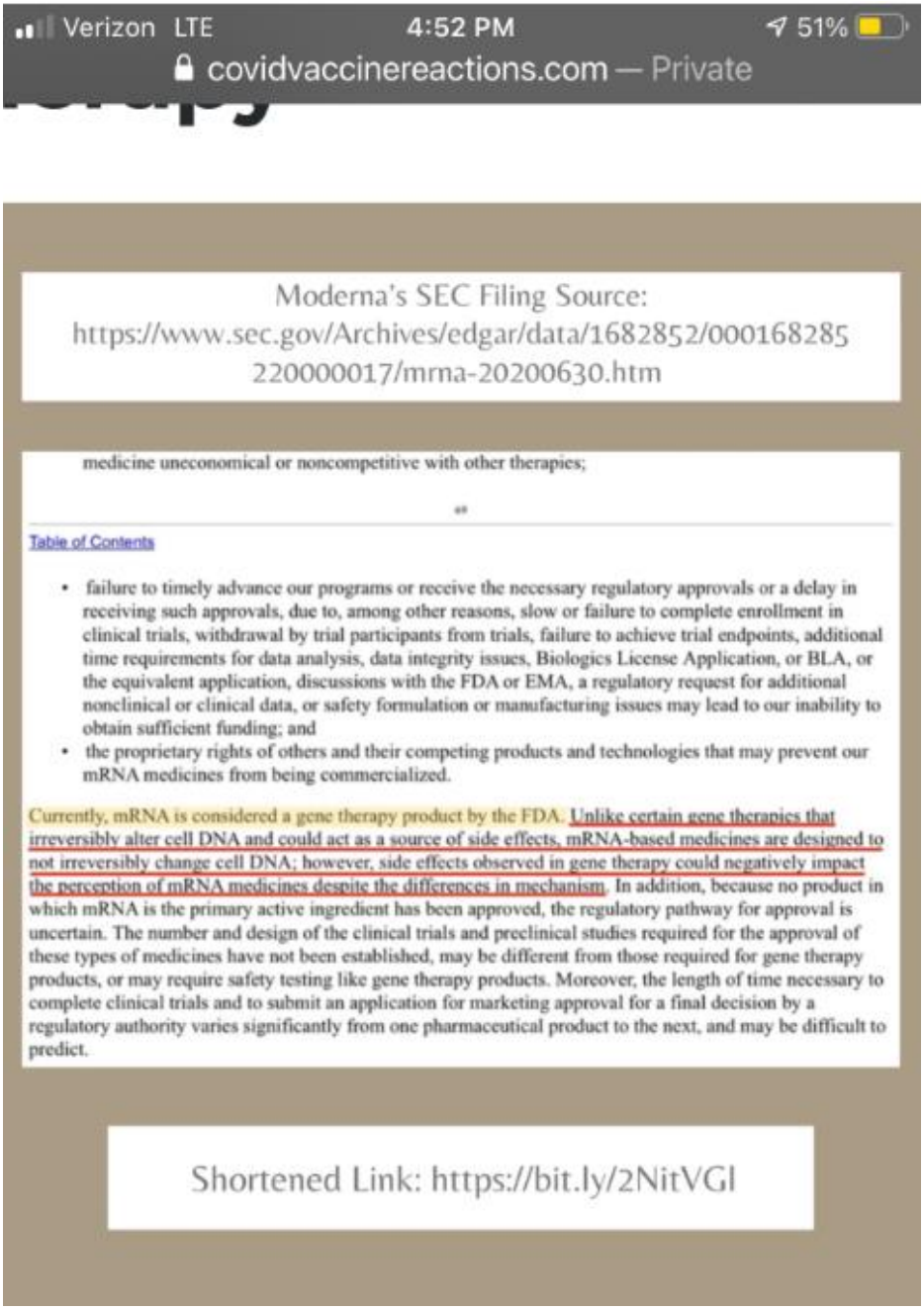
Moderna, Inc.
(Exact Name of Registrant as Specified in Its Charter)

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

Continued next page….



ENLARGED

Currently, mRNA is considered a gene therapy product by the FDA. Unlike certain gene therapies that irreversibly alter cell DNA and could act as a source of side effects, mRNA-based medicines are designed to not irreversibly change cell DNA; however, side effects observed in gene therapy could negatively impact the perception of mRNA medicines despite the differences in mechanism. In addition, because no product in which mRNA is the primary active ingredient has been approved, the regulatory pathway for approval is uncertain. The number and design of the clinical trials and preclinical studies required for the approval of

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].

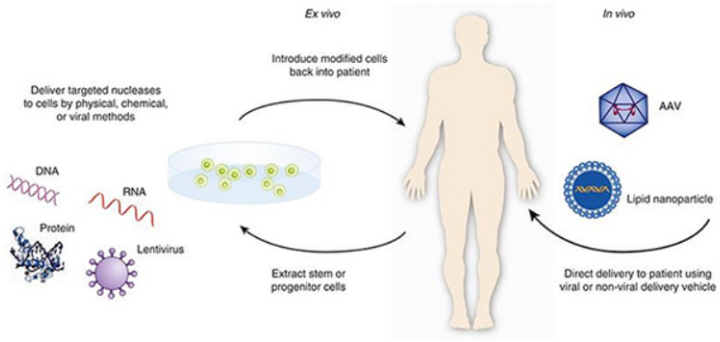
Gene therapy is a technique that modifies a person's genes to treat or cure disease. Gene therapies can work by several mechanisms:

- 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,

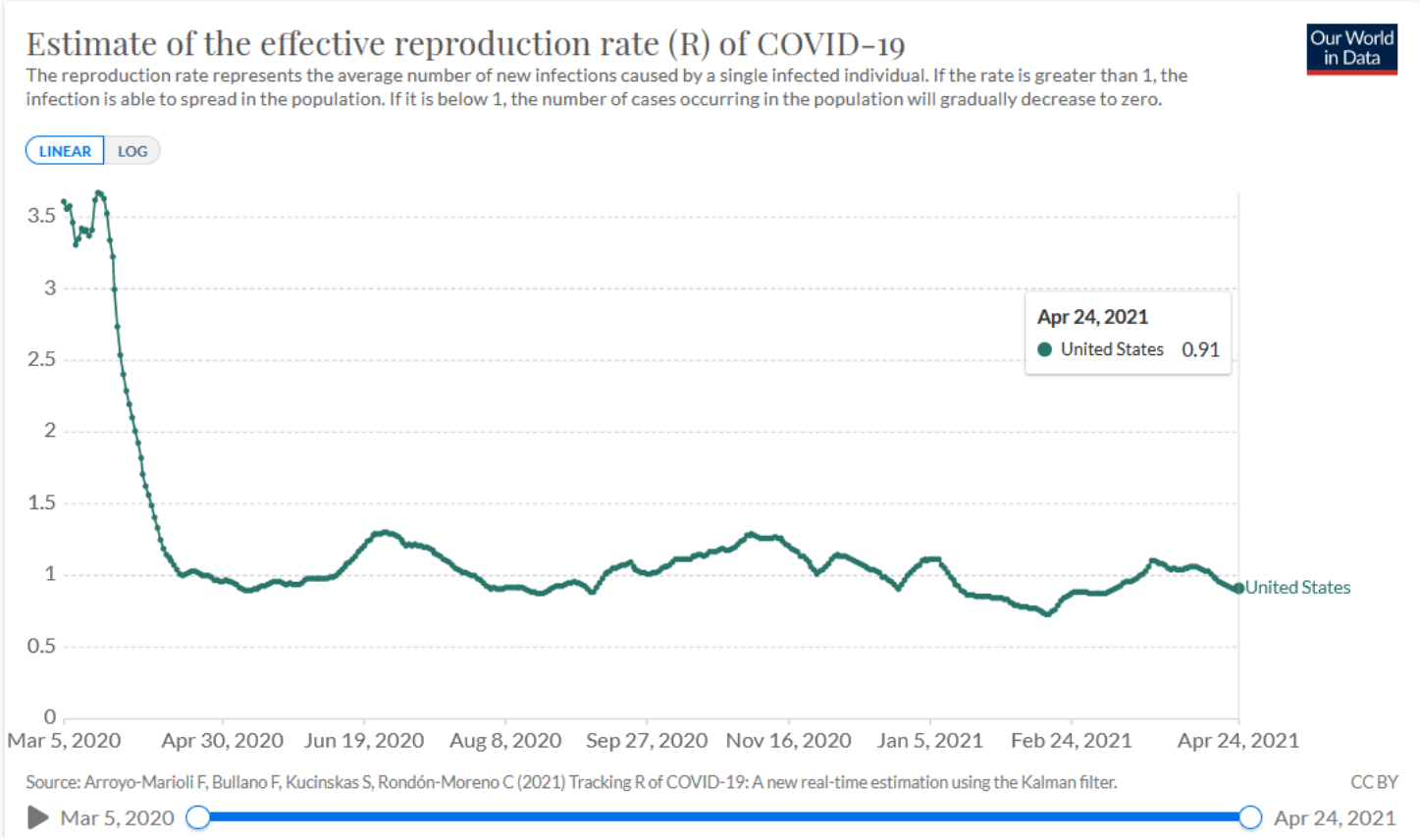
it would mean that we are over the number required to achieve herd immunity at a 60% coverage. Now there are certain things that have to be taken into consideration for this estimate to be accurate.

- 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),

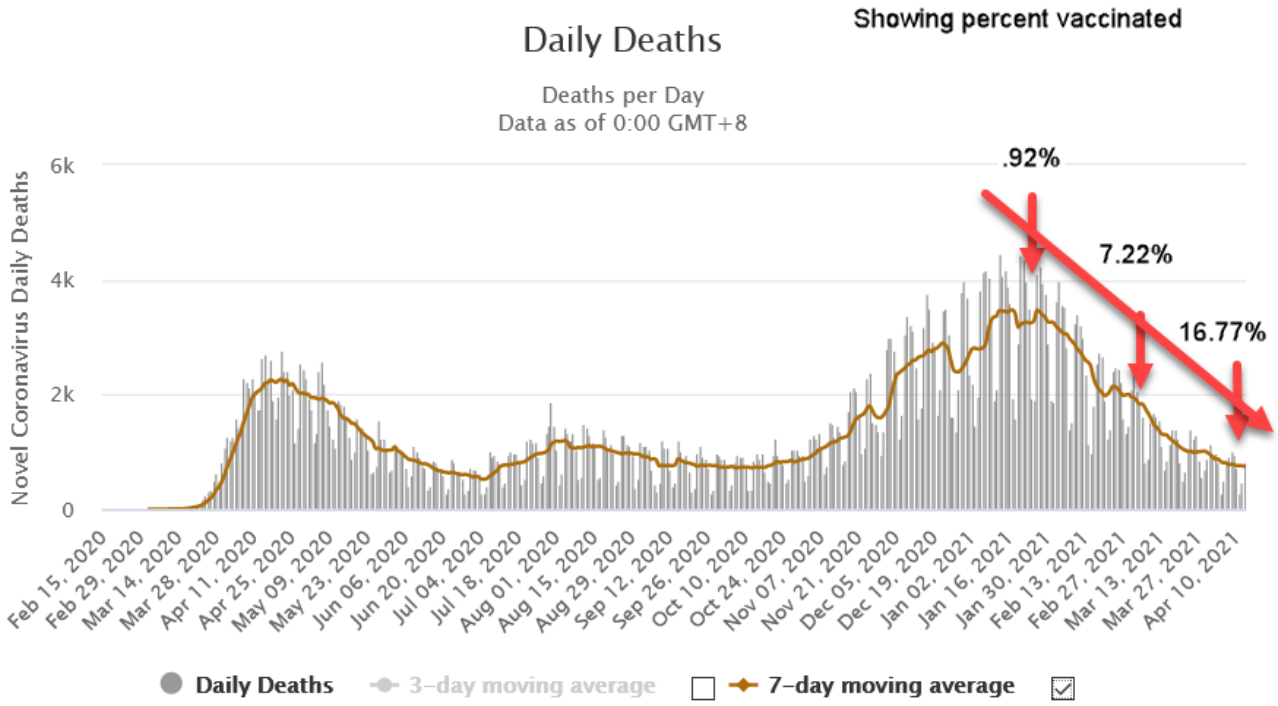


As of April 24th, the R-naught or Reproduction Rate of SARS-CoV-2 in the U.S. is under 1 at 0.91. That is a great sign and could be another indicator that we are reaching herd immunity.

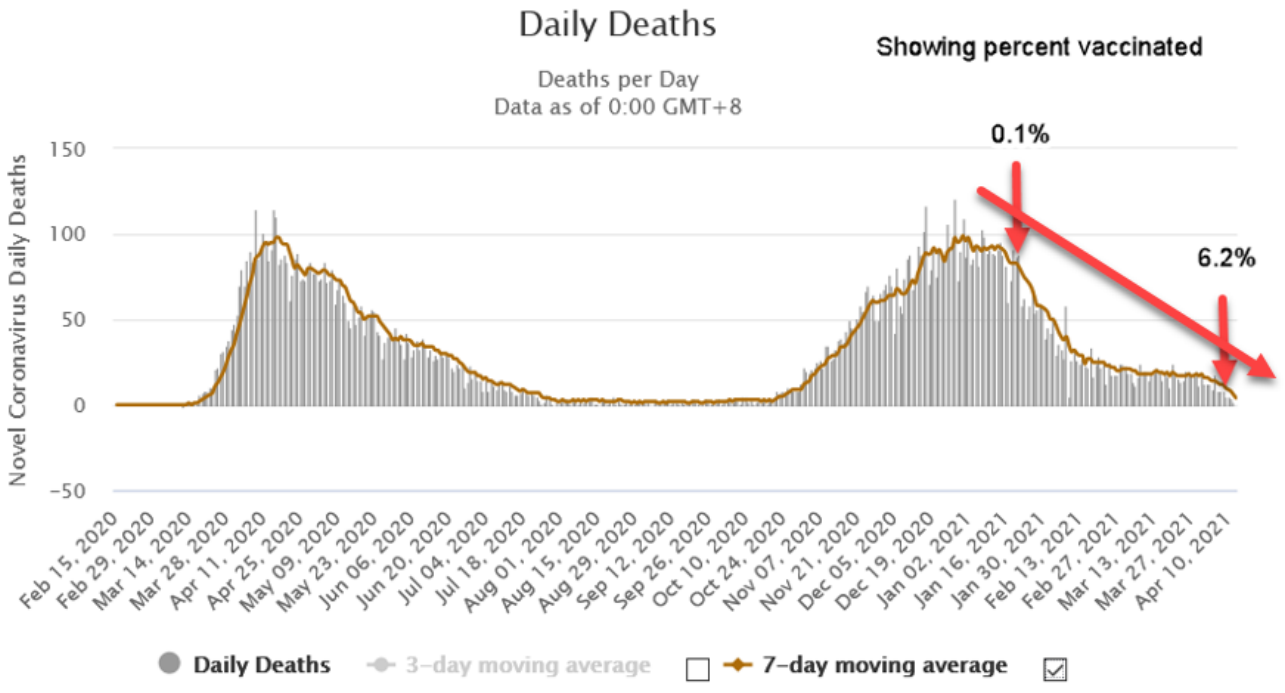
How much are the vaccines responsible for the drop in COVID-19 deaths?

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 June 1st, 2021

ACTION ALERT! We are facing an unprecedented crisis of injury and deaths from the COVID-19 vaccines. It must be stopped! Read this Citizen's Petition to the FDA from *Children's Health Defense* and comment on the FDA's web site.

This could be the most important citizen petition action you may ever take.

It is a BRILLIANT piece of work by Robert F. Kennedy Jr., Meryl Nass M.D. and the ***Children's Health Defense*** legal time. I have reproduced the Petition in its entirety here because it is so very vital that everyone helps in this effort.

Also, you can also go to this link and download the PDF AND COMMENT on this petition!

https://www.regulations.gov/document/FDA-2021-P-0460-0001 PLEASE share it widely!

Continued next page…

Children's Health Defense

www.childrenshealthdefense.org

May 16, 2021

Division of Dockets Management
Department of Health and Human Services
Food and Drug Administration
Acting Commissioner Janet Woodcock, M.D.
5630 Fishers Lane, Room 1061
Rockville, MD 20852

Dear Acting Commissioner Woodcock:

Enclosed is a Citizen Petition filed on behalf of Children's Health Defense by Meryl Nass, M.D., Scientific Advisory Board member, and Robert F. Kennedy, Jr., Board Chair and Chief Litigation Counsel, requesting that the FDA revoke Emergency Use Authorizations for existing COVID vaccines and refrain from approving and licensing them.

Dr. Nass and Mr. Kennedy look forward to your timely review of this petition. They are available to answer questions and to provide any additional relevant information.

Sincerely yours,

Mary Holland
President and General Counsel
(845) 445-7807
mary.holland@childrenshealthdefense.org

VIA ELECTRONIC FILING

May 16, 2021
Division of Dockets Management
Department of Health and Human Services
Food and Drug Administration
5630 Fishers Lane, Room 1061
Rockville, MD 20852

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND THE FOOD AND DRUG ADMINISTRATION
PETITION FOR ADMINISTRATIVE

ACTION REGARDING COVID-19 VACCINES
Docket No. _____

CITIZEN PETITION

On behalf of Children's Health Defense, the undersigned submit this petition under 21 C.F.R. § 10.20, § 10.30, § 50.23, § 600 − 680, § 601.2; 10 U.S.C. § 1107(f), § 1107a; 21 U.S.C. § 355(i)(4), § 360bbb-3; 42 U.S. Code § 247d; § 564 of the Federal Food, Drug, and Cosmetic Act (FDCA); the Public Readiness and Emergency Preparedness Act; the Public Health Service Act, and § 553(e) of the Administrative Procedures Act.
We request the Acting Commissioner of the Food and Drugs Administration (FDA) to issue, amend, revoke, or refrain from taking the administrative actions listed below regarding emergency use authorizations (EUAs), current and future new drug applications (NDAs), and biologics license applications (BLAs) for all COVID vaccines.

I. ACTIONS REQUESTED

1. FDA should revoke all EUAs and refrain from approving any future EUA, NDA or BLA for any COVID vaccine for all demographic groups because the current risks of serious adverse events or deaths outweigh the benefits, and because existing, approved drugs provide highly effective prophylaxis and treatment against COVID, mooting the EUAs.

2. Given the extremely low risk of severe COVID illness in children, FDA should immediately refrain from allowing minors to participate in COVID vaccine trials, refrain from amending EUAs to include children, and immediately revoke all EUAs that permit vaccination of children under 16 for the Pfizer vaccine and under 18 for other COVID vaccines.

3. FDA should immediately revoke tacit approval that pregnant women may receive any EUA or licensed COVID vaccines and immediately issue public guidance to that effect.

4. FDA should immediately amend its existing guidance for the use of the chloroquine drugs, ivermectin, and any other drugs demonstrated to be safe and effective against COVID, to comport with current scientific evidence of safety and efficacy at currently used doses and immediately issue notifications to all stakeholders of this change.

5. The FDA should issue guidance to the Secretary of the Defense and the President not to grant an unprecedented Presidential waiver of prior consent regarding COVID vaccines for Servicemembers under 10 U.S.C. § 1107(f) or 10 U.S.C. § 1107a.

6. The FDA should issue guidance to all stakeholders in digital and written formats to affirm that all citizens have the option to accept or refuse administration of investigational COVID vaccines without adverse work, educational or other non-health related consequences, under 21 U.S.C. § 360bbb-3(e)(1)(a)(ii)(III) [1] and the informed consent requirements of the Nuremberg Code.[2]

7. Pending revocation of COVID vaccine EUAs, FDA should issue guidance that all marketing and promotion of COVID vaccines must refrain from labeling them "safe and effective," as such statements violate 21 U.S.C. § 360bbb-3.

II. STATEMENT OF GROUNDS

A. Safety

8. Vaccine Adverse Event Reporting System (VAERS) data reveal unprecedented levels of deaths and other adverse events since the FDA issued Emergency Use Authorizations (EUAs) for three COVID vaccines. As of May 10, 2021, VAERS reported 4,434 deaths of people who received at least one COVID vaccination.[3]

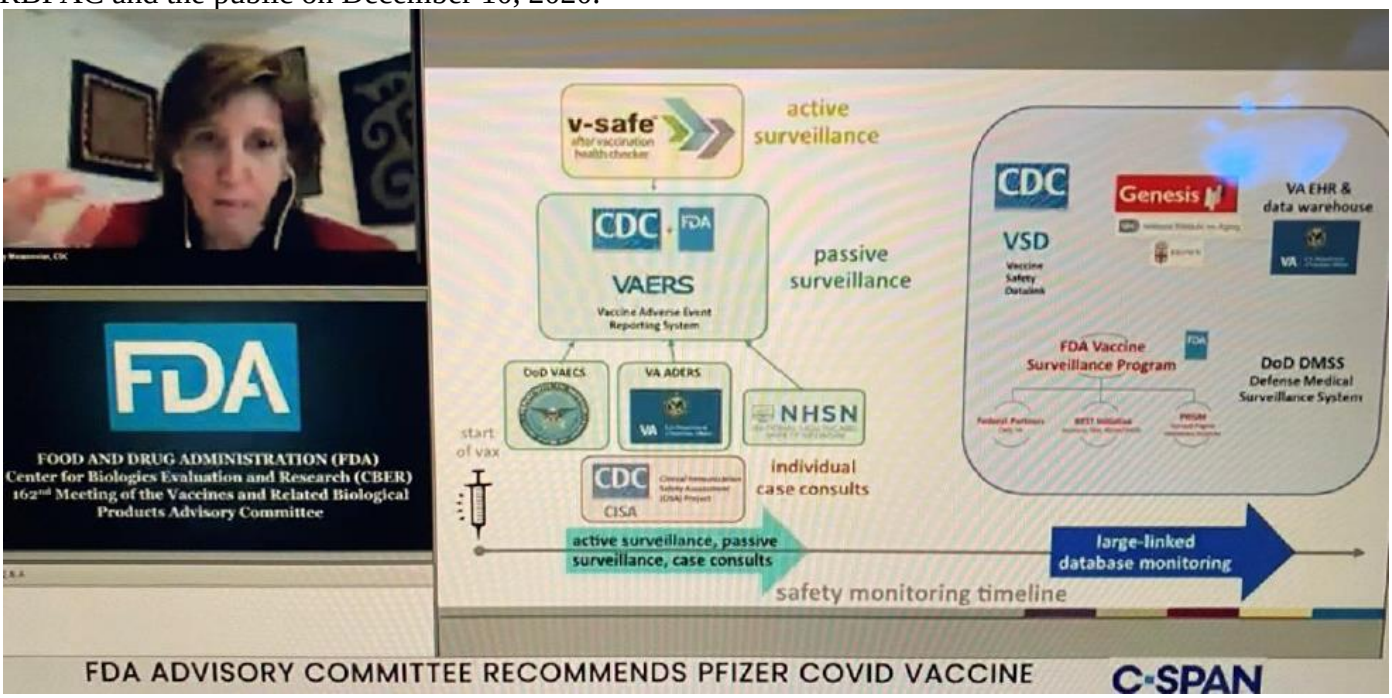
9. FDA and CDC have not responded to these data by issuing any warnings or restricting the use of these vaccines. Furthermore, the VAERS database is the only safety database to which the public has access. The government withholds extensive safety information from the public despite having at least ten additional data sources and expert consultants to analyze these data, according to Nancy Messonier, MD, the Director of the National Center for Immunization and Respiratory Diseases.[4] Examples include databases from the Centers for Medicare and Medicaid, the Veterans Administration, the Defense Department (DMSS), the Vaccine Safety Datalink and the "Genesis" database, which is operated in cooperation with the National Institutes of Health and Brown University and includes 250 long-term care facilities and 35,000 residents.

[1] 21 U.S.C. § 360bbb-3, Authorization for medical products for use in emergencies, https://www.govinfo.gov/content/pkg/USCODE-2011-title21/pdf/USCODE-2011-title21-chap9-subchapV-partE-sec360bbb-3.pdf.

[2] Nuremburg Code, BRITISH MEDICAL JOURNAL, No. 7070, Volume 313, p. 1448 (Dec. 7, 1996), https://media.tghn.org/medialibrary/2011/04/BMJ_No_7070_Volume_313_The_Nuremberg_Code.pdf.

[3] VAERS Vaccine Adverse Event Reporting System data, available at https://vaers.hhs.gov/.
[4] FDA meeting on COVID 19 and Emergency Use Authorization, Part 1 (Video), Dec. 10, 2020, available at https://www.c-span.org/video/?507053-1/fda-meeting-covid-19-vaccine-emergencyauthorization-part-1.

10. Dr. Messonier told the FDA and its Vaccines and Related Biological Products Advisory Committee (VRBPAC) on December 10, 2020 that it had 11 systems that would evaluate COVID vaccine safety. Five systems would be active at the start of the vaccine program, and an additional six systems would become active over ensuing weeks. She said that the VAERS system was being enhanced for long-term care facilities, and added, "Hopefully you'll understand how robust these systems are." Below is the graphic she presented to the VRBPAC and the public on December 10, 2020.



11. The CDC website, updated on May 11, 2021 states, "These vaccines have undergone and will continue to undergo the most intensive safety monitoring in U.S. history. This monitoring includes using both established and new safety monitoring systems to make sure that COVID-19 vaccines are safe."[5]

12. The CDC website states that "CDC and FDA physicians review each case report of death as soon as notified and CDC requests medical records to further assess reports."[6] By contrast, a CDC official told a reporter for *The Daily Beast* that it lacks a "good way to track deaths that occur after vaccination in real time." Furthermore, CDC told the reporter, "there are no current plans to include vaccination data in the current CDC Covid-19 mortality analysis."[7]

[5] CDC, *Safety of COVID-19 Vaccines* (updated May 11, 2021), https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/safety-of-vaccines.html.

[6] CDC, *Selected Adverse Events Reported after COVID-19 Vaccination* (updated May 11, 2021), https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html.

[7] Erin Banco, *White House asks CDC to study how many have died after COVID vaccine shots,*

13. Children's Health Defense asked CDC for information on post-vaccination deaths and injuries in early March 2021 and has yet to receive a response.[8]

14. Normally, licensed biologics manufacturers review adverse event reports pursuant to 21 C.F.R. § 600.80, while to date the CDC and the manufacturers appear to dispute most causal links to COVID vaccines. Any COVID vaccine license applicant "assumes responsibility for compliance with the applicable product and establishment standards" according to 21 C.F.R. § 600.3.[9] CDC asserts that a "review of available clinical information, including death certificates, autopsy, and medical records has not established a causal link to COVID-19 vaccines," yet recent assessments acknowledge "a plausible causal relationship between the J&J/Janssen COVID-19 vaccine and a rare and serious adverse event—blood clots with low platelets—which has caused deaths."[10] Denmark, among other nations, has banned the EUA J&J/Janssen COVID vaccine, stating, "the benefits of using the COVID-19 vaccine from J&J do not outweigh the risk of causing possible adverse effect in those who receive the vaccine."[11]

15. CDC calculated rates of adverse effects for anaphylaxis post-vaccination improperly, using VAERS reports as the numerator, even though CDC officials have acknowledged "it is not possible to use VAERS data to calculate how often an adverse event occurs in a population."[12] When Massachusetts General-Brigham hospitals evaluated the rate of anaphylaxis in employees post COVID vaccination, they found anaphylaxis rates approximately 50-100 times greater than the rates CDC calculated using VAERS data. (Pfizer rate 2.7/10,000 vaccinees and Moderna rate 2.3/10,000 vaccinees).[13] Anaphylaxis after vaccination has led to deaths. If this degree of underestimation holds true for other adverse events using the VAERS database, then the safety of COVID vaccines is considerably worse than it currently appears. This rate could be verified by querying the ten databases whose results have been hidden from the public.

DAILY BEAST (Jan. 28, 2021), https://www.thedailybeast.com/white-house-asks-cdc-to-studyhow-many-have-died-after-covid-vaccine-shots.

[8] Megan Redshaw, *64 Days and Counting — Why Won't the CDC Answer Our Questions?* THE DEFENDER (May 11, 2021), https://childrenshealthdefense.org/defender/64-days-why-wont-cdcanswer-questions/.

[9] Code of Federal Regulations Title 21 § 600.3, https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/cfrsearch.cfm?fr=600.3.

[10] CDC, *Selected Adverse Events Reported after COVID-19 Vaccination* (updated May 11,

2021), https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html.

[11] Vincent West, *Denmark ditches J&J COVID-19 shots from vaccination programme*, REUTERS (May 3, 2021), https://www.reuters.com/world/europe/denmark-excludes-jj-shot-vaccineprogramme-local-media-reports-2021-05-03/.

[12] CDC, Vaccine Adverse Event Reporting System (VAERS), https://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vaers/index.html.

[13] Blumenthal K. G., Robinson L. B., Camargo C. A., et al., *Acute Allergic Reactions to mRNA COVID-19 Vaccines*. JAMA, Vol. 325, No. 15, pp. 1562−1565 (Mar. 8, 2021), https://jamanetwork.com/journals/jama/fullarticle/2777417.

16. Other problems with vaccine safety assessment may exist because of inadequate animal toxicology and pharmacokinetic studies of COVID vaccines. Animal experiments failed to measure the quantity, duration and organ distribution of spike protein production. The animal experiments, incomprehensibly, failed to inject the actual vaccine to be tested during certain pharmacokinetic and toxicology tests. For example, in study 2.6.5.5B, only 2 of the 4 lipid nanoparticle (LNP) components were labeled and injected into rats, and their distribution and persistence in many organs were assessed at animal necropsy, from 15 minutes to 48 hours postinjection. For most organs, at 48 hours the amount of the two LNP components in each organ was still increasing. Thus, the ultimate distribution and persistence of the LNPs are unknown. And we have no information regarding duration and persistence of the mRNA or spike protein production in organs based on this study.[14]

17. A surrogate for mRNA (coding for spike protein) was an entirely different mRNA (coding for luciferase) in LNP injected into mice. In study 2.6.5.5A, bioluminescence was measured in liver through 9 days as a surrogate measure, while no attempt was made to evaluate the presence of spike protein in animal tissues, including in the brains of the experimental animals.[15] These surprising omissions have significant potential safety implications.

18. Given that only 1 to 13% of adverse reactions have been reported to the FDA and CDC via the VAERS passive reporting system, according to Lazarus et al., the high number of adverse events and deaths following COVID vaccines is alarming.[16] While the Pfizer vaccine has now been used for five months and administered to more than 60 million Americans, FDA has issued no new guidance about the vaccine based on these troubling data, apart from expanding its use in children.

19. The FDA must be aware that the only avenue for an injured party to claim benefits as a result of a COVID vaccine injury is the Countermeasures Injury Compensation Program (CICP).[17] The CICP requires petitioners to prove that the COVID vaccine caused their injuries; the program has an extremely short statute of limitations of one year. If the FDA, working with

[14] Study 2.6.5.5.B Pharmacokinetics: Organ Distribution. SARS-CoV-2 mRNA Vaccine (English Portion) (BNT162, PF-07302048), pp. 15-18, https://www.pmda.go.jp/drugs/2021/P20210212001/.

[15] *Id.*

[16] *See* Lazarus et al., *Electronic Support for Public Health-Vaccine Adverse Event Reporting System*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, DEPT. OF HEALTH AND HUMAN SERVICES (Sept. 30, 2010), https://digital.ahrq.gov/ahrq-funded-projects/electronic-supportpublic-health-vaccine-adverse-event-reporting-system; Shimabukuro et al., *Safety monitoring in the Vaccine Adverse Event Reporting System* (*VAERS*), VACCINE (Nov. 4, 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4632204/; S. Rosenthal and R. Chen, *The reporting sensitivities of two passive surveillance systems for vaccine adverse events*, AM J PUBLIC HEALTH (Dec. 1995), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1615747/.

[17] Health and Human Services Administration, *Countermeasures Injury Compensation Program*

(*CICP*), https://www.hrsa.gov/cicp.

the vaccine manufacturers, does not compile and publish an accurate list of adverse reactions, which is required for licensing, then these petitioners will have virtually no opportunity to prove injury or receive compensation.

B. Effectiveness

20. As with safety data on COVID vaccines, effectiveness data continue to evolve. Recently CDC acknowledged "vaccine breakthrough cases" where vaccinated subjects fall ill and potentially transmit the virus. CDC acknowledges that a "small percentage of people who are fully vaccinated against COVID-19 will still get sick and some may be hospitalized or die from COVID-

19. It's also possible that some fully vaccinated people might have infections, but not have symptoms (asymptomatic infections)."[18]

21. As of April 26, 2021, CDC reported over 9,000 "breakthrough cases" and 132 COVID-caused deaths among vaccinated people.[19] CDC tracks reports of breakthrough cases via the National Notifiable Diseases Surveillance System (NNDSS)[20] and has recently stopped reporting breakthrough cases absent death or hospitalization.[21] The British government has also identified efficacy problems stating, "The resurgence in both hospitalisations and deaths is dominated by those that have received two doses of the vaccine, comprising around 60% and 70% of the wave respectively."[22]

22. The U.K. data modelers attribute these rates to the high level of vaccine uptake in the most at-risk elderly age group.[23] Overall, the U.K. believes "evidence shows vaccines are ***sufficiently*** effective in reducing hospitalisations and deaths in those vaccinated."[24] The U.K. caveat "sufficiently" is significant compared to the unqualified "effective" label that the FDA currently permits to be communicated to the public.

[18] CDC, *What You Should Know About the Possibility of COVID-19 Illness After Vaccination*; (updated April 21, 2021), https://www.cdc.gov/coronavirus/2019-ncov/vaccines/effectiveness/why-measure-effectiveness/breakthrough-cases.html.

[19] CDC, *COVID-19 Breakthrough Case Investigations and Reporting* (updated April 30, 2021), https://www.cdc.gov/vaccines/covid-19/health-departments/breakthrough-cases.html.

[20] CDC, *National Notifiable Diseases Surveillance System* (*NNDSS*), https://wwwn.cdc.gov/nndss/.

[21] CDC, *COVID-19 Breakthrough Case Investigations and Reporting* (April 30, 2021), https://www.cdc.gov/vaccines/covid-19/health-departments/breakthrough-cases.html.

[22] *SPI-M-O: Summary of further modelling of easing restrictions – Roadmap Step 2*, p. 10 (Mar. 31, 2021), https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/975909/S1182_SPI-M-O_Summary_of_modelling_of_easing_roadmap_step_2_restrictions.pdf.

[23] *Id*.

[24] GOV.UK; *COVID-19 Response-Spring 2021* (*Summary*) (Feb. 22, 2021), https://www.gov.uk/government/publications/covid-19-response-spring-2021/covid-19-responsespring-2021-summary.

C. Misbranding as "Safe, Effective and FDA Approved"

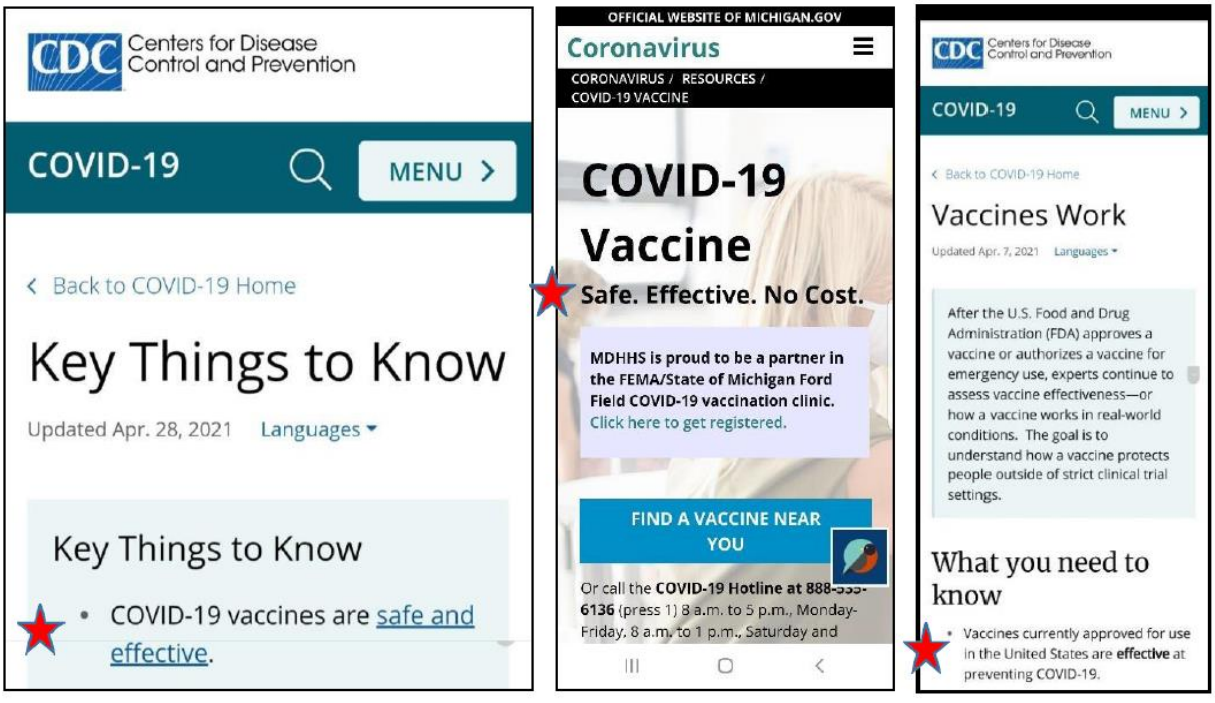
23. Recently the FDA sent a warning letter "RE: Unapproved and Misbranded Products Related to Coronavirus Disease 2019 (COVID-19)."[25] FDA warned that labeling COVID therapies as Safe, Effective or FDA Approved when they are not proven to be so by FDA standards violates § 505(a) of the FDCA, 21 U.S.C. § 355(a). The same standard should apply to COVID vaccines, as any such products are misbranded drugs and violate § 502 of the FDCA and 21 U.S.C. § 352.

24. The introduction or delivery for introduction of any such product into interstate commerce is prohibited under § 301(a) and (d) of the FDCA and 21 U.S.C. § 331(a) and (d). The FDA specifically warned a vendor: "We advise you to review your websites, product labels, and other labeling and promotional materials to ensure that you are not misleadingly representing your products as *safe and effective* for a COVID-19-related use for which they have *not been approved* by FDA and that you do not make claims that misbrand the products in violation of the FD&C Act."

25. FDA must ensure against misrepresenting COVID vaccine products as "safe and effective" when FDA has not so designated them. FDA's description of COVID vaccines pursuant to § 564(d)(3) of the Act states: "based on the totality of scientific evidence available to FDA…it is reasonable to believe that Pfizer-BioNTech COVID-19 Vaccine *may be effective* in preventing COVID-19 when used in accordance with this Scope of Authorization (Section II), pursuant to Section 564(c)(2)(A) of the Act." The FDA language on effectiveness provides a qualification similar to the above-mentioned U.K. regulatory language. FDA's precise technical language to manufacturers does not match its unequivocal "effective" claims on official government websites, including that of the CDC, as illustrated below.[26]

[25] FDA, *Warning Letter to Mercola.com, LLC* (Feb. 18, 2021), https://www.fda.gov/inspectionscompliance-enforcement-and-criminal-investigations/warning-letters/mercolacom-llc-607133-02182021.

[26] CDC, *Key things to know about COVID-19 vaccines* (May 10, 2021), https://www.cdc.gov/coronavirus/2019-ncov/vaccines/keythingstoknow.html;
CDC, *Safety of COVID-19 vaccines* (udated May 11, 2021), https://www.cdc.gov/coronavirus/2019- ncov/vaccines/safety/safety-of-vaccines.html;
FDA, *Letter to Pfizer* (May 10, 2021), https://www.fda.gov/media/144412/download.



D. EUA revocation, additional EUAs, and off-label use clarification for COVID therapies

26. On February 4, 2020 the Secretary of the Department of Health and Human Services (HHS) determined that there is a public health emergency that has a significant potential to affect national security or the health and security of United States citizens living abroad and that involves the virus that causes Coronavirus Disease (COVID-19). Based on this determination, the Secretary on March 27, 2020 declared that circumstances justify emergency use of drugs and biological products during the COVID-19 pandemic pursuant to § 564 of the FDCA (21 U.S.C. § 360bbb-3).

27. Since December 2020, several manufacturers have received EUAs for COVID vaccines. One of the criteria for these authorizations, beyond the existence of an emergency, is that there are "no adequate, approved, and available alternatives."[27] Many medical professionals and elected officials have objected to the inconsistent handling of EUAs for alternative treatments. Dr. Peter McCullough testified to the Texas Senate on March 10, 2021 that an 85% lower mortality rate from COVID would have been possible if government agencies had publicly recommended early treatments.[28] Now that COVID cases and deaths are decreasing because many if not most Americans are immune, the relative benefit of COVID vaccines has diminished.[29]

[27] FDA, *Emergency Use Authorization* (updated May 11, 2021), https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policyframework/emergency-use-authorization;
FDA, *FAQs on Emergency Use Authorizations* (*EUAs*) *for Medical Devices During the COVID-19 Pandemic* (updated April 23, 2021), https://www.fda.gov/medicaldevices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/faqsemergency-use-authorizations-euas-medical-devices-during-covid-19-pandemic.

28. Three U.S. Senators asked the FDA to clarify why it revoked the previously granted EUAs for hydroxychloroquine (HCQ) and chloroquine (CQ) and under what authority it regulates the practice of medicine. The Senators also asked what authority states have to regulate the prescribing and dispensing of drugs.[30] FDA issued and revoked EUAs for HCQ and CQ donated to the Strategic National Stockpile in a way that confused medical professionals, resulting in their reluctance to prescribe the drugs, including those not under EUA. FDA improperly recommended against the use of chloroquine drugs in outpatients, and against early treatment, which is when these antiviral drugs are likely to be effective. FDA appears to have collaborated with officials in dozens of states and even with certain pharmaceutical and pharmacy companies to restrict the prescribing and dispensing of chloroquine drugs against COVID. These unprecedented actions require explanation. The FDA must immediately revoke its recommendations for the limited use and withholding of these drugs during a life-threatening pandemic and must publicize its revocation widely.

29. Medical professionals also question FDA's approval of Investigational New Drug (IND) human trials performed by the University of Pittsburg (REMAP-COVID)[31] and the University of Philadelphia (PATCH)[32] using knowingly borderline lethal doses of HCQ in humans.There were more deaths in the HCQ arm than in the control arm of the REMAP-COVID study and in the other two large multicenter studies, the Solidarity and Recovery studies, that used excessive doses. The PATCH study ended after enrolling only 5 subjects.

30. In other FDA guidance regarding the chloroquine drugs, FDA made the misleading claim that "Hospitalized patients were likely to have greater prospect of benefit (compared to ambulatory patients with mild illness)," and that chloroquine drugs have a "slow onset of action." In its justification for restricting the use of chloroquine drugs, FDA also opined that "it is no longer reasonable to believe that oral formulations of HCQ and CQ may be effective in treating COVID- 19, nor is it reasonable to believe that the known and potential benefits of these products outweigh their known and potential risks."[33]

[28] Dr. Peter McCullough's testimony to the Texas Senate HHS Committee (Mar. 10, 2021), https://www.youtube.com/watch?v=QAHi3lX3oGM.

[29] Dr. Peter McCullough et al., *SARS-CoV-2 mass vaccination: Urgent questions on vaccine safety 2 that demand answers from international health agencies, regulatory 3 authorities, governments and vaccine developers* (May 8, 2021), https://www.andrewbostom.org/wpcontent/uploads/2021/05/Bruno-et-al.-Vaccine-Safety-Urgent-Manuscript-Preprint-May-8-2021.pdf.

[30] Senators Ted Cruz, Mike Lee, Ron Johnson, *Letter to FDA Commissioner Stephen Hahn* (Aug. 18, 2020), https://www.hsgac.senate.gov/imo/media/doc/2020-08-18%20RHJ%20Letter%20to%20FDA%20on%20HCQ%20+%20CQ.pdf.

[31] UNIVERSITY OF PITTSBURG, Department of Critical Care, *UPMC Leads Global Efforts to Fasttrack COVID-19 Therapies*, https://www.ccm.pitt.edu/node/1110.

[32] *Penn Launches Trial to Evaluate Hydroxychloroquine to Treat, Prevent COVID-19*, PENN MEDICINE NEWS (April 3, 2020), https://www.pennmedicine.org/news/news-releases/2020/april/penn-launches-trial-to-evaluate-hydroxychloroquine-to-treat-prevent-covid19; *The PATCH Trial* (*Prevention And Treatment of COVID-19 With Hydroxychloroquine*) (*PATCH*), CLINICALTRIALS.GOV (updated Dec. 10, 2020), https://clinicaltrials.gov/ct2/show/NCT04329923.

31. These claims fly in the face of substantial evidence of positive effects of the drugs when used early in the disease at usual, approved, therapeutic doses. FDA has chosen to ignore the many trials that were properly conducted. The FDA buttresses its contention of the dangers of these drugs based in part on the FDA-approved trial and other trials that administered excessive, non-therapeutic doses of HCQ and resulted in more deaths in the treated group than the placebo group.

32. Similarly, FDA exhibited bias regarding the effective and safe use of ivermectin for prophylactic use of COVID. In March 2021, the agency stated: "The FDA has not reviewed data to support use of ivermectin in COVID-19 patients to treat or to prevent COVID-19; however, some initial research is underway."[34] Yet already on April 10, 2020, FDA had issued a public warning against the use of ivermectin because, it claimed, Americans were purchasing over the counter (OTC) veterinary ivermectin as a COVID treatment.[35] Research from Australia had been published online a week earlier, on April 3, 2020, supporting use of ivermectin for COVID based on in vitro studies.[36]

33. Thus, FDA was aware at least 13 months ago that Americans were using ivermectin to treat and prevent COVID. How could FDA not have reviewed data on ivermectin during an entire year after it was informed about this use? That was a year during which dozens of studies about the drug's use were available as publications or preprints for both prophylaxis and treatment; during which there was a Senate hearing on the drug; and during which half a million Americans died from the disease, who had not been treated with effective medications because of FDA guidance.

34. Furthermore, ivermectin has been used OTC for COVID in many countries and regions with excellent reported treatment success. The drug's safety has been established with at least a billion doses used, and the drug is on the World Health Organization's list of essential drugs.

[33] FDA Letter revoking EUA for Hydroxychloroquine (Jun. 15, 2020), https://www.fda.gov/media/138945/download.

[34] FDA, *Why You Should Not Use Ivermectin to Treat or Prevent COVID-19* (updated May 10, 2021), https://www.fda.gov/consumers/consumer-updates/why-you-should-not-use-ivermectintreat-

or-prevent-covid-19.

[35] FDA Letter to Stakeholders, *Do Not Use Ivermectin Intended for Animals as Treatment for COVID-19 in Humans* (April 10 2020), https://www.fda.gov/animal-veterinary/product-safetyinformation/fda-letter-stakeholders-do-not-use-ivermectin-intended-animals-treatment-covid-19-humans.

[36] Leon Caly, Julian D. Druce, *The FDA-approved drug ivermectin inhibits the replication of SARS-CoV-2 in vitro*, ANTIVIRAL RESEARCH, vol. 178, 104787 (Jun. 2020), https://reader.elsevier.com/reader/sd/pii/S0166354220302011.

35. Many medical professionals suspect FDA's feigned ignorance about the drug was a prerequisite to issuing EUAs for COVID vaccines, given the EUA requirement that no approved drug may be available for the same indication. Ivermectin and hydroxychloroquine, both of which have extremely long biological half lives, can be given infrequently as prophylaxis for COVID. Hydroxychloroquine or chloroquine are used weekly to prevent malaria, and they have been used in the same way to prevent COVID. Ivermectin can be used once or twice yearly to prevent river blindness (onchocerciasis), and it has been used weekly or bi-weekly to prevent COVID. Many clinical trials have documented the benefits of both drugs for COVID prevention. Yet FDA has remained silent about these benefits, even though the efficacy of these preventive treatments probably supercedes that of COVID vaccines.

36. This petition encourages FDA to expeditiously evaluate existing ivermectin research and issue accurate guidance for its use against COVID, e.g., where "18 randomized controlled treatment trials of ivermectin in COVID-19 have found large, statistically significant reductions in mortality, time to clinical recovery, and time to viral clearance."[37] Additional studies have found it highly effective for both pre- and post-exposure prophylaxis of COVID.[38]

37. Finally, reflecting on the FDA's regulatory history is helpful: A proven association between the 1976–1977 swine influenza vaccine and approximately 400 cases of Guillain–Barré syndrome halted that particular national vaccination campaign.[39] The reported deaths following that swine flu vaccination campaign, 30 out of 40-45 million vaccinees,[40] were insignificant compared to the current reported death toll of 4,434 due to COVID vaccines, Today's death rate is more than 50 times higher than that which ended the swine flu vaccine campaign.

[37] P. Kory, G. Meduri et al., *Review of the Emerging Evidence Demonstrating the Efficacy of Ivermectin in the Prophylaxis and Treatment of COVID-19*, AMERICAN JOURNAL OF THERAPEUTICS (May-Jun 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8088823/.
Ahmed, Sabeena et al., *A five-day course of ivermectin for the treatment of COVID-19 may reduce the duration of illness*, INTERNATIONAL JOURNAL OF INFECTIOUS DISEASES, vol. 103, pp. 214-216 (Feb. 2021), https://pubmed.ncbi.nlm.nih.gov/33278625/;
Jans D. A. and Wagstaff K. M., *The broad spectrum host-directed agent ivermectin as an antiviral for SARS-CoV-2*? BIOCHEMICAL AND BIOPHYSICAL RESEARCH COMMUNICATIONS, vol. 538, pp. 163-172 (2021), https://pubmed.ncbi.nlm.nih.gov/33341233/.
Formiga, Fabio Rocha et al., *Ivermectin: an award-winning drug with expected antiviral activity against COVID-19*, JOURNAL OF CONTROLLED RELEASE, vol. 329, pp. 758-761 (Jan. 2021), https://pubmed.ncbi.nlm.nih.gov/33038449/.
Bhowmick, Subhrojyoti et al., *Safety and Efficacy of Ivermectin and Doxycycline Monotherapy and in Combination in the Treatment of COVID-19: A Scoping Review*, DRUG SAFETY, pp. 1-10 (Apr. 16, 2021), https://pubmed.ncbi.nlm.nih.gov/33864232/.

[38] *Ivermectin for COVID-19: real-time meta analysis of 55 studies*, COVID ANALYSIS (version 81, May 15, 2021), https://ivmmeta.com/.

[39] *See* CDC, H1N1 Flu, FACT SHEET: GUILLAIN- BARRÉ SYNDROME (GBS) (Dec. 15, 2009), https://www.cdc.gov/h1n1flu/vaccination/factsheet_gbs.htm#:~:text=Getting%20GBS%20from%20a%20vaccination,got%20the%20swine%20flu%20vaccine.

38. Regarding the halted swine flu vaccine program, the CDC's *Emerging Infectious Diseases Journal* concluded, "In 1976, the federal government wisely opted to put protection of the public first."[41] FDA should learn from this past experience and again put protection of the public first. It is imperative that the FDA swiftly take action to authorize alternative treatments.

E. Children

39. According to the National Center for Health Statistics data as of May 5, 2021, 282 children have died "involving COVID," whereas over 560,000 Americans have died "involving COVID."[42] Three thousand children have been diagnosed with a multi-system inflammatory disorder, of whom about 1%, or approximately 30, have died. Thus the relative risk for children due to COVID is very low.

40. By contrast, recent VAERS reports include the deaths of several children following COVID vaccination.[43] Five of the child death reports footnoted below involve apparent cardiac related deaths, and two were infants. There is one reported death in a 15 year old after receiving the Pfizer BioNTech vaccine, and another reported death of a 15 year old after receiving a Moderna vaccine. Each child must have been enrolled in a clinical trial, since their ages would have precluded them getting the vaccine legally under the EUA. There were only about 1,000 children in the 12-15 year age group in the vaccine arm of Pfizer's trial and probably about the same number in the vaccine arm of Moderna's trial. Thus, the death rate following either vaccination in this age group, assuming these children were trial enrollees, is approximately 2 in 2,000 or 0.1%.

[40] Rick Perlstein, *Gerald Ford Rushed Out a Vaccine. It Was a Fiasco*, THE NEW YORK TIMES (Sept. 2, 2020), https://www.nytimes.com/2020/09/02/opinion/coronavirus-vaccine-trump.html;
Donald G. McNeil, Jr., *Don't Blame Flu Shots for All Ills, Officials Say*, THE NEW YORK TIMES (Sept 27, 2009), https://www.nytimes.com/2009/09/28/health/policy/28vaccine.html.

[41] Sencer D. J., Millar J., *Reflections on the 1976 Swine Flu Vaccination Program*, EMERGING INFECTIOUS DISEASES, Vol. 12, No. 1, pp. 29-33 (Jan. 2006), https://wwwnc.cdc.gov/eid/article/12/1/05-1007_article.

[42] CDC, *Weekly Updates by Select Demographic and Geographic Characteristics*, Provisional Death Counts for Coronavirus Disease 2019 (COVID-19) (updated May 12, 2021), https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm#SexAndAge.

[43] VAERS reports include:
A 1-year-old,
https://medalerts.org/vaersdb/findfield.php?IDNUMBER=1261766&WAYBACKHISTORY=ON;

a 2-year-old,
https://medalerts.org/vaersdb/findfield.php?IDNUMBER=1255745&WAYBACKHISTORY=ON;

two 15-year-olds, https://www.medalerts.org/vaersdb/findfield.php?IDNUMBER=1187918 and https://www.medalerts.org/vaersdb/findfield.php?IDNUMBER=1242573;

two 16-year-olds, https://www.medalerts.org/vaersdb/findfield.php?IDNUMBER=1225942;

a 17-year old, https://www.openvaers.com/openvaers/1199455;

and an infant, https://www.medalerts.org/vaersdb/findfield.php?IDNUMBER=1166062.

41. There are 74 million children in the United States. 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.

42. A recent opinion piece in the *British Medical Journal* noted that "the likelihood of severe outcomes or death associated with COVID-19 infection is very low for children, undermining the appropriateness of an emergency use authorization for child covid-19 vaccines."[45] The authors also suggested child vaccinations could strategically harm vaccination efforts and increase vaccine hesitancy.[46]

F. Servicemembers' Prior Consent

43. Certain citizens and elected officials have recently encouraged the President of the United States to waive U.S. Servicemembers' right to prior consent for COVID vaccines.[47] According to 10 U.S.C. §1107(f), only the President of the United States may order such a waiver if he determines, in writing, that obtaining consent is not in the national security interest. The intent of any waiver of consent must be related to a member's participation in a "particular military operation," as opposed to the broad sweep some are encouraging.

44. Such a waiver is only permissible when obtaining prior consent is infeasible or contrary to the best interests of the military member. Clearly, prior consent for current servicemembers is feasible for COVID vaccines.[48] Because the President's authority is contingent on the standards set forth in § 505(i)(4) of the FDCA and 21 U.S.C. § 355(i)(4), and since the chain of command requires consultation with HHS, the FDA may issue guidance to the President on this matter.[49]

[44] Helen Branswell, *CDC advisory group gives green light to Pfizer's Covid vaccine for adolscents*," STAT (May 12, 2021), https://www.statnews.com/2021/05/12/cdc-advisory-groupgives-green-light-to-pfizers-covid-vaccine-for-adolescents/.

[45] W. Pegden, V. Prasad, S. Baral, *Covid vaccines for children should not get emergency use authorization*, BMJ (May 7, 2021), https://blogs.bmj.com/bmj/2021/05/07/covid-vaccines-forchildren-should-not-get-emergency-use-authorization/.

[46] *Id.*

[47] Jimmy Panetta, *Letter to President Biden* (Mar. 24, 2021), https://www.documentcloud.org/documents/20521870-panetta_dod-covid-vaccine-waiver.

[48] 21 U.S.C. § 50.23: Exception from general requirements, https://www.ecfr.gov/cgi-bin/textidx?node=se21.1.50_123&rgn=div8.

45. The specific law on EUA vaccines was codified in 10 U.S.C. § 1107a.[50] The § 1107a language is similar to § 1107(f) to ensure that troops are granted prior consent and have the "option to accept or refuse administration of a product." National leaders should continue to honor and respect servicemembers' rights. No President has ever waived servicemembers' prior consent under 10 U.S.C. § 1107(f) or 10 U.S.C. § 1107a, and FDA should advise that current circumstances do not warrant such drastic action.

G. Coercion and Compulsion

46. COVID vaccines are optional in accordance with 21 C.F.R. § 360bbb-3(e)(1)(a) as EUA products.[51] Yet throughout the United States, schools, businesses, government and industry are using coercive tactics to encourage, incentivize and compel COVID vaccination as a condition of employment, education and daily living. It is unlikely that most Americans would support such coercion if they were fully informed that COVID vaccines are for emergency use only, investigational, unapproved, and that individuals have the explicit right to refuse by law. Some states are considering or have approved legislation or executive action to bar vaccine mandates.[52] Some professional medical associations also have expressed opposition to these coercive tactics.[53]

47. Coercion and compulsory vaccination are inconsistent with the legal requirements to inform both healthcare workers administering EUA vaccines and vaccine recipients of the significant known and unknown benefits and risks of such use. Most importantly, the FDA must ensure all parties are aware of the "option to accept or refuse" administration of all EUA products and that alternatives are available. These disclosure requirements are entirely inconsistent with coercion, and government agencies should not publish information that violates the law. Information on the government websites of the Equal Employment Opportunity Commission (EEOC)[54] and the Occupational Safety and Health Administration (OSHA)[55] in fact ignore these federal disclosure requirements.

[49] *Id.*

[50] 10 U.S.C. § 1107a - Emergency use products, https://www.govinfo.gov/app/details/USCODE-2010-title10/USCODE-2010-title10-subtitleA-partII-chap55-sec1107a/summary.

[51] § 360bbb–3. Authorization for medical products for use in emergencies, https://www.govinfo.gov/content/pkg/USCODE-2011-title21/pdf/USCODE-2011-title21-chap9-subchapV-partE-sec360bbb-3.pdf.

[52] Pearson L., Brofsky J., et al., *50-state Update on Pending Legislation Pertaining to Employermandated Vaccination*, HUSCH BLACKWELL (updated April 20, 2021), https://www.huschblackwell.com/newsandinsights/50-state-update-on-pending-legislationpertaining-to-employer-mandated-vaccinations.

[53] Dr. Paul M. Kempen, *Open Letter from Physicians to Universities: Allow Students Back Without COVID Vaccine Mandate*, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS (Apr. 24, 2021), https://aapsonline.org/open-letter-from-physicians-to-universities-reverse-covidvaccine-mandates/.

48. The armed forces' experience with the very first EUA vaccine mandate against anthrax is instructive.[56] The military now administers the anthrax vaccine on a voluntary basis with informed consent, but only after a federal court halted the mandatory anthrax vaccine program because the FDA had improperly issued a license.[57]

49. The only language in the EUA law, 21 U.S.C. § 360bbb-3(e)(1)(A)(ii)(I-III), that could possibly be construed to imply mandates is the term "consequences" in clause III. Both statutory analysis and legislative history suggest that it is far more likely that this term applies to health-related consequences only, i.e., medical risks and benefits, since that is the topic of thatstatute section and because it does not refer to punitive measures or consequences, such as termination of employment or education.[58]

50. Another hazard of coercive policies and broad liability for industry is reliance on subpar manufacturers. One of the COVID vaccine manufacturing subcontractors today, Emergent BioSolutions, is the same company, with the same President and Board Chairman, which the FDA cited under its previous name, BioPort, for numerous violations of Good Manufacturing Practices.[59] The image below, taken from an FDA form in 2000, shows the citation to BioPort for deviations from acceptable manufacturing standards for vaccines.

[54] EEOC, *What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEOC Laws*, §§ K1 & K7 (updated Dec. 16, 2020), https://www.eeoc.gov/wysk/whatyou-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws.

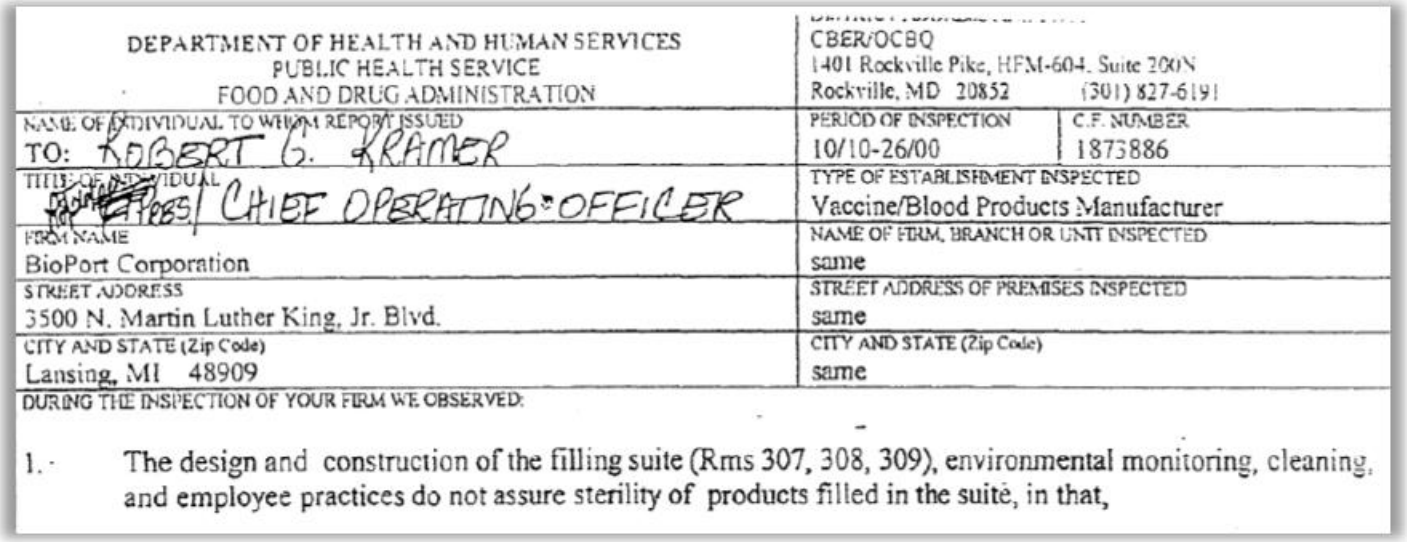
[55] Jeff Yoders, *OSHA Imposes New Guidance For Employer-Required COVID-19 Vaccines*, ENR (May 3, 2021), https://www.enr.com/articles/51691-osha-imposes-new-guidance-foremployer-required-covid-19-vaccines.

[56] FDA, *Anthrax Vaccine Adsorbed (AVA) EUA –ARCHIVED INFORMATION*, https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policyframework/emergency-use-authorization-archived-information#anthrax.

[57] *Determination and Declaration Regarding Emergency Use of Anthrax Vaccine Adsorbed for Prevention of Inhalation Anthrax*, FEDERAL REGISTER (Feb. 2, 2005), https://www.federalregister.gov/documents/2005/02/02/05-2027/determination-and-declarationregarding-emergency-use-of-anthrax- vaccine-adsorbed-for-preventionof?fbclid=IwAR22J58y3SQ2tVoEUlNgZVU-PmRxoou0P05i9WqS4SUiOcj9HyaiUJ8Dvrg.

[58] Parasidis E., Kesselheim A. S., *Assessing The Legality Of Mandates For Vaccines Authorized Via An Emergency Use Authorization*, HEALTH AFFAIRS (Feb. 16, 2021), https://www.healthaffairs.org/do/10.1377/hblog20210212.410237/full/.

[59] Richard Luscombe, *Emergent chief sold $10m in stock before company ruined 15m Covid vaccines*, THE GUARDIAN (Apr. 26, 2021), https://www.theguardian.com/business/2021/apr/26/emergent-biosolutions-robert-kramer-stockcovid-vaccines-error.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
FOOD AND DRUG ADMINISTRATION

CBER/OCBQ
1401 Rockville Pike, HFM-604, Suite 200N
Rockville, MD 20852 (301) 827-6191

NAME OF INDIVIDUAL TO WHOM REPORT ISSUED
TO: ROBERT G. KRAMER

PERIOD OF INSPECTION: 10/10-26/00
C.F. NUMBER: 1873886

TITLE OF INDIVIDUAL
FOR PROBS/ CHIEF OPERATING OFFICER

TYPE OF ESTABLISHMENT INSPECTED
Vaccine/Blood Products Manufacturer

FIRM NAME
BioPort Corporation

NAME OF FIRM, BRANCH OR UNIT INSPECTED
same

STREET ADDRESS
3500 N. Martin Luther King, Jr. Blvd.

STREET ADDRESS OF PREMISES INSPECTED
same

CITY AND STATE (Zip Code)
Lansing, MI 48909

CITY AND STATE (Zip Code)
same

DURING THE INSPECTION OF YOUR FIRM WE OBSERVED:

1. The design and construction of the filling suite (Rms 307, 308, 309), environmental monitoring, cleaning, and employee practices do not assure sterility of products filled in the suite, in that,

51. Today, Emergent BioSolutions, despite apparent FDA oversight, shipped out unauthorized bulk COVID vaccine ingredients for finishing and filling. Emergent BioSolutions shipped those ingredients to another entity, and the shipments eventually reached buyers in at least four other countries, according to the *New York Times*.[60] The FDA halted distribution in the U.S. and cited quality deviations[61] that mirrored those that American servicemembers witnessed 20 years ago with the anthrax vaccine.[62] People need to be informed about these manufacturing deviation patterns given the importance and wide use of these products.

52. States may lawfully mandate certain vaccines. But that is not the case for investigational, unapproved EUA medical products. The preemption doctrine,[63] based on the Supremacy Clause of the U.S. Constitution, Article VI., § 2,[64] requires that the federal requirements for informed consent supersede state laws and regulations that may violate EUA provisions. The FDA should support, defend and enforce federal laws that govern biologics, including EUA products. The option to refuse COVID vaccines is codified in federal law, and President Biden has affirmed this, saying, "I don't think it [vaccination against COVID] should be mandatory. I wouldn't demand it to be mandatory."[65]

[60] Chris Hamby, *Baltimore Vaccine Plant's Troubles Ripple Across 3 Continents*, THE NEW YORK TIMES (May 6, 2021), https://www.nytimes.com/2021/05/06/world/baltimore-vaccinecountries.html.

[61] FDA, HHS, Form FDA 483, Inspectional Observations (Apr. 20, 2021), https://www.fda.gov/media/147762/download.

[62] Historic FDA Form 483 Deviation Report Documenting that "The manufacturing process for Anthrax Vaccine is not validated." https://nebula.wsimg.com/30662205620a26a4b21274dc49888891?AccessKeyId=0BA19F97E21CB8613CD7&disposition=0&alloworigin=1.

[63] *Preemption*, CORNELL LAW SCHOOL, Legal Information Institute, https://www.law.cornell.edu/wex/preemption.

[64] U.S. Const. art. VI., § 2 , "This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." https://www.archives.gov/founding-docs/constitution-transcript.

H. Conclusion to Statement of Grounds

53. The FDA's mission is "protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products."[66] President Roosevelt's signing of the Federal Food, Drug, and Cosmetic Act (FDCA) closed many safety and efficacy loopholes and improved the landscape of consumer protection forever.[67] The 1962 Harris-Kefauver amendment[68] set in motion regulatory standards for biologics licensure that require proven efficacy, and the 1972 review sought to ensure proof of efficacy and no misbranding for biologics. These historic advances require reflection. The preamble to the 1972 review stated, '"The importance to the American public of safe and effective vaccines…and other biological products cannot be overstated."[69]

54. Biologics, as with all drugs and devices, must have adequate directions for use and be proven safe and effective before FDA approval and licensure. The FDA erred with the anthrax vaccine, and it took a Citizen Petition[70] and federal court decision to make the FDA comply with the FDCA.[71] At other times, the FDA has upheld its mission without prompting to make tough regulatory rulings, as the Supreme Court has acknowledged.[72] With this Petition, we look forward to the FDA's appropriate, tough regulatory action to bring its COVID vaccine regulations and guidance into line with federal law.

[65] Julia Manchester, *Biden: Coronavirus vaccine should not be mandatory*, THE HILL (Apr. 12, 2021), https://thehill.com/homenews/campaign/528834-biden-coronavirus-vaccine-should-notbe-mandatory.

[66] FDA, *What We Do*; https://www.fda.gov/about-fda/what-we-do#mission.

[67] FDA, *80 Years of the Federal Food, Drug, and Cosmetic Act* (Nov. 7, 2018), https://www.fda.gov/about-fda/fda-history-exhibits/80-years-federal-food-drug-and-cosmetic-act.

[68] FDA, *Kefauver-Harris Amendments Revolutionized Drug Development* (Oct. 9, 2012), https://www.fda.gov/consumers/consumer-updates/kefauver-harris-amendments-revolutionizeddrug-development.

[69] HHS, FDA, *Biological Products March 1936-March 1978*, Preamble, p. 56, 37 Fed. Reg. 16679.

[70] Citizen Petition, FDA Docket 01P-0471/CP1, https://img1.wsimg.com/blobby/go/4fa7f468-a250-4088-926e-3c56a998df1f/downloads/citizen%20petition%20ava%20rempfer%20dingle.pdf?ver=1620969217312, and Response thereto, https://downloads.regulations.gov/FDA-2001-P-0119-0003/attachment_1.pdf.

[71] *Doe # 1 v. Rumsfeld*, 297 F. Supp. 2d 119, 135; see par. F, reference to Citizen Petition, FDA docket 01p-0471, https://nebula.wsimg.com/2617051f041708e6b5335b6c885478d7?AccessKeyId=0BA19F97E21CB8613CD7&disposition=0&alloworigin=1.

[72] U.S. Reports: *Weinberger v. Hynson, Westcott & Dunning*, 412 U.S. 609 (1972), https://tile.loc.gov/storage- services/service/ll/usrep/usrep412/usrep412609/usrep412609.pdf.

[73] FDA, *Emergency Use Authorization for Vaccines explained* (updated Nov. 20, 2020), https://www.fda.gov/vaccines-blood-biologics/vaccines/emergency-use-authorization-vaccinesexplained.

55. Although EUA law is relatively recent, we ask the FDA to be ever cognizant of its longstanding, statutory mission and duty to protect the public health and to ensure that the American public receives only safe and effective vaccines. Most Americans are not aware of the strict compliance requirements for EUA COVID vaccines nor do they know that these biologics are "investigational" and "unapproved medical products."[73] They do not know that the FDA has not fully approved these vaccines as safe and effective under the FDCA. The reason Americans are unaware is because the FDA has failed to provide and enforce accurate public messaging. Reversing this trend is imperative; the FDA must comply with law.

56. Acting on this Citizen Petition will enhance the FDA's credibility with the public. Given the obvious safety, effectiveness, labeling and branding concerns over COVID vaccines detailed above, along with anticipated comments on this docket, we respectfully appeal to the FDA to implement the actions requested in this Petition.

III. ENVIRONMENTAL IMPACT

57. The undersigned hereby state that the relief requested in this Petition will have no environmental impact, and therefore an environmental assessment is not required under 21 C.F.R. §§ 25.30 and 25.31.

IV. ECONOMIC IMPACT

58. Economic impact information will be submitted upon request of the Acting Commissioner.

V. CERTIFICATION

59. The undersigned certify that, to their best knowledge and belief, this Petition all information and views on which the Petition relies, and that it includes representative data and information known to the Petitioners that are unfavorable to the Petition.

Respectfully submitted,

Meryl Nass, MD, Scientific Advisory Board Member

Robert F. Kennedy, Jr., Board Chair and Chief Litigation Counsel

It's looking more and more like the SARS-CoV-2 virus was engineered to be more infective to human epithelial cells. And the Wuhan lab origin with funding from the NIH looks almost certain.

This article all but confirms what I have been reporting on for over a year now, and that is that our own government was involved in the development of gain-of-function research, paused it due to a moratorium imposed because of the extreme risk involved, and then diverted funds to the lab in Wuhan China in order to continue the research. With guess who's fingerprints all over it?

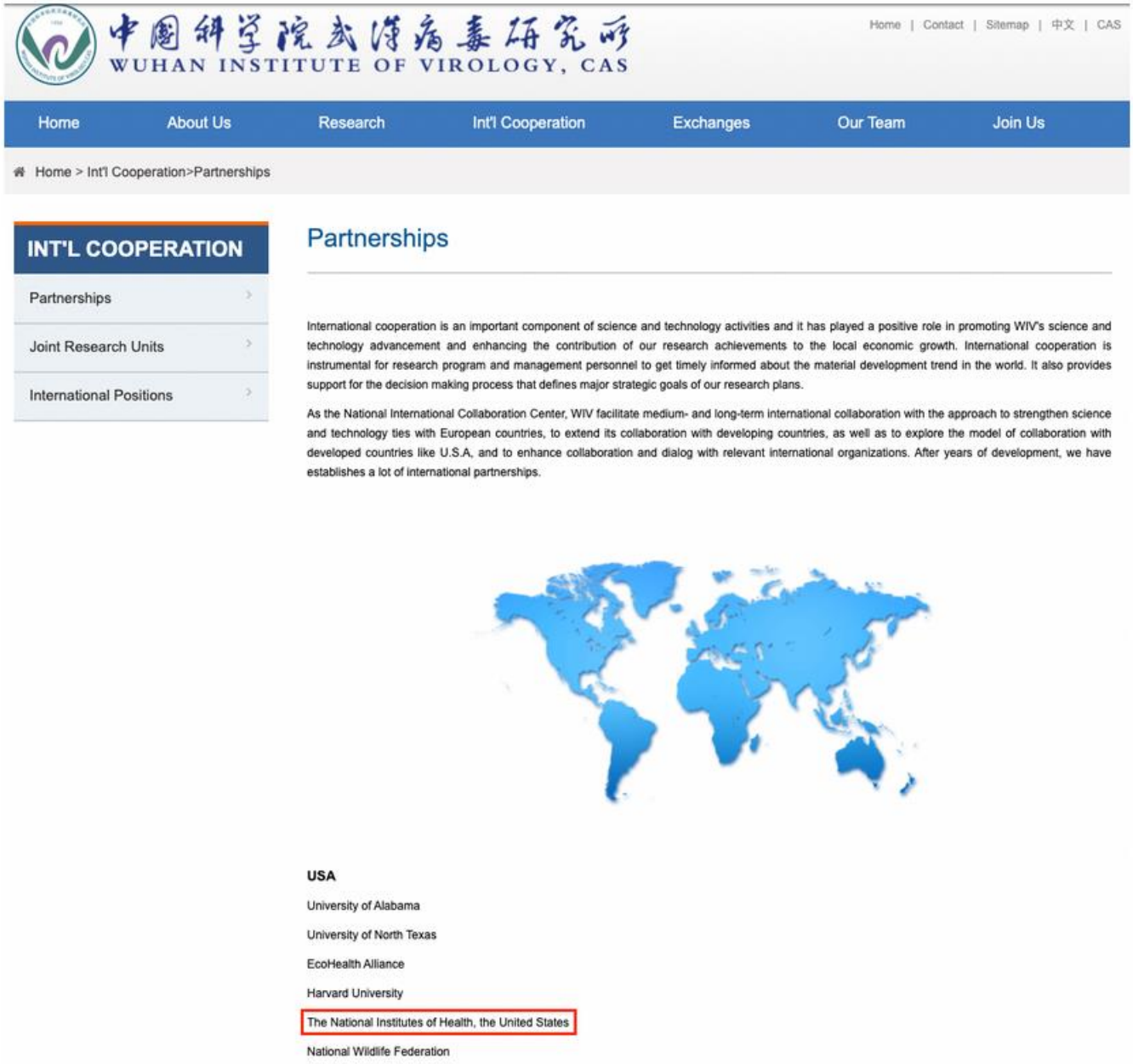
In a May 15th article posted on ***the National Pulse*** titled, **Wuhan Lab DELETED Fauci's NIH and Gain of Function Mentions From Old Web Pages in Early 2021**, portions of an attempted cover-up are exposed.

The short article in its entirety:

The Wuhan Institute of Virology scrubbed the U.S. National Institutes of Health as one of its research partners from its website in early 2021. The revelation comes despite Dr. Anthony Fauci insisting no relationship existed between the institutions.

Archived versions of the Wuhan lab's site also reveal a research update – "Will SARS Come Back?" – appearing to describe gain-of-function research being conducted at the institute by entities funded by Dr. Anthony Fauci's National Institute of Allergy and Infectious Diseases (NIAID).
On March 21st, 2021, the lab's website listed six U.S.-based research partners: University of Alabama, University of North Texas, EcoHealth Alliance, Harvard University, The National Institutes of Health (NIH), the United States, and the National Wildlife Federation.

Continued next page…



WUHAN LAB'S WEBSITE.

One day later, the page was revised to contain just two research partners – EcoHealth Alliance and the University of Alabama. By March 23rd, EcoHealth Alliance was the sole partner remaining.

EcoHealth Alliance is run by long-standing Chinese Communist Party-partner Dr. Peter Daszak, who National Pulse Editor-in-Chief Raheem Kassam has repeatedly claimed will be the first "fall guy" of the Wuhan lab debacle.

The Wuhan Institute of Virology's decision to wipe the NIH from its website came amidst heightened scrutiny that the lab was the source of COVID-19 – and that U.S. taxpayer dollars from the NIH may have funded the research. The unearthing of the lab's attempted coverup also follows a heated exchange between Senator Rand Paul and Fauci, who attempted to distance his organization from the Wuhan lab.

Beyond establishing a working relationship between the NIH and the Wuhan Institue of Virology, now-deleted posts from the site also detail studies bearing the hallmarks of gain-of-function research conducted with the Wuhan-based lab. Fauci, however, asserted to Senator Paul that “the NIH has not ever and does not now fund gain-of-function research in the Wuhan Institute of Virology.”

Continued next page with a large graphic…

Will SARS come back?

2015-12-04 | A A A [print][close]

The emergence of severe acute respiratory syndrome coronavirus (SARS-CoV) and Middle East respiratory syndrome (MERS)-CoV underscores the threat of cross-species transmission events leading to outbreaks in humans.

Recently, Prof. Zhengli Shi and Xingyi Ge from WIV, in cooperation with researchers from University of North Carolina, Harvard Medical School, Bellinzona Institute of Microbiology and etc, examine the disease potential of a SARS-like virus, SHC014-CoV, which is currently circulating in Chinese horseshoe bat populations. Using the SARS-CoV reverse genetics system, the scientists generated and characterized a chimeric virus expressing the spike of bat coronavirus SHC014 in a mouse-adapted SARS-CoV backbone. The results indicate that group 2b viruses encoding the SHC014 spike in a wild-type backbone can efficiently use multiple orthologs of the SARS receptor human angiotensin converting enzyme II (ACE2), replicate efficiently in primary human airway cells and achieve in vitro titers equivalent to epidemic strains of SARS-CoV. Evaluation of available SARS-based immune-therapeutic and prophylactic modalities revealed poor efficacy; both monoclonal antibody and vaccine approaches failed to neutralize and protect from infection with CoVs using the novel spike protein.

On the basis of these findings, they synthetically re-derived an infectious full-length SHC014 recombinant virus and demonstrate robust viral replication both in vitro and in vivo. The work suggests a potential risk of SARS-CoV re-emergence from viruses currently circulating in bat populations.

Source: Nature Medicine doi:10.1038/nm.3985
Image: medicalxpress.com

2015 ARTICLE.

A summary of the work conducted by Wuhan Institute of Virology researchers “in cooperation with researchers from University of North Carolina (UNC), Harvard Medical School, Bellinzona Institute of Microbiology and etc” describes scientists as “generating and characterizing a chimeric virus,” noting how

modifications allowed the virus to "replicate efficiently in primary human airway cells and achieve in vitro titers equivalent to epidemic strains of SARS-CoV":

"Using the SARS-CoV reverse genetics system, the scientists generated and characterized a chimeric virus expressing the spike of bat coronavirus SHC014 in a mouse-adapted SARS-CoV backbone. The results indicate that group 2b viruses encoding the SHC014 spike in a wild-type backbone can efficiently use multiple orthologs of the SARS receptor human angiotensin converting enzyme II (ACE2), replicate efficiently in primary human airway cells and achieve in vitro titers equivalent to epidemic strains of SARS-CoV. Evaluation of available SARS-based immune-therapeutic and prophylactic modalities revealed poor efficacy; both monoclonal antibody and vaccine approaches failed to neutralize and protect from infection with CoVs using the novel spike protein."

"On the basis of these findings, they synthetically re-derived an infectious full-length SHC014 recombinant virus and demonstrate robust viral replication both in vitro and in vivo," the article concludes.

During Fauci and Senator Paul's recent exchange, the NIAID Director was also pressed on gain-of-function research carried out by UNC researcher Dr. Ralph. Baric, who has received 173 grants from Fauci's agency. "Dr. Baric is not doing gain-of-function research, and if it is, it is according to the guidelines and is being conducted in North Carolina. If you look at the grant and if you look at the progress reports, it is not gain-of-function, despite the fact that people tweet that, write about it," Fauci responded to Senator Paul despite UNC being listed as a research partner in the blog post above.

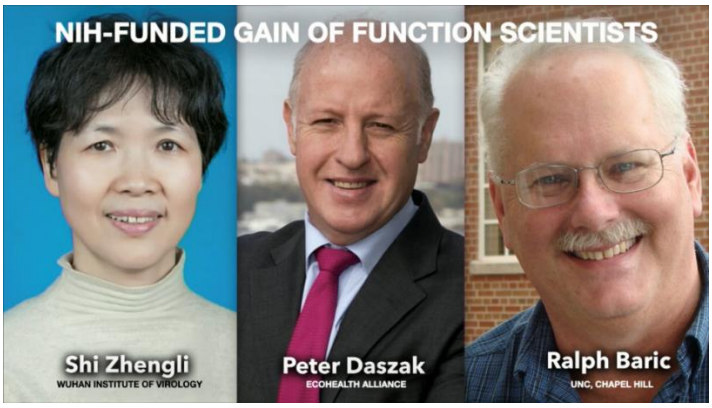
The Wuhan Institute of Virology wiping evidence of gain-of-function research and its ties to the NIH also follow the National Pulse unearthing interviews where Fauci asserts he's "trying to hire" Chinese Communist Party researchers.

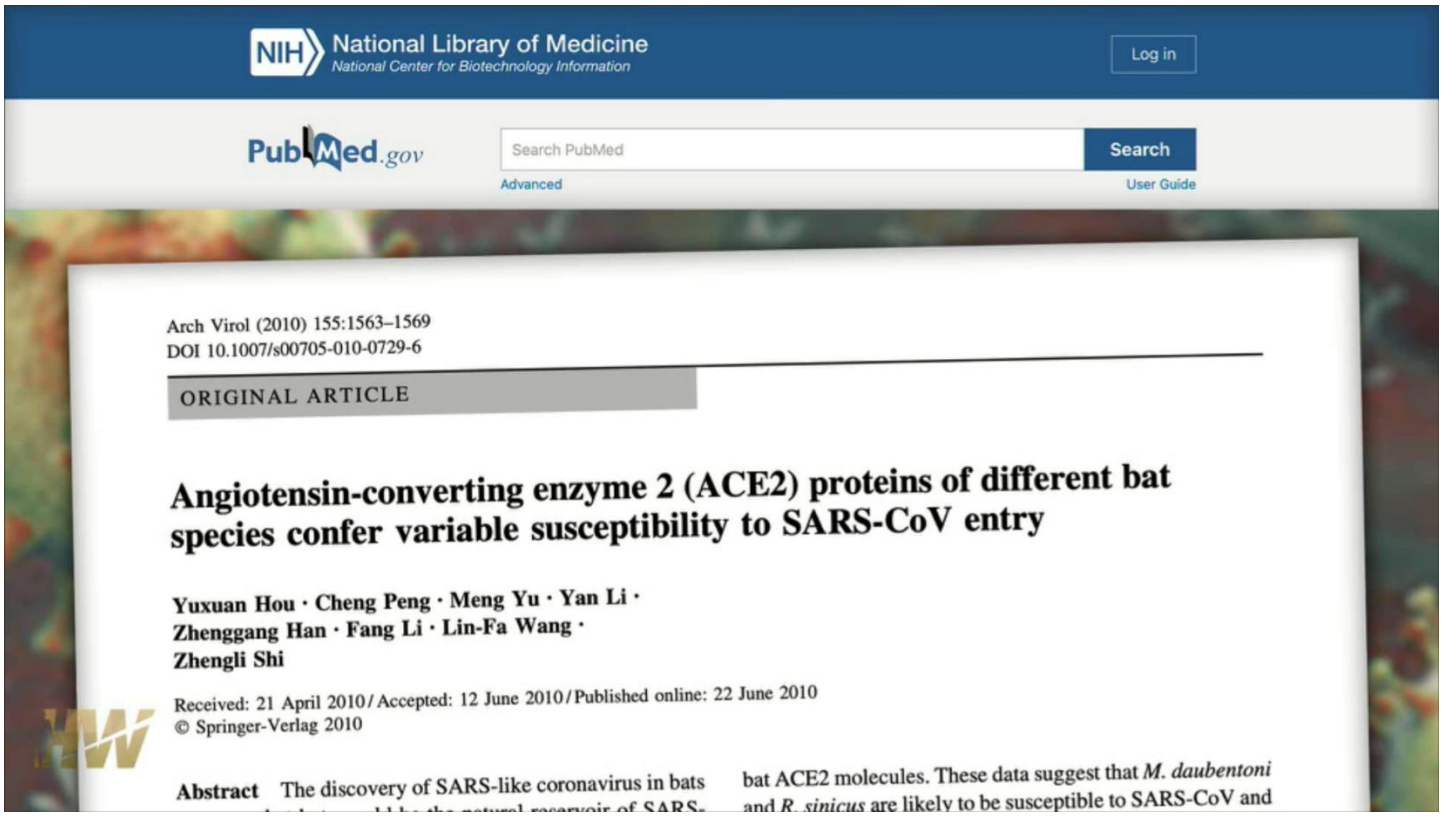
https://thenationalpulse.com/exclusive/wuhan-lab-erases-nih-ties-gof-research/

More evidence- The Highwire NAILED it!

One of the most compelling cases I have seen yet of these connections was that made by Del Bigtree and ***the Highwire*** team during their May 13th episode titled **IS COVID-19 A BIO-WEAPON?**
https://thehighwire.com/videos/is-covid-19-a-bio-weapon/

Here are some screen captures of some of the key graphics they showed. In addition, they showed interviews with Dr. Ralph Baric and Peter Daszak of ***EcoHealth Alliance*** both essentially bragging about what they can do in modifying coronaviruses and in the case of Dr. Baric, having the capability of hiding the signature showing that it was manipulated in a lab. I would highly recommend that you go and watch it in its entirety.





Arch Virol (2010) 155:1563–1569
DOI 10.1007/s00705-010-0729-6

ORIGINAL ARTICLE

Angiotensin-converting enzyme 2 (ACE2) proteins of different bat species confer variable susceptibility to SARS-CoV entry

Yuxuan Hou · Cheng Peng · Meng Yu · Yan Li · Zhenggang Han · Fang Li · Lin-Fa Wang · Zhengli Shi

Received: 21 April 2010 / Accepted: 12 June 2010 / Published online: 22 June 2010

Abstract The discovery of SARS-like coronavirus in bats

bat ACE2 molecules. These data suggest that *M. daubentoni* and *R. sinicus* are likely to be susceptible to SARS-CoV and

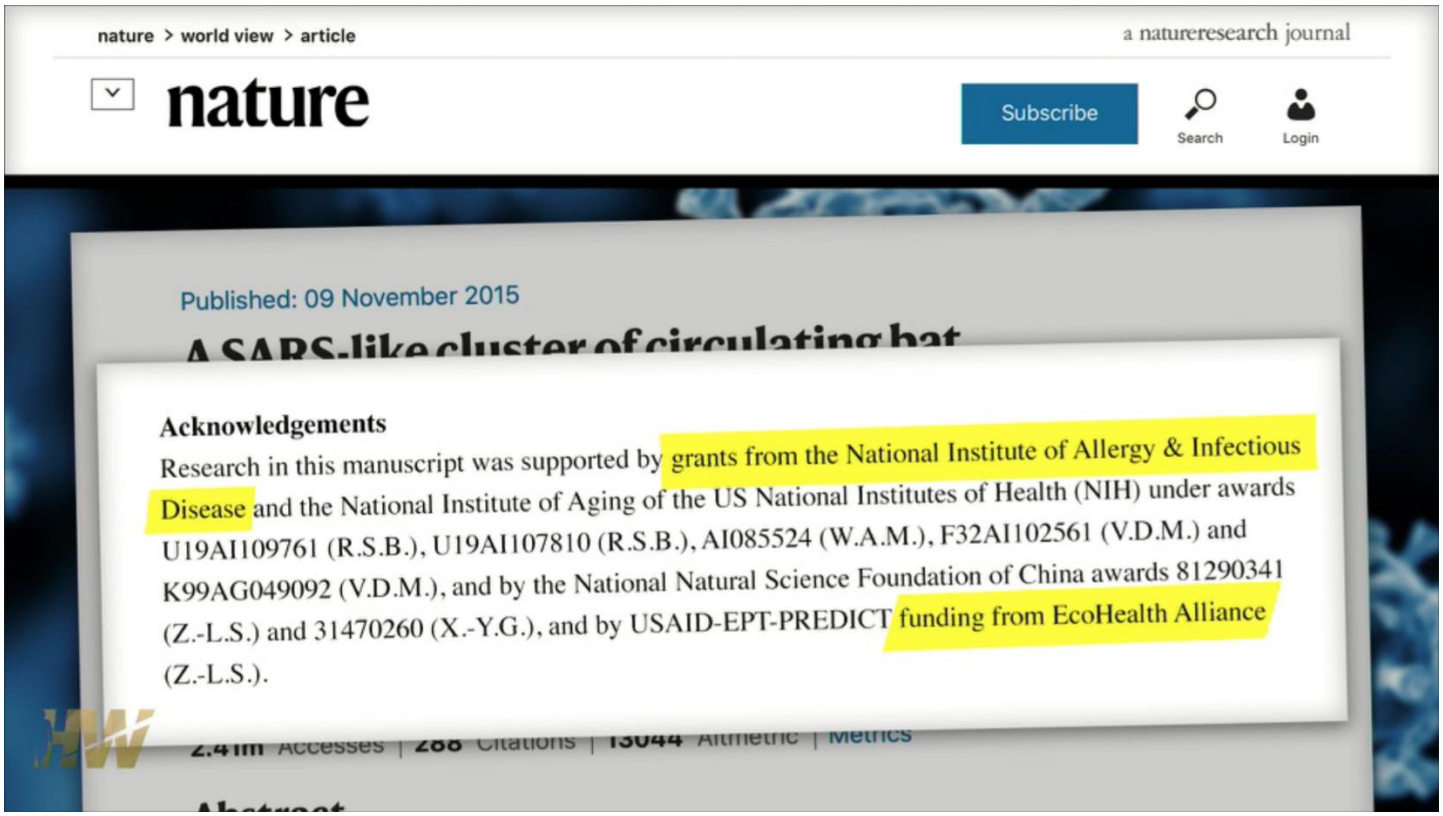
Baric to lead $10 million NIH grant

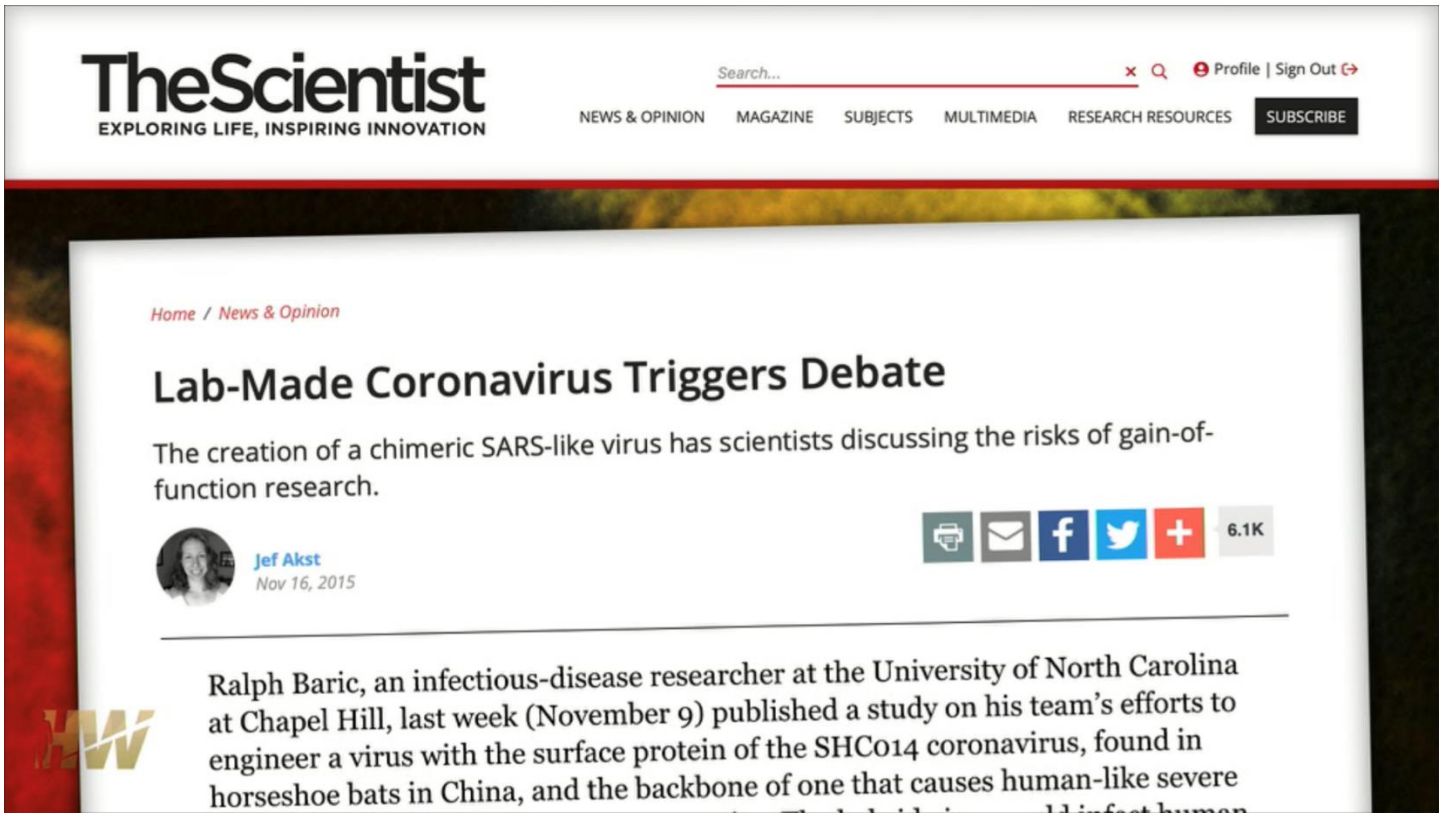
EPIDEMIOLOGY NEWS, RECOGNITIONS AND AWARDS, RESEARCH NEWS

Sept. 9, 2013

A team of researchers at The University of North Carolina at Chapel Hill and the University of Wisconsin has received a National Institutes of Health grant for more than $10 million to study the pathogenic activity of viruses including severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS), Ebola, highly pathogenic influenza and herpesvirus HHV8.


nature > world view > article
a natureresearch journal
nature
Subscribe
Search
Login
Published: 09 November 2015
A SARS-like cluster of circulating bat coronaviruses shows potential for human emergence
Vineet D Menachery, Boyd L Yount Jr, Kari Debbink, Sudhakar Agnihothram, Lisa E Gralinski, Jessica A Plante, Rachel L Graham, Trevor Scobey, Xing-Yi Ge, Eric F Donaldson, Scott H Randell, Antonio Lanzavecchia, Wayne A Marasco, Zhengli-Li Shi & Ralph S Baric
Nature Medicine 21, 1508–1513(2015) | Cite this article
2.41m Accesses | 288 Citations | 13044 Altmetric | Metrics


nature > world view > article
a natureresearch journal
nature
Subscribe
Search
Login
Published: 09 November 2015
Acknowledgements
Research in this manuscript was supported by grants from the National Institute of Allergy & Infectious Disease and the National Institute of Aging of the US National Institutes of Health (NIH) under awards U19AI109761 (R.S.B.), U19AI107810 (R.S.B.), AI085524 (W.A.M.), F32AI102561 (V.D.M.) and K99AG049092 (V.D.M.), and by the National Natural Science Foundation of China awards 81290341 (Z.-L.S.) and 31470260 (X.-Y.G.), and by USAID-EPT-PREDICT funding from EcoHealth Alliance (Z.-L.S.).



TheScientist
EXPLORING LIFE, INSPIRING INNOVATION

Search... Profile | Sign Out

NEWS & OPINION MAGAZINE SUBJECTS MULTIMEDIA RESEARCH RESOURCES SUBSCRIBE

Home / News & Opinion

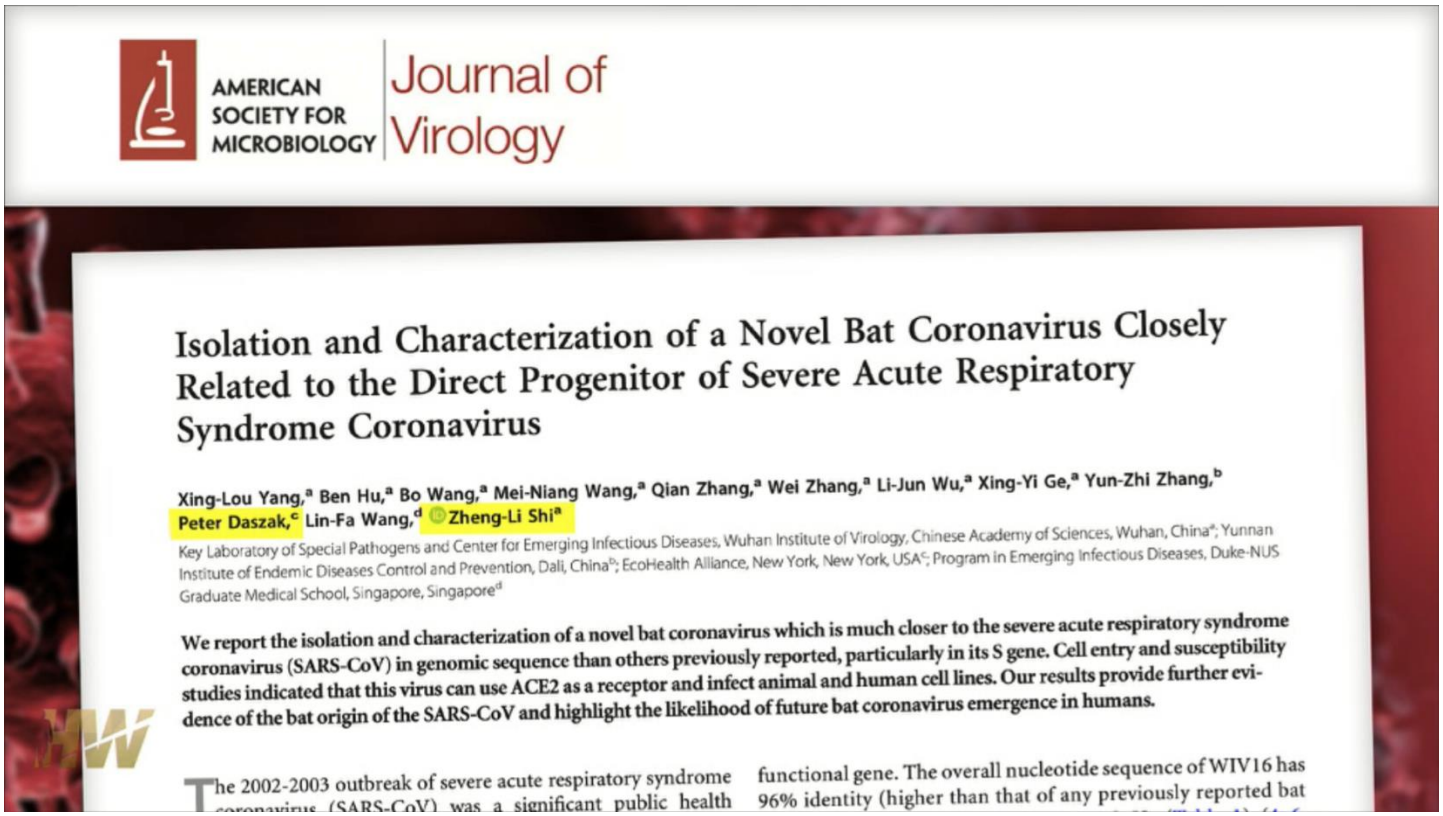
Lab-Made Coronavirus Triggers Debate

The creation of a chimeric SARS-like virus has scientists discussing the risks of gain-of-function research.

6.1K

Jef Akst
Nov 16, 2015

Ralph Baric, an infectious-disease researcher at the University of North Carolina at Chapel Hill, last week (November 9) published a study on his team's efforts to engineer a virus with the surface protein of the SHC014 coronavirus, found in horseshoe bats in China, and the backbone of one that causes human-like severe



AMERICAN SOCIETY FOR MICROBIOLOGY | Journal of Virology

Isolation and Characterization of a Novel Bat Coronavirus Closely Related to the Direct Progenitor of Severe Acute Respiratory Syndrome Coronavirus

Xing-Lou Yang,[a] Ben Hu,[a] Bo Wang,[a] Mei-Niang Wang,[a] Qian Zhang,[a] Wei Zhang,[a] Li-Jun Wu,[a] Xing-Yi Ge,[a] Yun-Zhi Zhang,[b] Peter Daszak,[c] Lin-Fa Wang,[d] Zheng-Li Shi[a]

Key Laboratory of Special Pathogens and Center for Emerging Infectious Diseases, Wuhan Institute of Virology, Chinese Academy of Sciences, Wuhan, China[a]; Yunnan Institute of Endemic Diseases Control and Prevention, Dali, China[b]; EcoHealth Alliance, New York, New York, USA[c]; Program in Emerging Infectious Diseases, Duke-NUS Graduate Medical School, Singapore, Singapore[d]

We report the isolation and characterization of a novel bat coronavirus which is much closer to the severe acute respiratory syndrome coronavirus (SARS-CoV) in genomic sequence than others previously reported, particularly in its S gene. Cell entry and susceptibility studies indicated that this virus can use ACE2 as a receptor and infect animal and human cell lines. Our results provide further evidence of the bat origin of the SARS-CoV and highlight the likelihood of future bat coronavirus emergence in humans.

The 2002-2003 outbreak of severe acute respiratory syndrome coronavirus (SARS-CoV) was a significant public health

functional gene. The overall nucleotide sequence of WIV16 has 96% identity (higher than that of any previously reported bat

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4810638/pdf/zjv3253.pdf

AMERICAN SOCIETY FOR MICROBIOLOGY | Journal of Virology

Isolation and Characterization of a Novel Bat Coronavirus Closely Related to the Direct Progenitor of Severe Acute Respiratory Syndrome Coronavirus

We recently isolated a bat SL-CoV strain (WIV1) and constructed an infectious clone of another strain (SHC014); significantly, these strains are closely related to SARS-CoV and capable of using the same cellular receptor (angiotensin-converting enzyme 2 [ACE2]) as SARS-CoV (6, 7).

coronavirus (SARS-CoV) in genomic sequence than others previously reported, particularly in its S gene. Cell entry and susceptibility studies indicated that this virus can use ACE2 as a receptor and infect animal and human cell lines. Our results provide further evidence of the bat origin of the SARS-CoV and highlight the likelihood of future bat coronavirus emergence in humans.

The 2002-2003 outbreak of severe acute respiratory syndrome coronavirus (SARS-CoV) was a significant public health

functional gene. The overall nucleotide sequence of WIV16 has 96% identity (higher than that of any previously reported bat

AMERICAN SOCIETY FOR MICROBIOLOGY | Journal of Virology

Isolation and Characterization of a Novel Bat Coronavirus Closely Related to the Direct Progenitor of Severe Acute Respiratory Syndrome Coronavirus

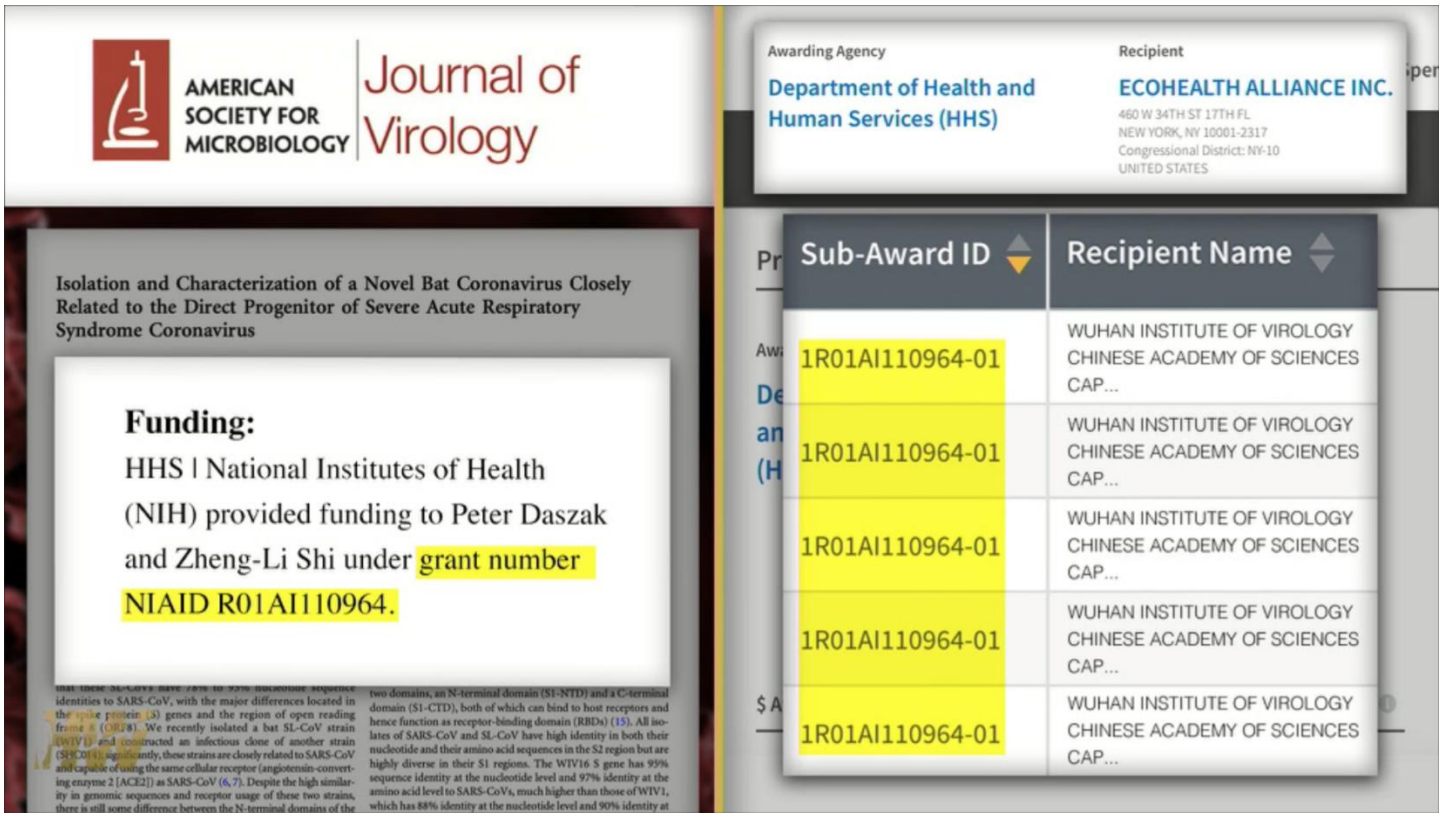
Funding:

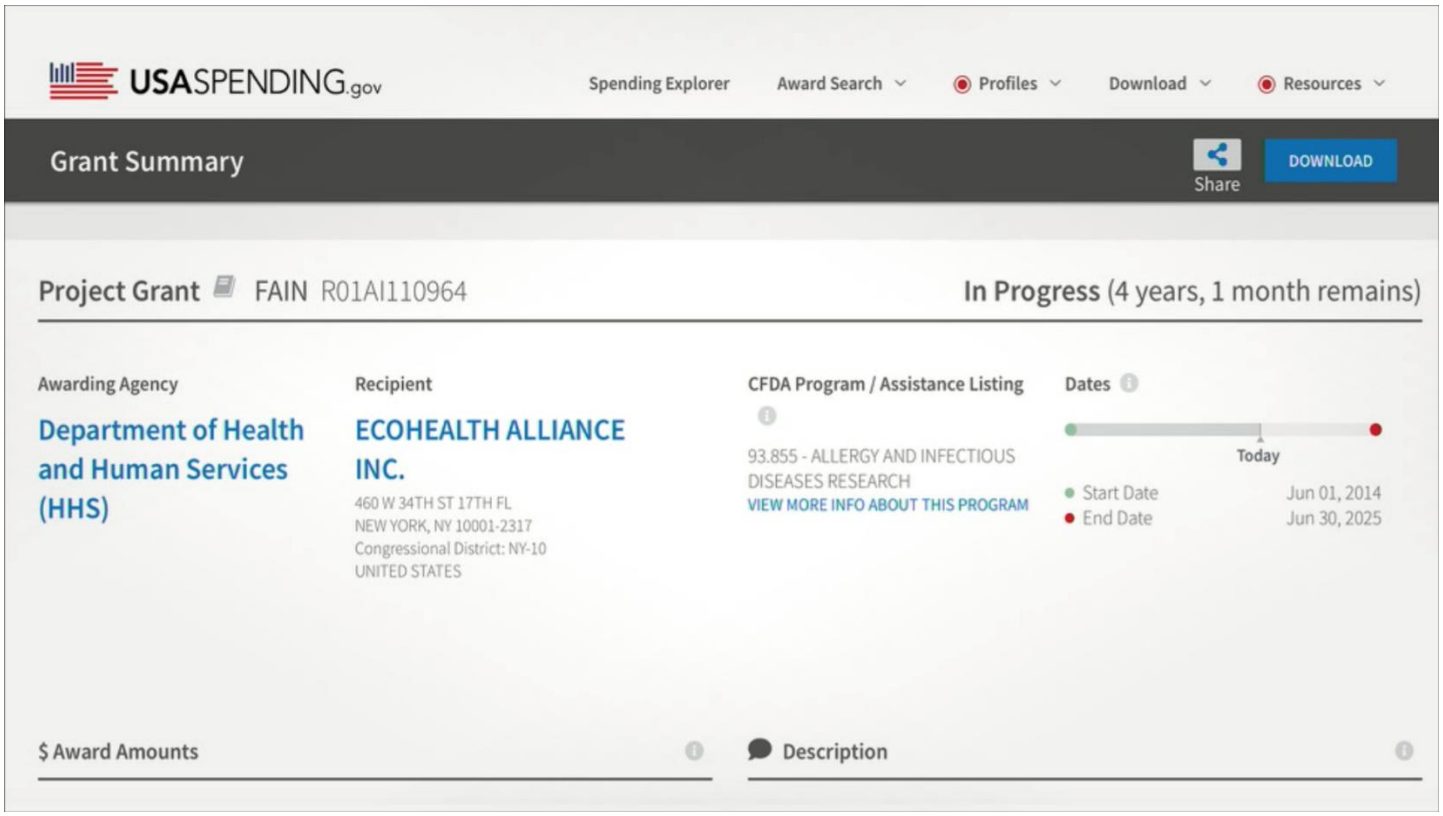
HHS | National Institutes of Health (NIH) provided funding to Peter Daszak and Zheng-Li Shi under grant number NIAID R01AI110964.

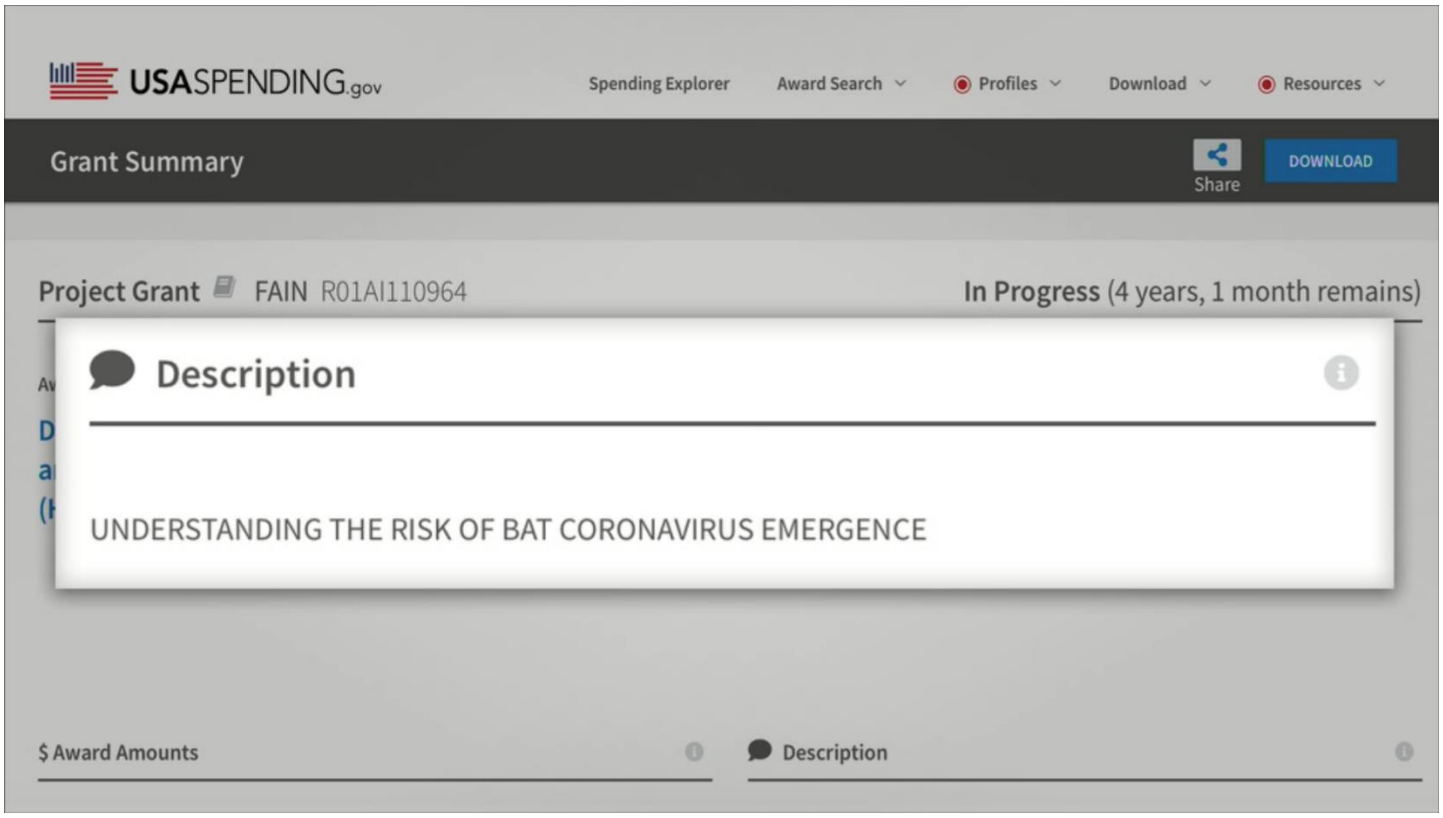
coronavirus (SARS-CoV) in genomic sequence than others previously reported, particularly in its S gene. Cell entry and susceptibility studies indicated that this virus can use ACE2 as a receptor and infect animal and human cell lines. Our results provide further evidence of the bat origin of the SARS-CoV and highlight the likelihood of future bat coronavirus emergence in humans.

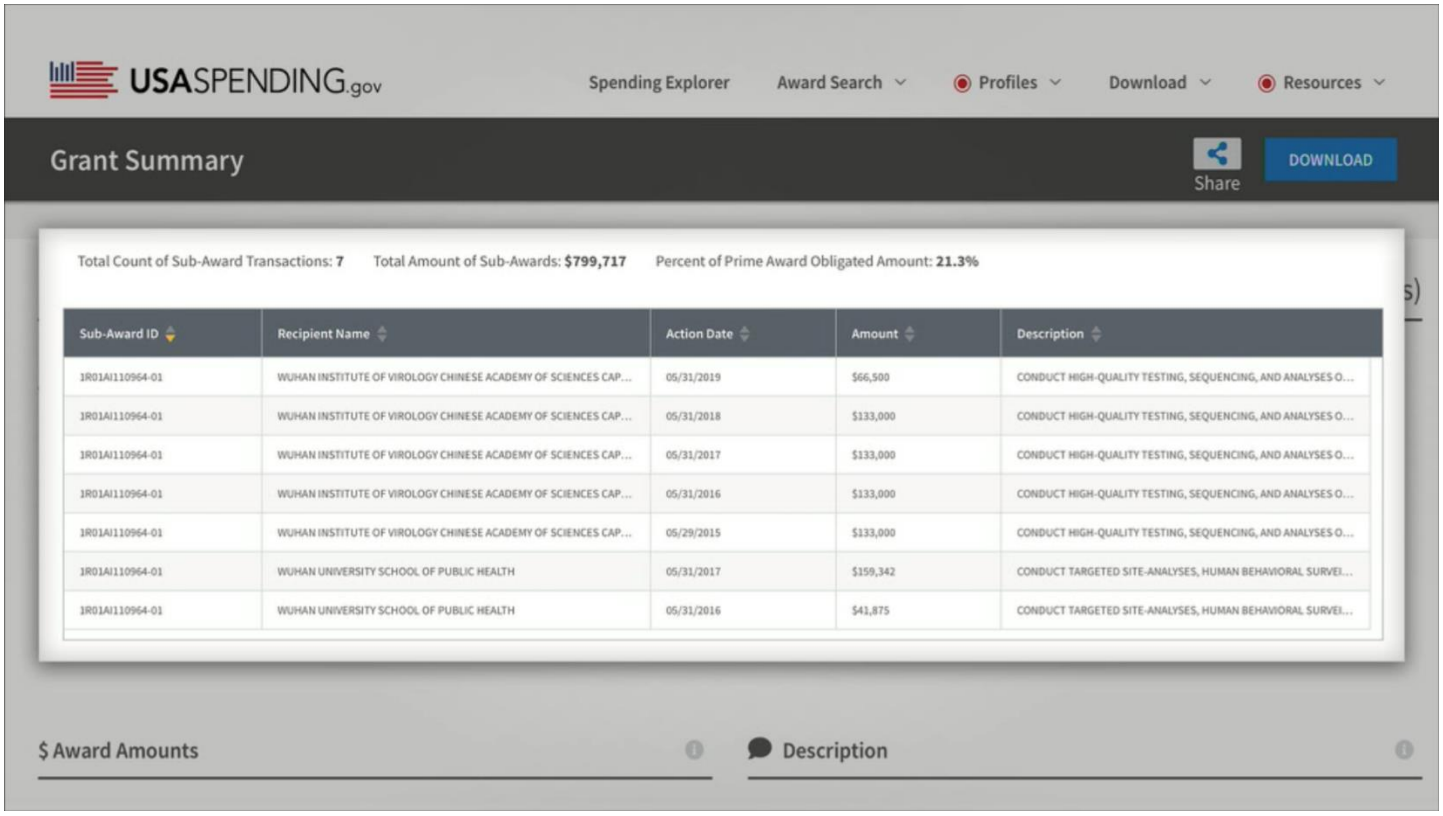
The 2002-2003 outbreak of severe acute respiratory syndrome coronavirus (SARS-CoV) was a significant public health

functional gene. The overall nucleotide sequence of WIV16 has 96% identity (higher than that of any previously reported bat


AMERICAN SOCIETY FOR MICROBIOLOGY | Journal of Virology
Isolation and Characterization of a Novel Bat Coronavirus Closely Related to the Direct Progenitor of Severe Acute Respiratory Syndrome Coronavirus
Funding:
HHS | National Institutes of Health (NIH) provided funding to Peter Daszak and Zheng-Li Shi under grant number NIAID R01AI110964.
Awarding Agency
Department of Health and Human Services (HHS)
Recipient
ECOHEALTH ALLIANCE INC.
460 W 34TH ST 17TH FL
NEW YORK, NY 10001-2317
Congressional District: NY-10
UNITED STATES
Sub-Award ID
Recipient Name
1R01AI110964-01
WUHAN INSTITUTE OF VIROLOGY CHINESE ACADEMY OF SCIENCES CAP...
1R01AI110964-01
WUHAN INSTITUTE OF VIROLOGY CHINESE ACADEMY OF SCIENCES CAP...
1R01AI110964-01
WUHAN INSTITUTE OF VIROLOGY CHINESE ACADEMY OF SCIENCES CAP...
1R01AI110964-01
WUHAN INSTITUTE OF VIROLOGY CHINESE ACADEMY OF SCIENCES CAP...
1R01AI110964-01
WUHAN INSTITUTE OF VIROLOGY CHINESE ACADEMY OF SCIENCES CAP...

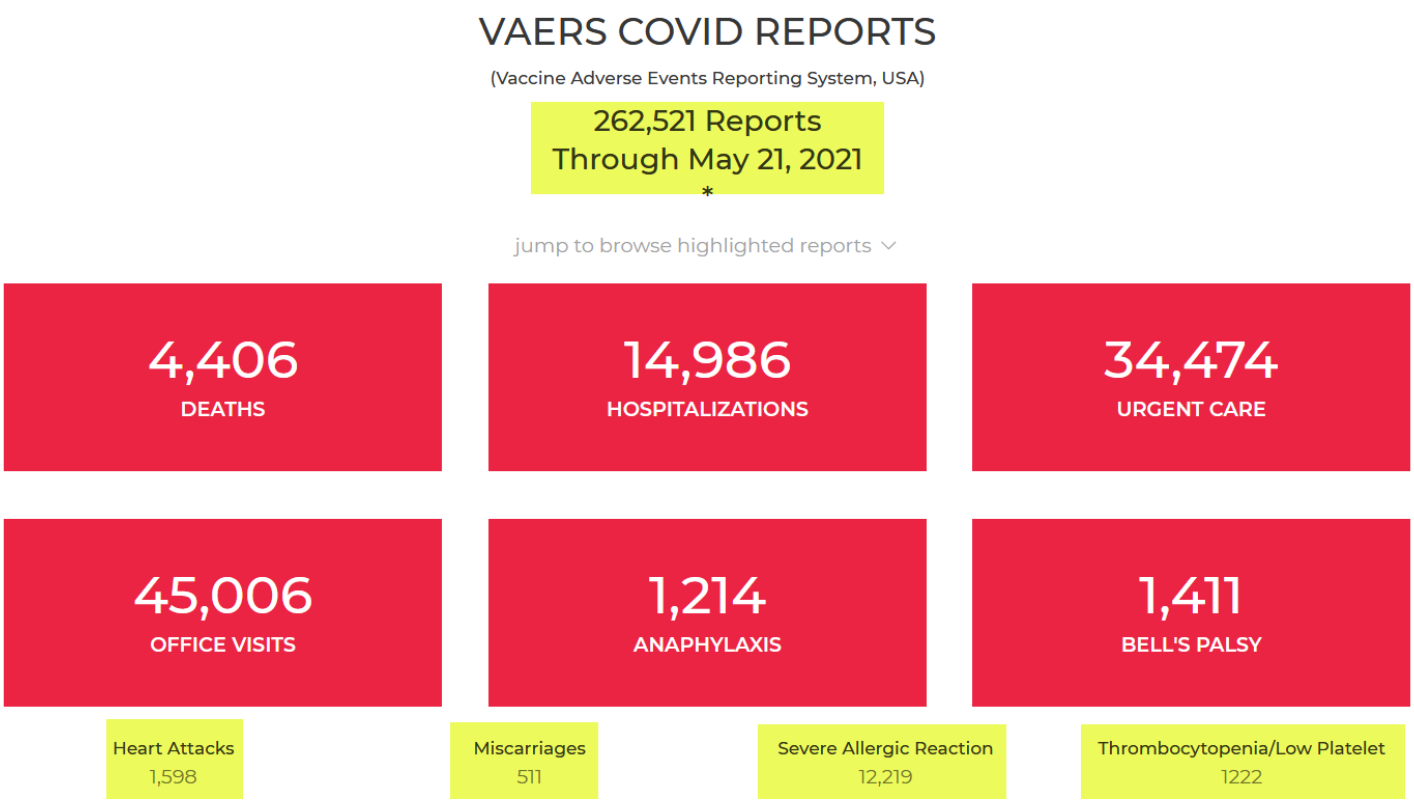

USASPENDING.gov
Spending Explorer
Award Search
Profiles
Download
Resources
Grant Summary
Share
DOWNLOAD
Project Grant
FAIN R01AI110964
In Progress (4 years, 1 month remains)
Awarding Agency
Department of Health and Human Services (HHS)
Recipient
ECOHEALTH ALLIANCE INC.
460 W 34TH ST 17TH FL
NEW YORK, NY 10001-2317
Congressional District: NY-10
UNITED STATES
CFDA Program / Assistance Listing
93.855 - ALLERGY AND INFECTIOUS DISEASES RESEARCH
VIEW MORE INFO ABOUT THIS PROGRAM
Dates
Today
Start Date Jun 01, 2014
End Date Jun 30, 2025
$ Award Amounts
Description


USASPENDING.gov
Spending Explorer
Award Search
Profiles
Download
Resources
Grant Summary
Share
DOWNLOAD
Project Grant
FAIN R01AI110964
In Progress (4 years, 1 month remains)
Description
UNDERSTANDING THE RISK OF BAT CORONAVIRUS EMERGENCE
$ Award Amounts
Description


USASPENDING.gov
Spending Explorer
Award Search
Profiles
Download
Resources
Grant Summary
Share
DOWNLOAD
Total Count of Sub-Award Transactions: 7
Total Amount of Sub-Awards: $799,717
Percent of Prime Award Obligated Amount: 21.3%
Sub-Award ID
Recipient Name
Action Date
Amount
Description
1R01AI110964-01 WUHAN INSTITUTE OF VIROLOGY CHINESE ACADEMY OF SCIENCES CAP... 05/31/2019 $66,500 CONDUCT HIGH-QUALITY TESTING, SEQUENCING, AND ANALYSES O...
1R01AI110964-01 WUHAN INSTITUTE OF VIROLOGY CHINESE ACADEMY OF SCIENCES CAP... 05/31/2018 $133,000 CONDUCT HIGH-QUALITY TESTING, SEQUENCING, AND ANALYSES O...
1R01AI110964-01 WUHAN INSTITUTE OF VIROLOGY CHINESE ACADEMY OF SCIENCES CAP... 05/31/2017 $133,000 CONDUCT HIGH-QUALITY TESTING, SEQUENCING, AND ANALYSES O...
1R01AI110964-01 WUHAN INSTITUTE OF VIROLOGY CHINESE ACADEMY OF SCIENCES CAP... 05/31/2016 $133,000 CONDUCT HIGH-QUALITY TESTING, SEQUENCING, AND ANALYSES O...
1R01AI110964-01 WUHAN INSTITUTE OF VIROLOGY CHINESE ACADEMY OF SCIENCES CAP... 05/29/2015 $133,000 CONDUCT HIGH-QUALITY TESTING, SEQUENCING, AND ANALYSES O...
1R01AI110964-01 WUHAN UNIVERSITY SCHOOL OF PUBLIC HEALTH 05/31/2017 $159,342 CONDUCT TARGETED SITE-ANALYSES, HUMAN BEHAVIORAL SURVEI...
1R01AI110964-01 WUHAN UNIVERSITY SCHOOL OF PUBLIC HEALTH 05/31/2016 $41,875 CONDUCT TARGETED SITE-ANALYSES, HUMAN BEHAVIORAL SURVEI...
$ Award Amounts
Description

Latest VAERS COVID vaccine injury reports and the incredibly more likely astronomical 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, and evidence shows that they may be 100 times higher!



Latest VAERS COVID vaccine injury reports and the incredibly more likely astronomical numbers

The U.S. government 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., 205,000 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 20,500 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 2021 and nothing has been done to accomplish this vital information system. And lives hang in the balance.

Another example of under-reporting: A recent analysis of anaphylactic reactions from COVID-19 vaccines find that they are significantly under-reported

This is from an ICAN Legal Update from April 22nd, 2021 referencing a letter that ICAN sent to ***the Advisory Committee on Immunization Practices (ACIP)***

A letter sent to each of the 16 voting members of ACIP raises the serious concern that there may be additional cases of CVST that have not been reported to VAERS. The letter explained that underreporting of anaphylaxis, another serious event that occurs immediately after vaccination, was instructive as to why cases of CVST would be underreported.

According to the CDC, "Anaphylaxis after COVID-19 vaccination is **rare** and occurred in approximately 2 to 5 people per million vaccinated in the United States based on events reported to VAERS." In contrast, a recent study at Mass General Brigham assessed anaphylaxis after COVID-19 vaccines in a clinical setting and found "severe reactions consistent with anaphylaxis occurred at a rate of 2.47 per 10,000 vaccinations." **This is equivalent to 50 times to 120 times more cases of anaphylaxis than what VAERS and the CDC are reporting.** This raises serious concerns regarding under-reporting of CVST, other clotting issues, and thrombocytopenia following receipt of the Janssen COVID-19 vaccine.

New report out of Israel reveals shocking levels of adverse reactions from the Pfizer vaccine

Israeli People Committee's Report Find Catastrophic Side Effects Of Pfizer Vaccine To Every System In Human Body 05-05-2021

The Israeli People Committee (IPC), a civilian body made of leading Israeli health experts, has published its April report into the Pfizer vaccine's side effects indicating damage to almost every system in the human body. If the findings by IPC are genuine, then Pfizer vaccine is linked to more deaths in Israel than AstraZeneca's in the whole of Europe. The findings are catastrophic on every possible level. This is a detailed report that highlights the most devastating findings.

Some key excerpts:

"According to Central Bureau of Statistics data during January-February 2021, at the peak of the Israeli mass vaccination campaign, there was a 22% increase in overall mortality in Israel compared with the previous year."
"In fact, January-February 2021 have been the deadliest months in the last decade, with the highest overall mortality rates compared to corresponding months in the last 10 years."

The IPC finds that "amongst the 20-29 age group the increase in overall mortality has been most dramatic. In this age group, we detect an increase of 32% in overall mortality in comparison with previous year."

"Statistical analysis of information from the Central Bureau of Statistics, combined with information from the Ministry of Health, leads to the conclusion that the mortality rate amongst the vaccinated is estimated at about 1: 5000 (1: 13000 at ages 20-49, 1: 6000 at ages 50-69, 1: 1600 at ages 70+)."

"According to this estimate, it is possible to estimate the number of deaths in Israel in proximity of the vaccine, as of today, at about 1000-1100 people."

"There is a high correlation between the number of people vaccinated per day and the number of deaths per day, in the range of up to 10 days, in all age groups."

"Ages 20-49 – a range of 9 days from the date of vaccination to mortality, ages 50-69 – 5 days from the date of vaccination to mortality, ages 70 and up – 3 days from the date of vaccination to mortality."

The IPC also reveals that the "the risk of mortality after the second vaccine is higher than the risk of mortality after the first vaccine."

This is not only about the death risk, as per the reports of IPC, "as of the date of publication of the report, 2066 reports of side effects have accumulated in the Civil Investigation Committee and the data continue to come in.

These reports indicate damage to almost every system in the human body. Our analysis found a relatively high rate of heart-related injuries.

26% of all cardiac events occurred in young people up to the age of 40, with the most common diagnosis in these cases being Myositis or Pericarditis.

*Also, a **high rate of massive vaginal bleeding, neurological damage, and damage to the skeletal and skin systems has been observed.***

It should be noted that a significant number of reports of side effects are related, directly or indirectly, to Hypercoagulability (infarction), Myocardial infarction, stroke, miscarriages, impaired blood flow to the limbs, pulmonary embolism."

End of excerpts

https://sarahwestall.com/israeli-people-committees-report-find-catastrophic-side-effects-of-pfizer-vaccine-to-every-system-in-human-body/

Time to blow your mind- This is how they do it – how they lie with statistics from study results to sell more drugs/vaccines

As I did research on the statistical reporting from an article from the British medical journal ***Lancet Microbe***, I will report on in a couple pages, I gained some clarity that gave me an ahhh-ha moment and made me furious at the same time. I found this article that explained the fuzzy math techniques that drug companies use to peddle their products to an unsuspecting public and truthfully many doctors who have no clue about how they do this.

Understanding how they do this and what these calculations mean will help you see through the smoke and mirrors on the percentages of efficacy (effectiveness) of the COVID-19 vaccines.

Number Needed to Treat (NNT): A tool to analyze harms and benefits

A key to making an informed medical choice is weighing potential benefits versus potential harms.

But how do you know how likely you are to benefit from a medical treatment or procedure?

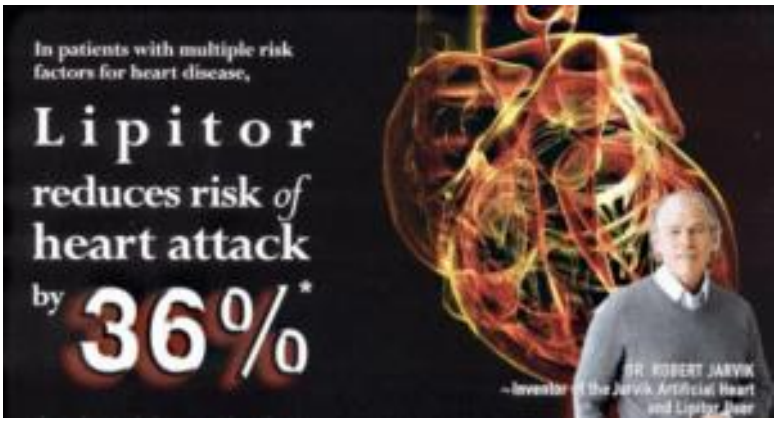
One statistic that can help is called the **Number Needed to Treat**, or **NNT**.

The NNT tells us the number of people we need to give a drug (or other intervention) to in order for *just one person* to receive a benefit (or, to prevent just one adverse outcome).

How to calculate NNT

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.



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.)

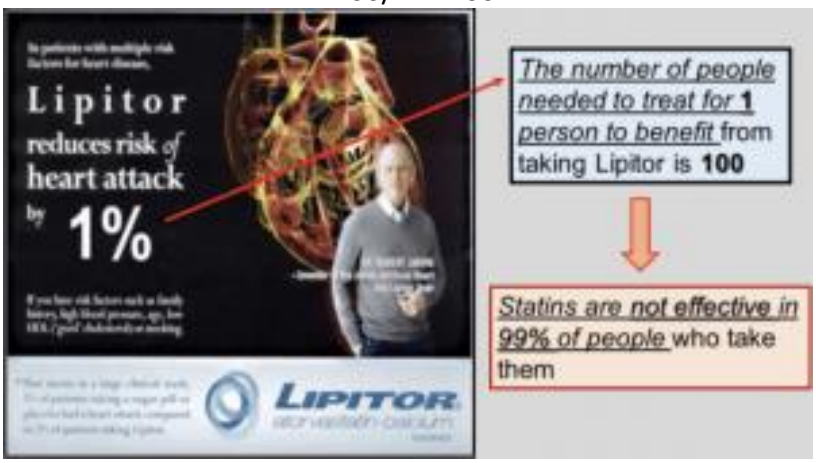
This 36% number comes from a randomized trial called ASCOT-LLA published in The Lancet in 2003. It showed that 1.9% of people taking Lipitor suffered a heart attack, while 3.0% of the placebo group had one. The *relative risk reduction*, or RRR, is the ratio of the two risks and is calculated by subtracting 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.

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 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."*

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.

Looking at how NNT is calculated it becomes clear that the ideal NNT would be one, because it would mean that all who were treated benefited. But as you might guess, an NNT=1 is rarely, if ever, seen. So what sort of NNT's are we looking for?

A very helpful 2016 article on NNT by STAT provides some guidance. It quotes a 2006 study from the University of Toronto which offers these guidelines:

An NNT of 5 or less (≤5) was probably associated with a meaningful health benefit … (while) … an NNT of 15 or more (≥15) was quite certain to be associated with, at most, a small net health benefit.

https://www.healthnewsreview.org/toolkit/tips-for-understanding-studies/number-needed-to-treat/

End of excerpts

Wait until you see what the NNT for the vaccines is! You will be shocked!!!! (although they call it NNV for Number Needed to Vaccinate in order for one person to benefit)

How effective are the COVID-19 vaccines- REALLY?

I have reported previously on the analysis of the clinical trial data for the Pfizer and Moderna vaccines by Dr. Peter Doshi, an Associate Editor for the ***British Medical Journal***. He found the efficacy to be just a fraction of what the manufacturers reported after their own trials.

Here is just a snippet from that report:

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).

He also had criticisms with the Moderna trial data…

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

Another reason the reported "effectiveness" of the vaccines is all smoke and mirrors as this article from the medical journal *Lancet Microbe* reveals

Now another criticism of the reporting of the vaccine efficacy data reported in the British medical journal ***Lancet Microbe*** April 20, 2021. The commentary is by three physicians and titled, **COVID-19 vaccine efficacy and effectiveness—the elephant (not) in the room.**

I'm going to reproduce a good portion of the commentary, because of its importance and the profound impact on understanding on the way these things are portrayed.

From the commentary:

(Bold highlights are mine)

Furthermore, excerpts of these results have been widely communicated and debated through press releases and media, sometimes in misleading ways. Although attention has focused on vaccine efficacy and comparing the reduction of the number of symptomatic cases, fully understanding the efficacy and effectiveness of vaccines is less straightforward than it might seem. Depending on how the effect size is expressed, a quite different picture might emerge (figure; appendix).

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.

ARR is also used to derive an estimate of vaccine effectiveness, which is the number needed to vaccinate (NNV) to prevent one more case of COVID-19 as 1/ARR.

NNVs bring a different perspective: 76 for the Moderna– NIH, 78 for the AstraZeneca–Oxford, 80 for the Gamaleya, 84 for the J&J, and 117 for the Pfizer–BioNTech vaccines. The explanation lies in the combination of vaccine efficacy and different background risks of COVID-19 across studies: 0·9% for the Pfizer–BioNTech, 1% for the Gamaleya, 1·4% for the Moderna–NIH, 1·8% for the J&J, and 1·9% for the AstraZeneca–Oxford vaccines. ARR (and NNV) are sensitive to background risk— the higher the risk, the higher the effectiveness— as exemplified by the analyses of the J&J's vaccine on centrally confirmed cases compared with all cases:8 both the numerator and denominator change, RRR does not change (66–67%), but the one-third increase in attack rates in the unvaccinated group (from 1·8% to 2·4%) translates in a one-fourth decrease in NNV (from 84 to 64).

There are many lessons to learn from the way studies are conducted and results are presented. With the use of only RRRs, and omitting ARRs, reporting bias is introduced, which affects the interpretation of vaccine efficacy. When communicating about vaccine efficacy, especially for public health decisions such as choosing the type of vaccines to purchase and deploy, having a full picture of what the data actually show is important, and ensuring comparisons are based on the combined evidence that puts vaccine trial results in context and not just looking at one summary measure, is also important. Such decisions should be properly informed by detailed understanding of study results, requiring access to full datasets and independent scrutiny and analyses.

Unfortunately, comparing vaccines on the basis of currently available trial (interim) data is made even more difficult by disparate study protocols, including primary endpoints (such as what is considered a COVID-19 case, and when is this assessed), types of placebo, study populations, background risks of COVID-19 during the study, duration of exposure, and different definitions of populations for analyses both within and between studies, as well as definitions of endpoints and statistical methods for efficacy. Importantly, we are left with the unanswered question as to whether a vaccine with a given efficacy in the study population will have the same efficacy in another population with different levels of background risk of COVID-19. This is not a trivial question because transmission intensity varies between countries, affected by factors such as public health interventions and virus variants. 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.

Uncoordinated phase 3 trials do not satisfy public health requirements; platform trials designed to address public health relevant questions with a common protocol will allow decisions to be made, informed by common criteria and uniform assessment. **These considerations on efficacy and effectiveness are based on studies measuring prevention of mild to moderate COVID-19 infection; they were not designed to conclude on prevention of hospitalisation, severe disease, or death, or on prevention of infection and transmission potential. Assessing the suitability of vaccines must consider all indicators, and involve safety, deployability, availability, and costs.**

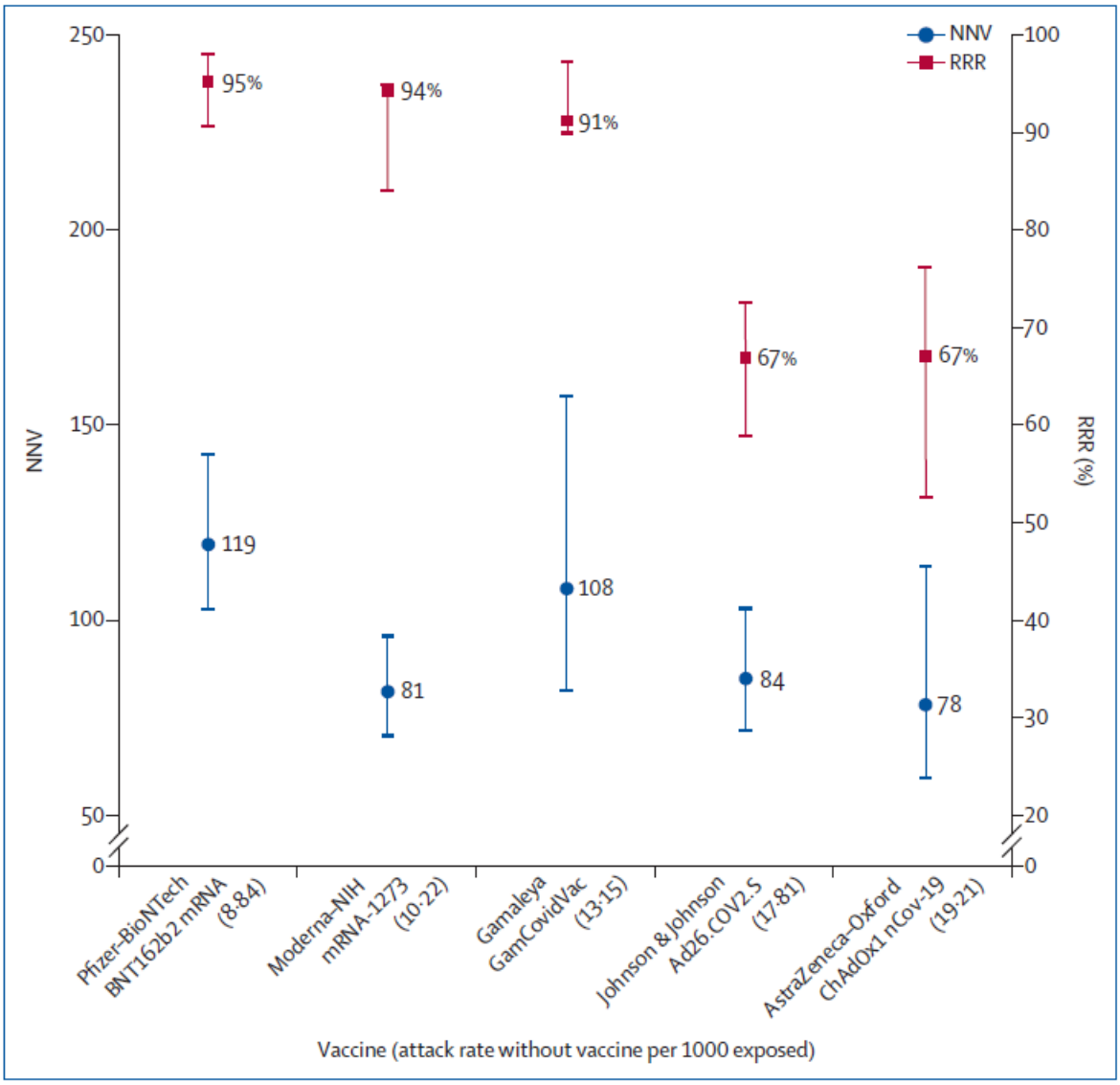


Figure: **RRR and NNV with 95% CI ranked by attack rate in the unvaccinated (placebo) group for five COVID-19 vaccines**
The lower the NNV and the higher the RRR, the better the vaccine efficacy. Details are in the appendix (p 3). RRR=relative risk reduction. NNV=numbers needed to vaccinate. NIH=US National Institutes of Health.

https://www.thelancet.com/journals/lanmic/article/PIIS2666-5247(21)00069-0/fulltext

So, looking at the chart above, the Number Needed to Vaccinate (NNV) for one person to benefit from the vaccine is the following for the different vaccines:

<u>These are the results based on clinical trial data:</u> (which as stated above doesn't consider the entire population)

Pfizer: 119 (although when calculated real-world in the entire Israeli population as cited above the NNV is 217!)
Moderna: 81
Gamaleya: 108
J & J: 84
Astra Zeneca: 78

When you hear people like Dr. Fauci saying the effectiveness of the Pfizer vaccine is 95%, the public assumes he knows what he is talking about. But does he? Is he knowingly parroting Pfizer's talking point sales pitch? Is he ignorant about the statistical reporting bias and misleading information he is telling the world? Is he a useful idiot or a complicit liar? These are serious questions. Because if he is ignorant about how things should be reported, he has no business being in the job he is in at the NIAID, or as the "trusted" spokesperson for the media and to the public. If he is not ignorant about how to truthfully report study results, then he is nothing more than a drug rep and has no business in the position he is in as the "trusted" spokesperson for the media and to the public. Either way, we need someone else who can tell the public the truth in that capacity.

There also may be some inherent challenges with just reporting NNT to the public. A decision as to which patient may want to assume the risk of the medication based on being that one person in X number of people who may benefit should always be between a doctor, their patient and the patient's ability to do their own research. It may boil down to their genetic and clinical risk factors. But isn't that the exact same argument for the vaccines? The decision should be up to each individual based on providing them with ALL the information and in consultation with their doctors looking at all the risk vs. benefits making a calculated decision. True science. True medical care. True informed consent. And a process of true critical thinking.

Pharma can lie with statistics to deceive people and the World Health Organization continues to suppress proven effective treatments

This appeared May 11th, 2021.

≡ Forbes

BREAKING | May 11, 2021, 02:49pm EDT | 71,175 views

Indian State Will Offer Ivermectin To Entire Adult Population — Even As WHO Warns Against Its Use As Covid-19 Treatment

Siladitya Ray Forbes Staff

Business

Covering breaking news and tech policy stories at Forbes.

Updated May 11, 2021, 02:51pm EDT

TOPLINE The World Health Organisation warned against the use of the anti-parasitic drug Ivermectin in treating Covid-19 on Tuesday after the Indian state of Goa announced it would give the drug to all its adult residents based on an unproven claim that it may help reduce the severity of Covid-19 infections.

Quote from the article…

In its assessment of Ivermectin as a potential treatment for Covid-19, the U.S. National Institutes of Health noted that there is insufficient data for it to recommend the use of the drug, and added: "Results from adequately powered, well-designed, and well-conducted clinical trials are needed to provide more specific, evidence-based guidance on the role of ivermectin in the treatment of COVID-19."

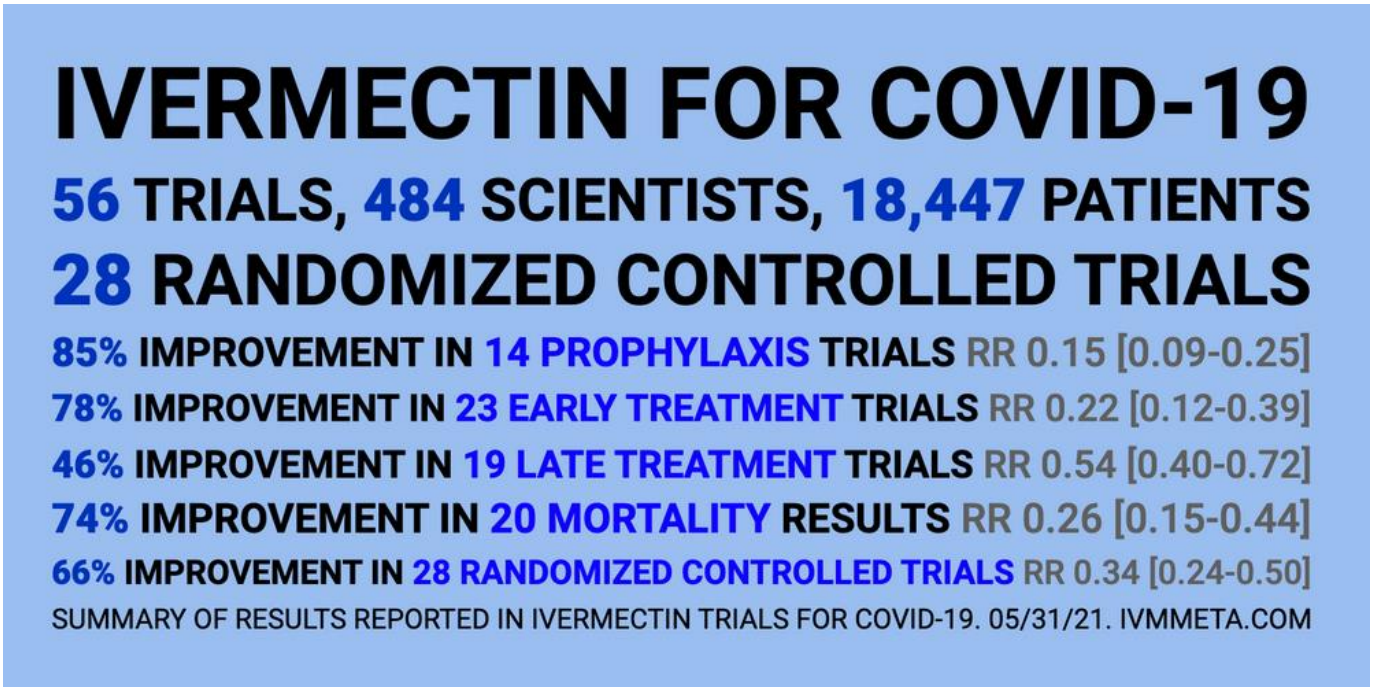
https://www.forbes.com/sites/siladityaray/2021/05/11/indian-state-will-offer-ivermectin-to-entire-adult-population---even-as-who-warns-against-its-use-as-covid-19-treatment/amp/

Same old story. W.H.O., FDA and N.I.H. protect big pharma and their COVID-19 vaccine interests, while people die unnecessarily.

What is the evidence for effectiveness?

There is PLENTY!

- This web site https://c19study.com/ currently contains 56 trials showing significant benefit. The site contains many excellent graphs and ways of looking at the evidence. Here is a screen capture of the summary results graphic on May 31st, 2021.



- Here is a 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

- 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/

- Go back to the **Citizen Petition** filed by Robert F. Kennedy ***and Children's Health Defense*** near the beginning of this newsletter and look at all of the evidence presented in that legal challenge which supports the high rate of effectiveness of Ivermectin and Hydroxychloroquine/zinc.

It is time the FDA, NIH and the WHO stop working so hard to shoot down safe, inexpensive, readily available and effective drugs like Ivermectin and Hydroxychloroquine with zinc for early treatment of COVID-19. It is time they accept the overwhelming evidence and help save countless lives. Although, as long as the vaccines are under Emergency Use Authorization (EUA), admitting there is a safe and effective treatment for COVID-19 would negate the need for the E.U.A. and the vaccines. What are their true motives? Who are they really protecting, the health of the people of the world, or the interests of pharma? Just asking the MOST important question.

Tucker Carlson is the fearless leader of the counter-narrative to the mainstream media's steady diet of fear, hysteria and misinformation!

Tucker Carlson is quickly becoming one of the most admired media leaders in telling the truth based on the actual data and statistics surrounding COVID-19, the government's response and the "vaccines".

Watch this incredible monolog whereby Tucker uses the CDC's own data and makes the case that there is real risk from the COVID-19 vaccines, a risk that every person must calculate for themselves.

Tucker: How many Americans have died after taking COVID vaccines?

May. 06, 2021 - 15:44 - 'Tucker Carlson Tonight' host takes a look at the potential risks that come with taking vaccines.

https://video.foxnews.com/v/6252794642001?playlist_id=5198073478001#sp=show-clips

How deadly are the COVID-19 vaccines compared to the flu vaccine this year?

That is a really provocative question, isn't it? Let's take a look at that.

Let's take the lower end of the estimated 194 million to 197 million doses projected for the 2020-2021 flu season.

- There have been 30 reported deaths from the flu vaccine to the ***Vaccine Adverse Event Reporting System (VAERS)*** between August 2020 and May 2021.

- Dividing 194,000,000 by 30 gives us a number of 1 death per 6,466,667 doses of the various flu

vaccines.

- Since the rollout of the COVID-19 vaccines and up through May 29th, 2021 there have been approximately 167 million people vaccinated with the experimental COVID-19 vaccines.

- Through that same period of time there have been a reported 4,500 deaths to ***VAERS***.

.

- **Dividing 167,000,000 by 4,500 deaths equals one death for every 37,411 people vaccinated!!**

That makes the COVID-19 vaccines 174 times more deadly than the flu vaccines! And that is comparing apples to apples by using the same reporting system however flawed it may be. Even though VAERS has been shown to only report less than 1% of the actual number of vaccine adverse events according to the 2010 ***CDC*** funded ***Harvard*** study.
https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf

Another way to look at 174 times more deadly, is 17,400 percent deadlier! Yet not a peep from the CDC, the FDA, HHS or the media, especially considering that the Swine Flu vaccination program was scrapped after 25 reported deaths. Isn't that interesting?

References:

Number of deaths from the flu vaccine August 2020 through May 25th, 2021

https://medalerts.org/vaersdb/findfield.php

Search Results

From the 5/21/2021 release of VAERS data:

Found 30 cases where Vaccine targets Influenza (FLU(H1N1) or FLU3 or FLU4 or FLUA3 or FLUC3 or FLUC4 or FLUN(H1N1) or FLUN3 or FLUN4 or FLUR3 or FLUR4 or FLUX or FLUX(H1N1) or H5N1 or FLUA4) and Patient Died and Vaccination Date on/after '2020-08-01'

Table

Age	Count	Percent
< 3 Years	6	20%
3-6 Years	1	3.33%
6-9 Years	1	3.33%
12-17 Years	1	3.33%
17-44 Years	2	6.67%
44-65 Years	4	13.33%
65-75 Years	2	6.67%
75+ Years	11	36.67%
Unknown	2	6.67%
TOTAL	30	100%

https://medalerts.org/vaersdb/help/help.php

***Terrible footnote:** As can be seen above, there have been 9 deaths reported in children under 17 years of age from the flu vaccine this flu season. Compare that to 1 death from influenza this year as I reported earlier in this newsletter!

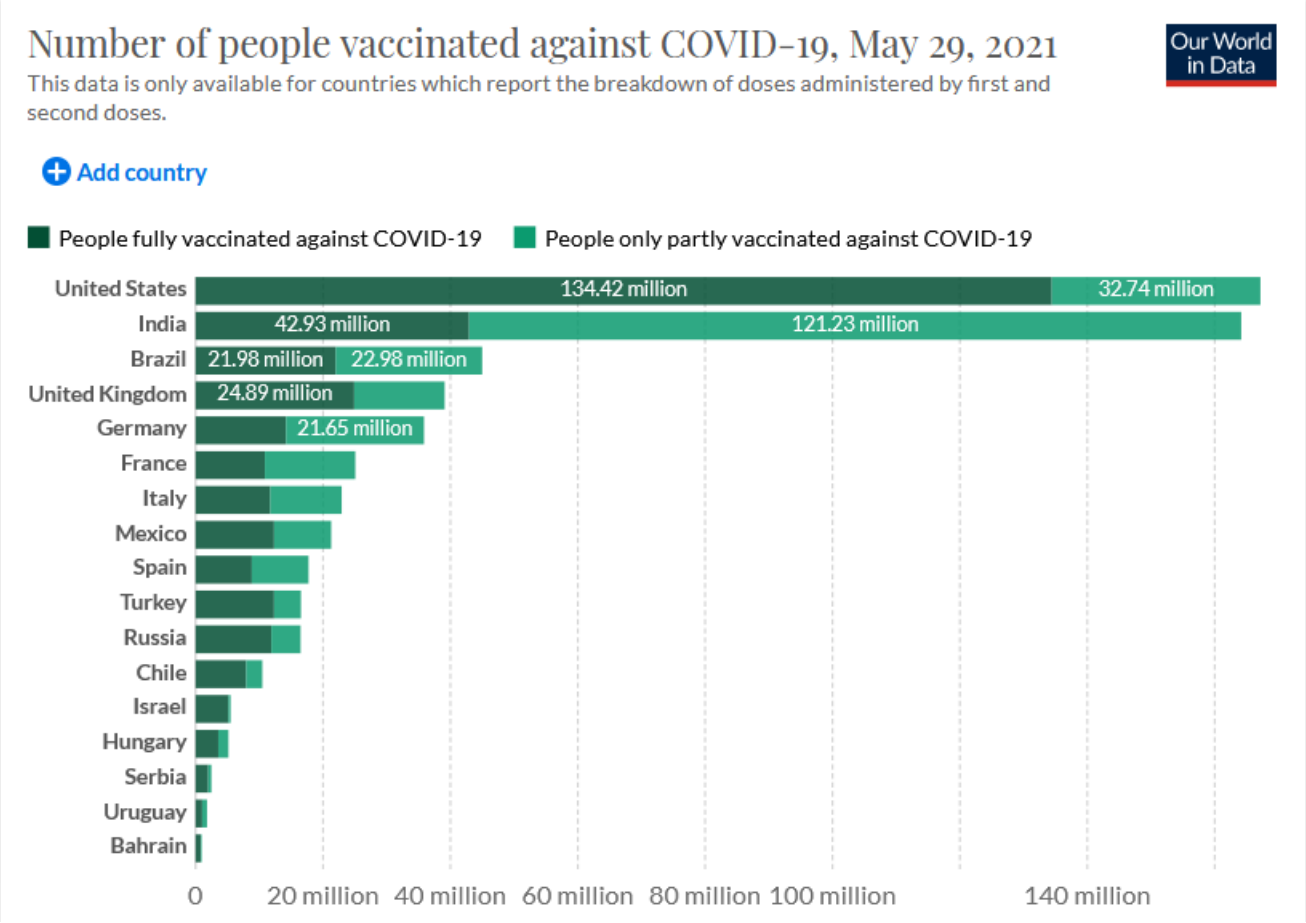
Number of flu vaccines from the CDC's website:

Influenza vaccine distribution information for the 2020-2021 season is posted here as CDC receives it, typically on Fridays. Please continue to check this page for the most up-to-date information.

Flu vaccine is produced by private manufacturers, so supply depends on manufacturers. For the 2020-2021 season, manufacturers have projected they will provide as many as 194 to 198 million doses of influenza vaccine for the U.S. market. (Projections may change as the season progresses.) As noted below, manufacturers are already distributing flu vaccine with no significant delays reported (Additional information on vaccine supply and distribution for the 2020-2021 influenza season is available). However, because of the record number of doses being produced this season, production and distribution will occur over a longer period.

https://www.cdc.gov/flu/prevent/vaccine-supply-distribution.htm

Number of people vaccinated with the COVID-19 vaccines
(Adding the 134.42 million and the 32.74 million)

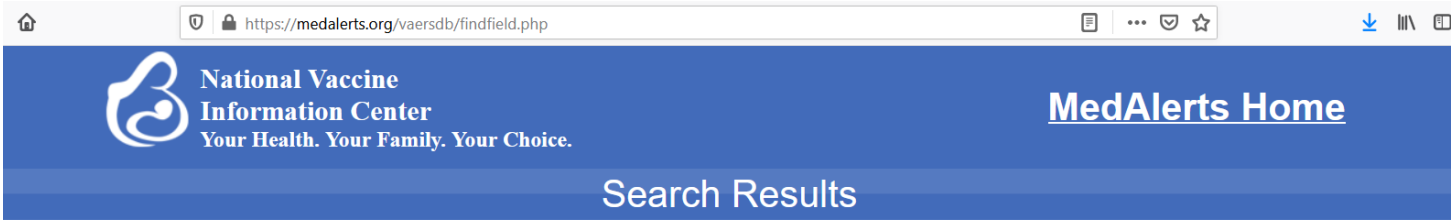


Deaths from COVID-19 vaccines reported to VAERS as of May 21st, 2021.

See the graphic earlier in the newsletter through May 21st showing 4,406 deaths. Sad to say, there have been between 200 and 250 additional deaths reported per week, thus by the end of May there will most likely be 300-400 deaths reported, bringing the total to around 4,750 reported deaths, although all indications are that the number is much higher.

How does the number of reported deaths in the U.S. from the COVID-19 vaccines compare to all deaths from all vaccines in the last 30 years?

As of the start of the COVID-19 vaccine campaign in December, there have been 8,980 vaccine related deaths reported to VAERS from ALL vaccines since 1990 (30 years).



From the 5/21/2021 release of VAERS data:

Found 8,980 cases where Patient Died and Vaccination Date on/before '2020-11-30'

Table

Age	Count	Percent
< 3 Years	3,901	43.44%
3-6 Years	167	1.86%
6-9 Years	77	0.86%
9-12 Years	82	0.91%
12-17 Years	200	2.23%
17-44 Years	420	4.68%
44-65 Years	472	5.26%
65-75 Years	424	4.72%
75+ Years	789	8.79%
Unknown	2,448	27.26%
TOTAL	8,980	100%

Taking the 4,406 reported deaths through May 21st, 2021 and dividing by 8,980 and multiplying X 100 calculates to 49%. That means that in just over 5 months we have seen half as many deaths from the COVID-19 vaccines as we have been reported from all the vaccines in the previous 30 years combined!

That is horrific!

Video showing the rise in COVID-19 cases and deaths after countries implemented their mass vaccination program

This video is shocking if true. I have not verified the data behind the results they show, but I have read articles written about the same phenomenon in various countries around the world. I did go to the website listed on the video and found some interesting things, although it is entirely possible that the person that put together the video simply used their data and is not affiliated with them. They are affiliated with ***The Institute for Health Metrics and Evaluation (IHME)*** from the ***University of Washington***, the group that brought us all the wildest projections of death from COVID at the very beginning along with the ***Imperial College of London*** triggering the 15 days…no 30 days…no 15 months to flatten the curve world-wide lockdowns. Their "partners" tab listed such groups as the ***Melinda and Bill Gates Foundation, Facebook, Google*** and the ***W.H.O.*** among

many others. Before I discovered their partners, I was wondering why their graphs emphasized masks so much, and as a benefit far above that which any published science would support even if it was slanted in favor of masking.

I am providing two links in case either are taken down….

https://articles.mercola.com/sites/articles/archive/2021/05/27/mass-vaccination-triggers-spike-covid-19-cases.aspx

https://www.youtube.com/watch?v=xSrc_s2Gqfw&t=97s

More evidence that cases and deaths have risen dramatically after mass vaccination efforts begin

A Forbes online article conforms what you have just been reading, but they put an interesting spin on it. They deflect the blame from the vaccines and suggest that the rise in cases and deaths are due to the governments relaxing their restrictions too soon as the topline description in this screen capture declares.

Forbes

Some Countries With The Highest Vaccination Rates Are Facing A Surge In Covid Deaths And Infections—Experts Say Complacency Is Partly To Blame

Robert Hart Forbes Staff
Business
I cover breaking news.

TOPLINE Some countries with the world's highest vaccination rates are also battling devastating surges of Covid-19 and the highest death tolls, a worrying trend that has left experts and officials wondering whether successful inoculation drives have lulled governments into easing restrictions too soon and the public into a false sense of security.

From the article

Uruguay has endured the highest Covid-19 death rate in the world per capita for several weeks, despite having one of the world's most successful inoculation drives, a common situation in a number of other highly vaccinated countries like Bahrain and the Maldives.

Controlling for population, Bahrain (0.9 deaths per 100,000 people) and the Maldives (1) have similarly grim metrics and have reported far greater death rates than countries like the U.S. (0.15) and India (0.29) for a large part of May.
Other countries like Chile and the Seychelles rank among the worst Covid infection surges in the world, though each have higher vaccination levels than the U.S., with experts warning that lifting restrictions too early may have made the public unduly complacent.

50%. - Of the world's most vaccinated countries mentioned in this story, all have at least this proportion of their population partially vaccinated against Covid-19. Data is available for Bahrain (53%), Chile (55%), the Maldives (57%), the Seychelles (72%) and Uruguay (50%).

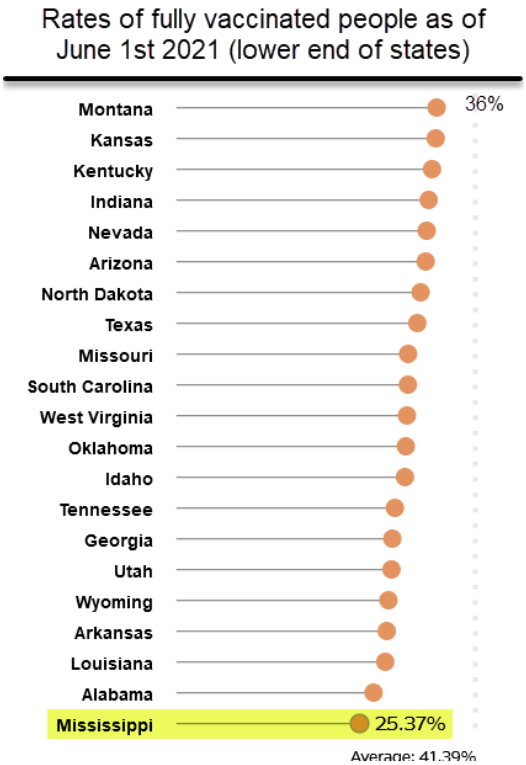
End of excerpts

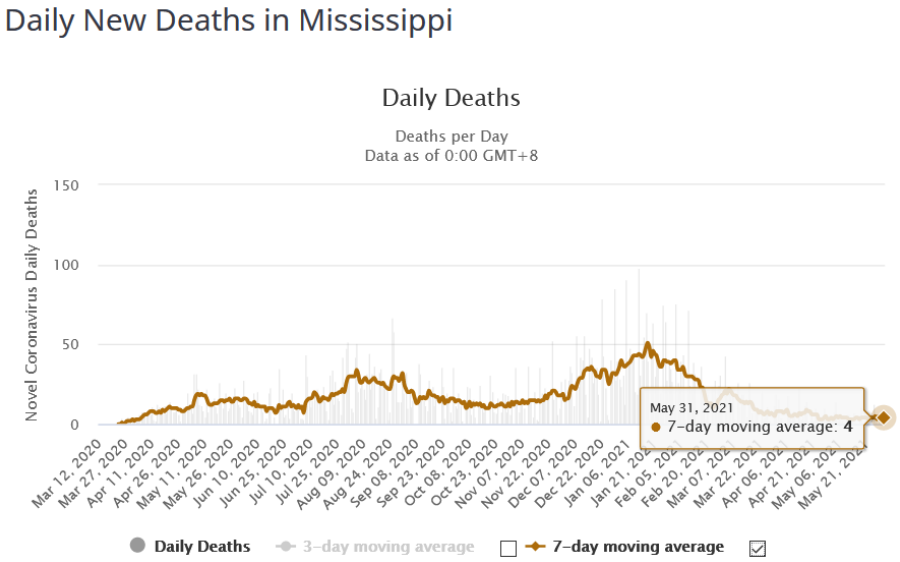
They close the article with this interesting paragraph…

"Polling in the U.S. indicates unvaccinated people are more likely to be comfortable engaging in everyday activities than their vaccinated compatriots, a potential issue for the states relaxing pandemic restrictions based on high vaccination rates."

How are the states with the lowest percentage of their population vaccinated faring?

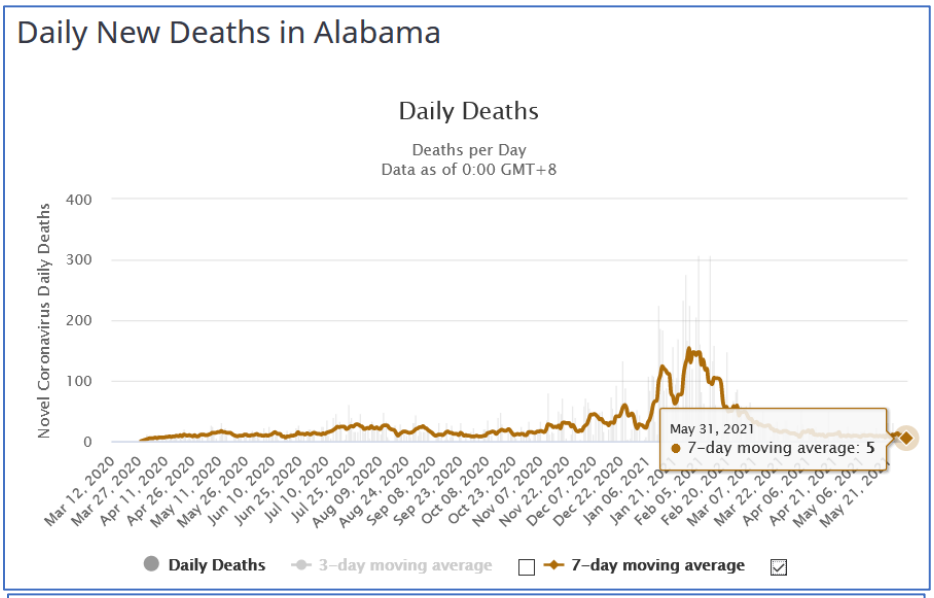
Well that last statement from the previous story sounds good on paper for those pushing the vaccine agenda, but it doesn't translate well in the real world. Here are some examples of that, looking at U.S. states with the lowest vaccination rates and how they are doing in COVID-19 deaths, which after all is the metric that is the most telling as the one everyone would like to avoid.

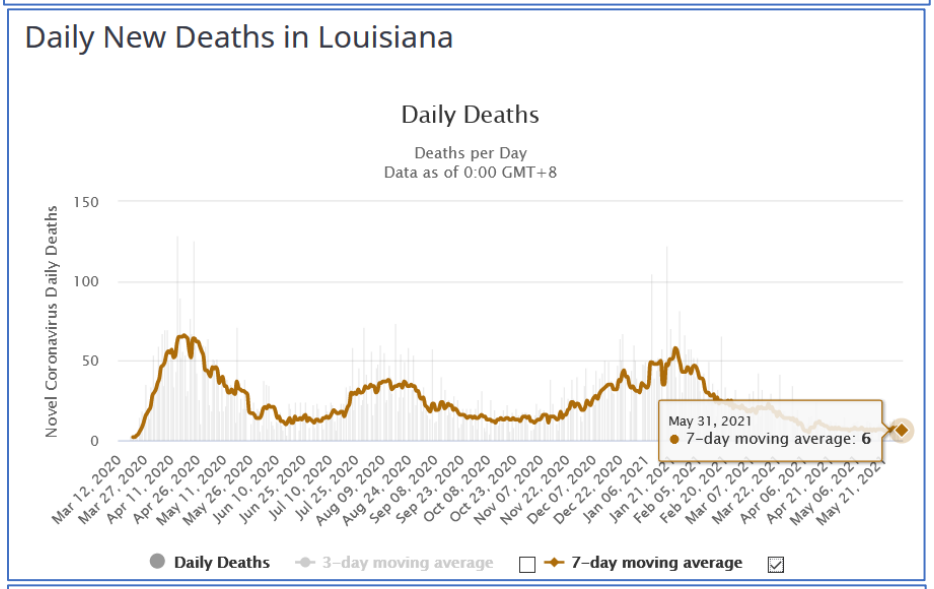


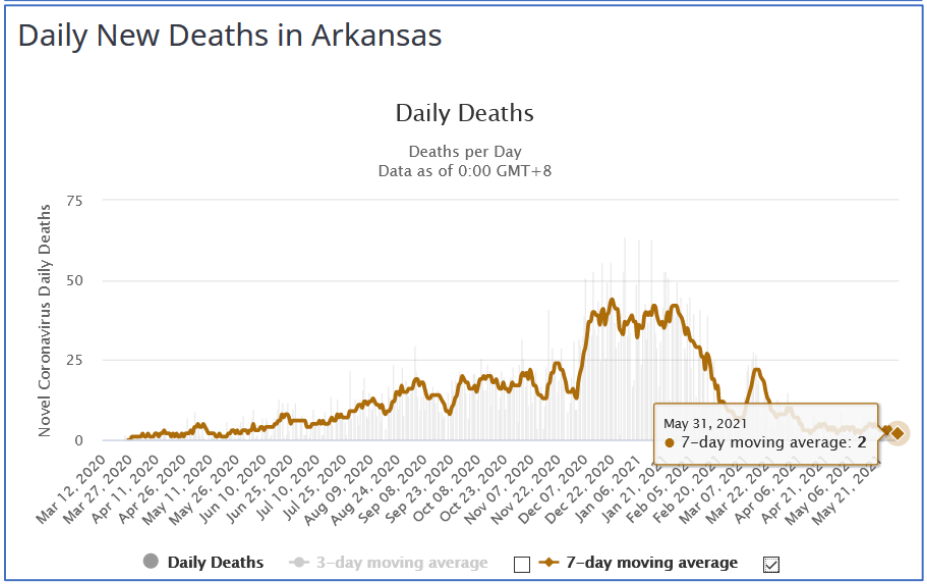


https://coronavirus.jhu.edu/vaccines/us-states

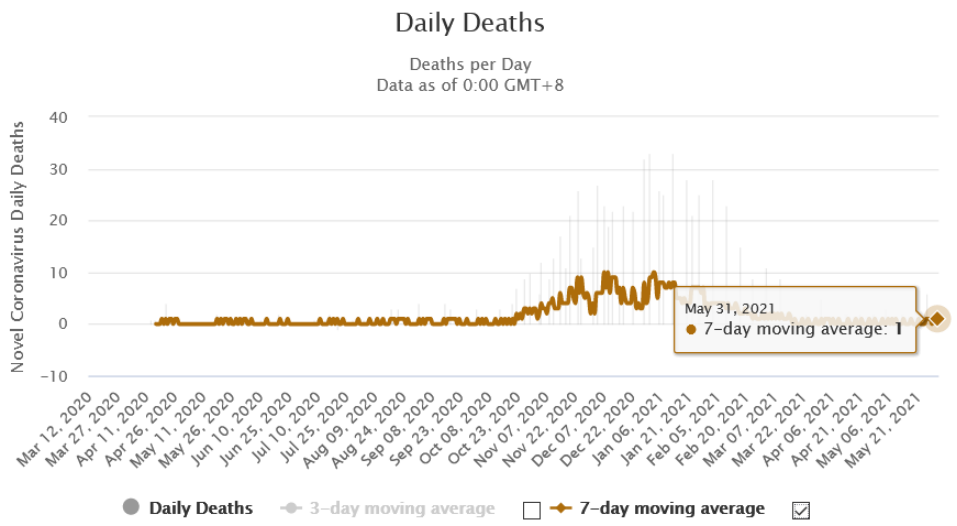
See the death rates for the states with the lowest vaccination rates in order over the next four pages…





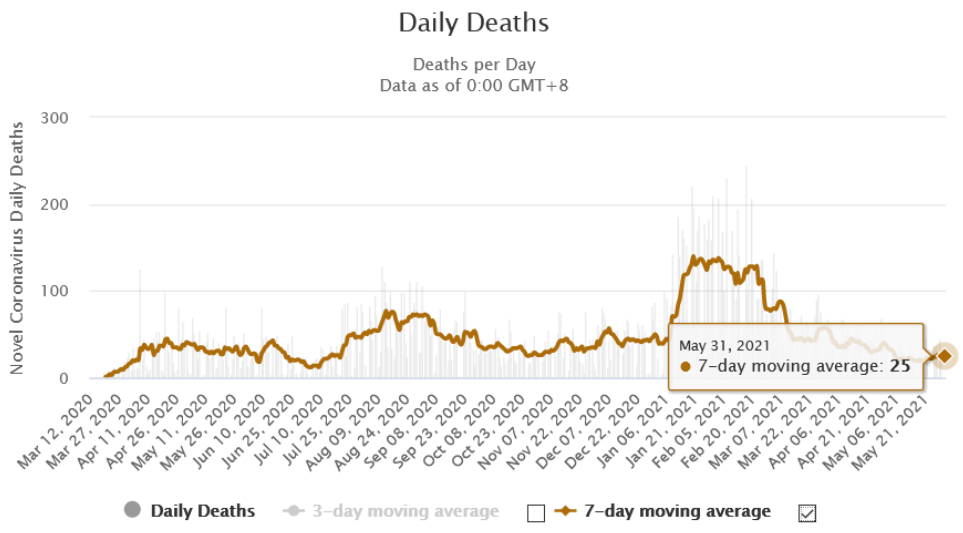


Daily New Deaths in Wyoming

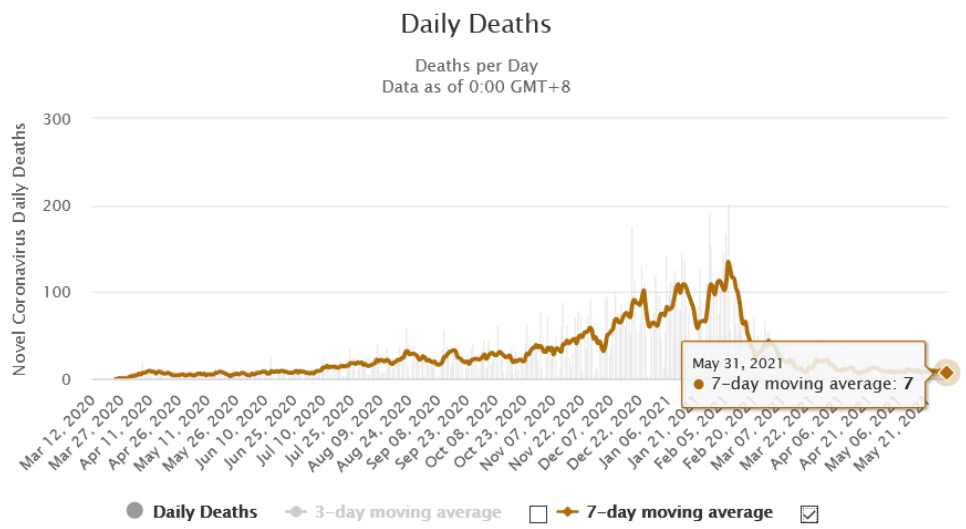


Daily New Deaths in Utah

Daily New Deaths in Georgia

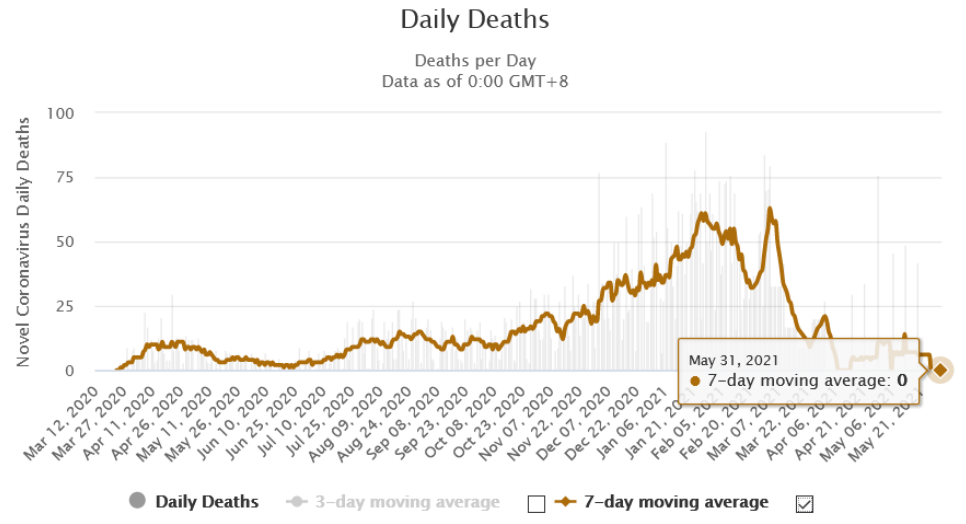


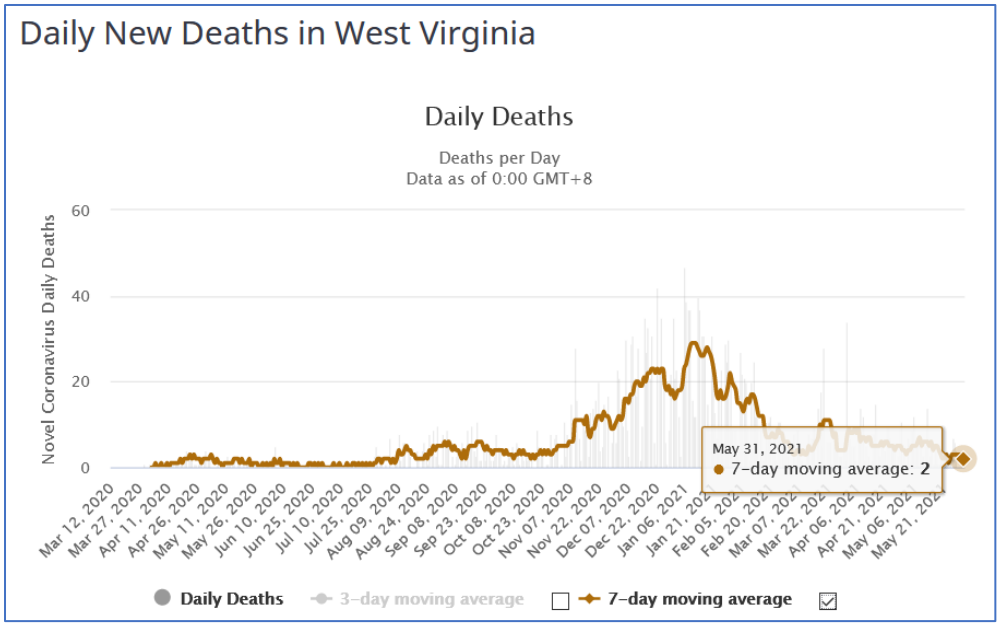
Daily New Deaths in Tennessee

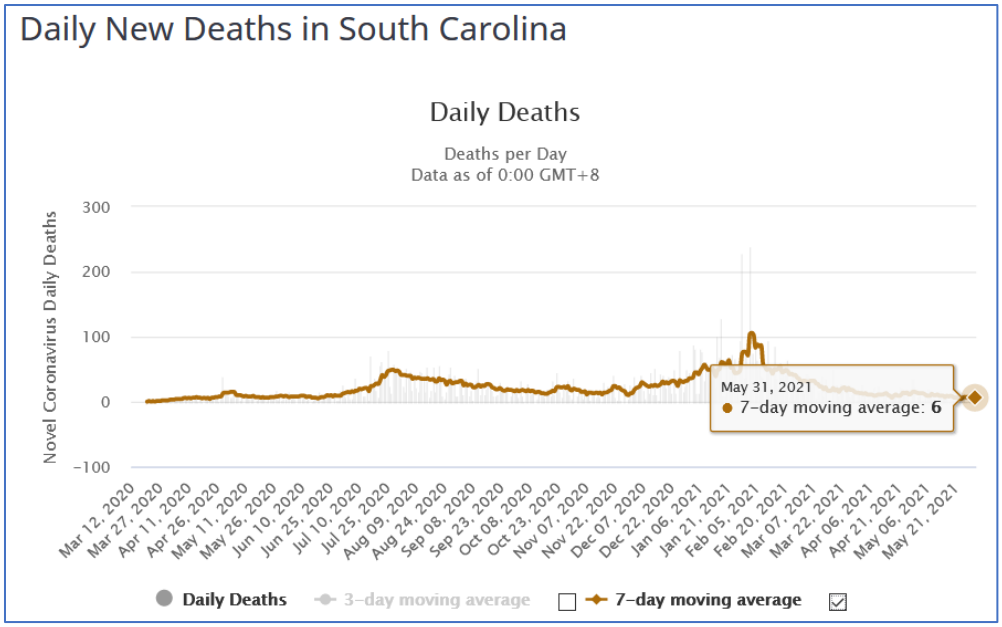


Daily New Deaths in Idaho

Daily New Deaths in Oklahoma







How's that narrative looking that we have to get to 70% of people vaccinated to save the day looking now?

The coming Nuremberg style trials

Justice may be coming for many of those that have not only potentially caused but also those that have coopted this infectious disease outbreak and amplified it through intentional and extraordinary measures to perpetuate unbelievable fear and suffering, much of which was completely avoidable.

In a May 12th article by Steve Beckow titled, **The New Nuremberg Trials 2021**, the case is laid out for the day of reckoning for the multi-pronged and scientifically unjustified public health approaches to the COVID-19 experience. With 1,000 attorneys and 10,000 medical experts on board, the real prospect exists that justice may well be served in the international courts.

Here is the article in its entirety

A team of over 1,000 lawyers and over 10,000 medical experts led by Dr. Reiner Fuellmich **(a German attorney)** have begun legal proceedings against the CDC, WHO & the Davos Group for crimes against humanity. Fuellmich and his team present the faulty PCR test and the order for doctors to label any comorbidity death as a Covid death as fraud. The PCR test was never designed to detect pathogens and is 100% faulty at 35 cycles. All the PCR tests overseen by the CDC are set at 37 to 45 cycles. The CDC admits that any tests over 28 cycles are not admissible for a positive reliable result. This alone invalidates over 90% of the alleged covid cases */* "infections" tracked by the use of this faulty test.

In addition to the flawed tests and fraudulent death certificates, the "experimental" vaccine itself is in violation of Article 32 of the Geneva Convention. Under Article 32 of the 1949 Geneva Convention IV, "mutilation and medical or scientific experiments not necessitated by the medical treatment of a protected person· are prohibited. According to Article 147, conducting biological experiments on protected persons is a grave breach of the Convention. The "experimental" vaccine is in violation of all 10 of the Nuremberg Codes which carry the death penalty for those who seek to violate these International Laws.

The "vaccine" fails to meet **the following five requirements** to be considered a vaccine and is by definition a medical "experiment" and trial:

1. ***Provides immunity to the virus***

This is a "leaky" gene therapy that does not provide immunity to Covid and claims to reduce symptoms yet double vaccinated are now 60% of the patients requiring ER or ICU with covid infections.

2. ***Protects recipients from getting the virus***

This gene-therapy does not provide immunity and double-vaccinated can still catch and spread the virus. *Reduces deaths from the virus infection* This gene-therapy does not reduce deaths from the infection. Double-vaccinated infected with Covid have also died.

3. ***Reduces deaths from the virus infection***

This gene-therapy does not reduce deaths from the infection. Double-vaccinated infected with Covid have also died.

4. ***Reduces circulation of the virus***

This gene-therapy still permits the spread of the virus as it offers zero immunity to the virus.

5. ***Reduces transmission of the virus***

This gene therapy still permits the transmission of the virus as it offers zero immunity to the virus.

<u>Violations of the Nuremberg Code are as follows:</u>

Nuremberg Code #1: Voluntary Consent is Essential

No person should be forced to take a medical experiment without informed consent. Many media, pol itical and nonmedical persons are telling people to take the shot. They offer no information as to the adverse effects or dangers of this gene-therapy. All you hear from them is - " safe and effective" and " benefits outweigh the risks." Countries are using lockdowns, duress and threats to force people to take this vaccine or be prohibited to participate in free society under the mandate of a Vaccine Passport or Green Pass. During the Nuremberg trials, even the media was prosecuted and members were put to death for lying to the public, along with many of the doctors and Nazis found guilty of Crimes Against Humanity.

Nuremberg Code #2: Yield Fruitful Results Unprocurable By Other Means

As listed above, the gene-therapy does not meet the criteria of a vaccine and does not offer immunity to the virus. There are other medical treatments that yield fruitful results against Covid such as lvermectin, Vitamin D, Vitamin C, Zinc and boosted immune systems for flu and colds.

Nuremberg Code #3: Base Experiments on Results of Animal Experimentation and Natural History of Disease

This gene therapy skipped animal testing and went straight to human trials. In mRNA research that Pfizer used – a candidate study on mRNA with rhesus macaques monkeys using BNT162b2 mRNA and in that study all the monkeys developed pulmonary inflammation but the researchers considered the risk low as these were young healthy monkeys from the age of 2-4. Israel has used Pfizer and the International Court of Law has accepted a claim for 80% of the recipients having pulmonary inflammation from being injected with this gene-therapy. Despite this alarming development Pfizer proceeded to develop their mRNA for Covid without animal testing.

Nuremberg Code #4: Avoid All Unnecessary Suffering and Injury

Since the rollout of the experiment and listed under the CDC VAERS reporting system over 4,000 deaths and 50,000 vaccine injuries have been reported in America. In the EU over 7,000 deaths and 365,000 vaccine injuries have been reported. This is a grievous violation of this code.

Nuremberg Code #5: No Experiment to be Conducted if There 's Reason to Think Injury or Death Viii/I Occur

See #4, based on fact-based medical data this gene-therapy is causing death and injury. Past research on mRNA also shows several risks that have been ignored for this current trial gene-experiment. A 2002 study on SARS-CoV-1 spike proteins showed they cause inflammation, immunopathology, blood clots, and impede Angiotensin 2 expression. This experiment forces the body to produce this spike-protein inheriting all these risks.

Nuremberg Code #6: Risk Should Never Exceed the Benefit

Covid-19 has a 98-99% recovery rate. The vaccine injuries, deaths and adverse side-effects of mRNA gene-therapy far exceed this risk. The use of "leaky" vaccines was banned for agriculture use by the US and EU due to the Marek Chicken study that shows 'hot-viruses' and variants emerge ... making the disease even more deadly. Yet, this has been ignored for human use by the CDC knowing fully the risk of new deadlier variants emerge from leaky vaccinations. The CDC is fully aware that the use of leaky vaccines facilitates the emergence of hot (deadlier) strains. Yet they've ignored this When it comes to humans.

Nuremberg Code #7: Preparation Must Be Made Against Even* a *Remote Possibility of Injury, Disability or Death

There were no preparations made. This gene therapy skipped animal trials. The pharmaceutical companies' own Phase 3 human clinical trials will not conclude until *202212023.* These vaccines were approved under an Emergency Use only act and forced on a misinformed public. They are NOT FDA-approved.

Nuremberg Code #8: Experiment Must Be Conducted by Scientifically Qualified Persons

Politicians, media and actors claiming that this is a safe and effective vaccine are not qualified. Propaganda is not medical science. Many retail outlets such as Walmart & drive-through vaccine centers are not qualified to administer experimental medical gene-therapies to the uninformed public.

Nuremberg Code #9: Anyone Must Have the Freedom to Bring the Experiment to an End At Any Time

Despite the outcry of over 85,000 doctors, nurses, virologists and epidemiologists - the experiment is not being ended. In fact, there are currently many attempts to change laws in order to force vaccine compliance. This includes mandatory and forced vaccinations. Experimental 'update' shots are planned for every 6 months without any recourse to the growing number of deaths and injuries already caused by this experiment. These 'update' shots will be administered without any clinical trials. Hopefully this new Nuremberg Trial will put an end to this crime against humanity.

Nuremberg Code #10: The Scientist Must Bring the Experiment to an End At Any Time ff There's Probable Cause of it Resulting in Injury or Death

It is clear in the statistical reporting data that this experiment is resulting in death and injury yet all the politicians, drug companies and so-called experts are not making any attempt to stop this gene-therapy experiment from inflicting harm on a misinformed public.

What can you do to help put an end to this crime against humanity? Share this information. Hold your politicians, media, doctors and nurses accountable - that if they are complicit in this crime against humanity they too are subject to the laws set forth in the Geneva Convention and Nuremberg Code and can be tried, found guilty and put to death. Legal proceedings are moving forward, evidence has been collected and a large growing body of experts are sounding the alarm.

Visit ***the Covid Committee*** website at: https://corona-ausschuss.de/ and if you have been affected by this crime, report the event, persons involved, and as much detail to the following website: https://www.securewhistleblower.com/

end of excerpts

How many of those codes from Nuremberg are being violated today? Nearly every one!

Did Pfizer know people taking their vaccine could shed the spike protein to others? And is that what is happening?

There is some speculation that Pfizer knew that there may be the possibility of a form of shedding of the spike protein to others in the clinical trials. Now before some say, “shedding could never occur from this kind of vaccine”, consider this…

A document titled **Design and Analysis of Shedding Studies for Virus or Bacteria-Based Gene Therapy and Oncolytic Products - Guidance for Industry** was published by the ***U.S. Department of Health and Human Services Food and Drug Administration*** and the ***Center for Biologics Evaluation and Research*** in **August 2015**

I believe the Introduction of this document removes any doubt as to whether this is possible or not.

Introduction:

The Center for Biologics Evaluation and Research (CBER)/Office of Cellular, Tissue, and Gene Therapies (OCTGT) is issuing this guidance to provide you, sponsors of virus or bacteria-based gene therapy products (VBGT products)[1] and oncolytic viruses or bacteria (oncolytic products)[2] with recommendations on how to conduct shedding studies during preclinical and clinical development. For purposes of this guidance, the term "shedding" means release of VBGT or oncolytic products from the patient through one or all of the following ways: excreta (feces); secreta (urine, saliva, nasopharyngeal fluids etc.); or through the skin (pustules, sores, wounds). Shedding is distinct from biodistribution because the latter describes how a product is spread within the patient's body from the site of administration while the former describes how it is excreted or released from the patient's body. Shedding raises the possibility of transmission of VBGT or oncolytic products[3] from treated to untreated individuals (e.g., close contacts and health care professionals). This guidance represents FDA's current thinking on how and when shedding data should be collected for VBGT and oncolytic products during preclinical and clinical development and how shedding data can be used to assess the potential for transmission to untreated individuals. This guidance finalizes the draft guidance of the same title dated July 2014.

End of the introduction

Because the spike protein is the genetic material transported into the host and reproduced by the host's cells and the fact that the spike protein has been found to be a cellular damaging factor in and of itself aside from the rest of the virus, it would be highly suspect as a progenitor of symptoms people have been experiencing after casual exposure to vaccinated individuals. So, while the spike protein is not the full virus and cannot infect cells in the same way as the full SARS-CoV-2 virus, it is theoretically possible that it can trigger cellular pathology and immune responses that could lead to varying degrees of complications. This may possibly occur due to binding with the ACE-2 receptors or just upregulating inflammatory cytokines as an immune response to the spike protein and spike protein fragments circulating in the body.

These next excerpts are from the Pfizer study protocol C4591001 document titled, **A PHASE 1/2/3, PLACEBO-CONTROLLED, RANDOMIZED, OBSERVER-BLIND, DOSE-FINDING STUDY TO EVALUATE THE SAFETY, TOLERABILITY, IMMUNOGENICITY, AND EFFICACY OF SARS-COV-2RNA VACCINE CANDIDATES AGAINST COVID-19 IN HEALTHY INDIVIDUALS**

Abbreviations:
SAE = serious adverse event
SUSAR = suspected unexpected serious adverse reaction
WOCBP = woman/women of childbearing potential

The following are found on pages 67-69.

8.3.5. Exposure During Pregnancy or Breastfeeding, and Occupational Exposure Exposure to the study intervention
under study during pregnancy or breastfeeding and occupational exposure are reportable to Pfizer Safety within 24 hours of investigator awareness.

8.3.5.1. Exposure During Pregnancy (EDP).

An EDP occurs if:

- A female participant is found to be pregnant while receiving or after discontinuing study intervention.

- A male participant who is receiving or has discontinued study intervention exposes a female partner prior to or around the time of conception.

- A female is found to be pregnant while being exposed or having been exposed to study intervention due to environmental exposure. Below are examples of environmental exposure during pregnancy:

- A female family member or healthcare provider reports that she is pregnant after having been exposed to the study intervention by inhalation or skin contact

A male family member or healthcare provider who has been exposed to the study intervention by inhalation or skin contact then exposes his female partner prior to or around the time of conception. The investigator must report EDP to Pfizer Safety within24 hours of the investigator's awareness, irrespective of whether an SAE has occurred. The initial information submitted should include the anticipated date of delivery (see below for information related to termination of pregnancy).

- If EDP occurs in a participant or a participant's partner, the investigator must report this information to Pfizer Safety on the Vaccine SAE Report Form and an EDP Supplemental Form, regardless of whether an SAE has occurred. Details of the pregnancy will be collected after the start of study intervention and until 6 months after the last dose of study intervention.

- If EDP occurs in the setting of environmental exposure, the investigator must report information to Pfizer Safety using the Vaccine SAE Report Form and EDP Supplemental Form. Since the exposure information does not pertain to the participant enrolled in the study, the information is not recorded on a CRF; however, a copy of the completed Vaccine SAE Report Form is maintained in the investigator site file. Follow-up is conducted to obtain general information on the pregnancy and its outcome for all EDP reports with an unknown outcome. The investigator will follow the pregnancy until completion (or until pregnancy termination) and notify Pfizer Safety of the outcome as a follow-up to the initial EDP Supplemental Form. In the case of a live birth, the structural integrity of the neonate can be assessed at the time of birth. In the event of a termination, the reason(s) for termination should be specified and, if clinically possible, the structural integrity of the terminated fetus should be assessed by gross visual inspection (unless pre procedure test findings are conclusive for a congenital anomaly and the findings are reported). Abnormal pregnancy outcomes are considered SAEs. If the outcome of the pregnancy meets the criteria for an SAE (ie, ectopic pregnancy, spontaneous abortion, intrauterine fetal demise, neonatal death, or congenital anomaly), the investigator should follow the procedures for reporting SAEs. Additional information about pregnancy outcomes that are reported to Pfizer Safety as SAEs follows:

•Spontaneous abortion including miscarriage and missed abortion;

•Neonatal deaths that occur within 1month of birth should be reported, without regard to causality, as SAEs. In addition, infant deaths after 1month should be reported as SAEs when the investigator assesses the infant death as related or possibly related to exposure to the study intervention.

Additional information regarding the EDP may be requested by the sponsor. Further follow-up of birth outcomes will be handled on a case-by-case basis (eg, follow-up on preterm infants to identify developmental delays). In the case of paternal exposure, the investigator will provide the participant with the Pregnant Partner Release of Information Form to deliver to his partner. The investigator must document in the source documents that the participant was given the Pregnant Partner Release of Information Form to provide to his partner.

8.3.5.2. Exposure During Breastfeeding

An exposure during breastfeeding occurs if:

•A female participant is found to be breastfeeding while receiving or after discontinuing study intervention.

•A female is found to be breastfeeding while being exposed or having been exposed to study intervention (ie, environmental exposure).An example of environmental exposure during breastfeeding is a female family member or healthcare provider who reports that she is breastfeeding after having been exposed to the study intervention by inhalation or skin contact. The investigator must report exposure during breastfeeding to Pfizer Safety within 24 hours of the investigator's awareness, irrespective of whether an SAE has occurred.The information must be reported using the Vaccine SAE Report Form. When exposure during breastfeeding occurs in the setting of environmental exposure, the exposure information does not pertain to the participant enrolled in the study, so the information is not recorded on a CRF. However, a copy of the completed Vaccine SAE Report Form is maintained in the investigator site file.An exposure during breastfeeding report is not created when a Pfizer drug specifically approved for use in breastfeeding women (eg, vitamins) is administered in accord with authorized use. However, if the infant experiences an SAE associated with such a drug, the SAE is reported together with the exposure during breastfeeding.

8.3.5.3. Occupational Exposure

An occupational exposure occurs when a person receives unplanned direct contact with the study intervention, which may or may not lead to the occurrence of an AE. Such persons may include healthcare providers, family members, and other roles that are involved in the trial participant's care.

8.3.5.3. Occupational Exposure

An occupational exposure occurs when a person receives unplanned direct contact with the study intervention, which may or may not lead to the occurrence of an AE. Such persons may include healthcare providers, family members, and other roles that are involved in the trial participant's care. The investigator must report occupational exposure to Pfizer Safety within 24 hours of the investigator's awareness, regardless of whether there is an associated SAE. The information must be reported using the Vaccine SAE Report Form.

Since the information does not pertain to a participant enrolled in the study, the information is not recorded on a CRF; however, a copy of the completed Vaccine SAE Report Form is maintained in the investigator site file.

There is also a section related to contraception during the study period on pages 132-135. This is just a portion of that section:

10.4 . Appendix 4: Contraceptive Guidance

10.4.1. Male Participant Reproductive Inclusion Criteria

Male participants are eligible to participate if they agree to the following requirements during the intervention period and for at least 28daysafter the last dose of study intervention, which corresponds to the time needed to eliminate reproductive safety risk of the study intervention(s):

- •Refrain from donating sperm. PLUS either:
- •Be abstinent from heterosexual intercourse with a female of childbearing potential as their preferred and usual lifestyle (abstinent on a long-term and persistent basis) and agree to remain abstinent. OR
- •Must agree to use a male condom when engaging in any activity that allows for passage of ejaculate to another person.
- •In addition to male condom use, a highly effective method of contraception may be considered in WOCBP partners of male participants (refer to the list of highly effective methods below in Section 10.4.4).

10.4.2. Female Participant Reproductive Inclusion Criteria

A female participant is eligible to participate if she is not pregnant or breastfeeding, and at least 1of the following conditions applies:

- •Is not a WOCBP (see definitions below in Section 10.4.3). OR
- •Is a WOCBP and using an acceptable contraceptive method as described below during the intervention period (for a minimum of28 days after the last dose of study intervention). The investigator should evaluate the effectiveness of the contraceptive method in relationship to the first dose of study intervention. The investigator is responsible for review of medical history, menstrual history, and recent sexual activity to decrease the risk for inclusion of a woman with an early undetected pregnancy.

https://media.tghn.org/medialibrary/2020/11/C4591001_Clinical_Protocol_Nov2020_Pfizer_BioNTech.pdf

The Material Safety Data Sheet reported “No information/data available” for many aspects of the ingredients and their potential adverse effects. And it gives these general precautions:

4.1. Description of first aid measures

- Inhalation Remove to fresh air. Seek immediate medical attention/advice.
- Eye contact Rinse thoroughly with plenty of water for at least 15 minutes, lifting lower and upper eyelids. Consult a physician.

- Skin contact Remove contaminated clothing. Flush area with large amounts of water. Use soap. Seek medical attention.
- Ingestion Never give anything by mouth to an unconscious person. Wash out mouth with water. Do not induce vomiting unless directed by medical personnel. Seek medical attention immediately.

In addition, it does mention something that seems concerning…

5.2. <u>Special hazards arising from the substance or mixture</u>

Specific hazards arising from the chemical- Fine particles (such as mists) may fuel fires/explosions.

Hazardous combustion products- Formation of toxic gases is possible during heating or fire.

5.3. <u>Advice for firefighters</u>

Special protective equipment for fire-fighters Firefighters should wear self-contained breathing apparatus and full firefighting turnout gear. Use personal protection equipment.

https://safetydatasheets.pfizer.com/DirectDocumentDownloader/Document?prd=PF00092~~PDF~~MTR~~PFEM~~EN

The evidence shows that the spike protein by itself can cause disease in the body

An April 30th, 2021 article published in the journal ***Circulation Research*** titled **<u>SARS-CoV-2 Spike Protein Impairs Endothelial Function via Downregulation of ACE 2</u>**, show how the spike protein itself damages cells, confirming COVID-19 as a primary vascular disease. These researchers are from the ***Salk Institute***.

From the study

SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2) infection relies on the binding of S protein (Spike glycoprotein) to ACE (angiotensin-converting enzyme) 2 in the host cells. Vascular endothelium can be infected by SARS-CoV-2, which triggers mitochondrial reactive oxygen species production and glycolytic shift. Paradoxically, ACE2 is protective in the cardiovascular system, and SARS-CoV-1 S protein promotes lung injury by decreasing the level of ACE2 in the infected lungs. <u>In the current study, we show that S protein alone can damage vascular endothelial cells (ECs) by downregulating ACE2 and consequently inhibiting mitochondrial function.</u>

Interestingly, it describes the damaging changes in the cells and signaling molecules and then says this…

These changes of pACE2, ACE2, MDM2 expression, and AMPK activity in endothelium were recapitulated by in vitro experiments using pulmonary arterial ECs infected with **Pseu-Spike which was rescued by treatment with N-acetyl-L-cysteine, a reactive oxygen species inhibitor.** (I have covered N-acetyl-L-cysteine (NAC) as a nutrient of the month and protective nutrient against progression of COVID-19 related thrombosis in a previous newsletter).

Although the use of a noninfectious pseudovirus is a limitation to this study, our data reveals that S protein alone can damage endothelium, manifested by impaired mitochondrial function and eNOS activity but

increased glycolysis. It appears that S protein in ECs increases redox stress which may lead to AMPK deactivation, MDM2 upregulation, and ultimately ACE2 destabilization.

End of excerpts

https://www.ahajournals.org/doi/10.1161/CIRCRESAHA.121.318902

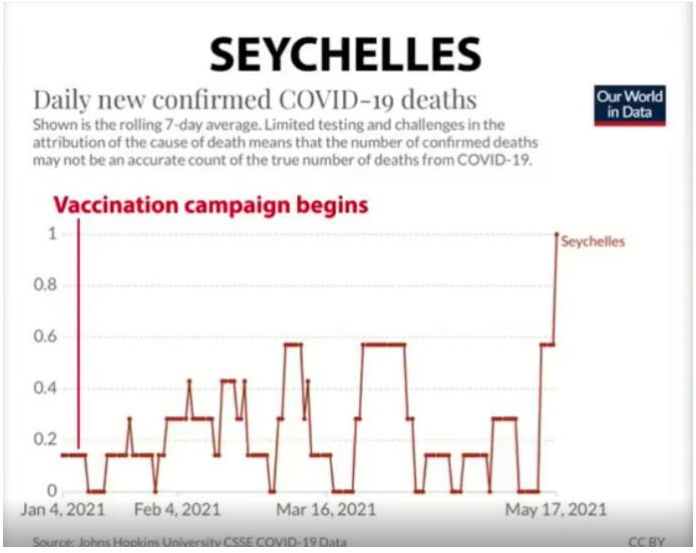
These findings have vast implications for many of the injuries including clotting, bleeding and pathology of the circulatory system and various organs that we are seeing from the COVID-19 vaccines, as they turn our bodies into spike protein manufacturing plants.

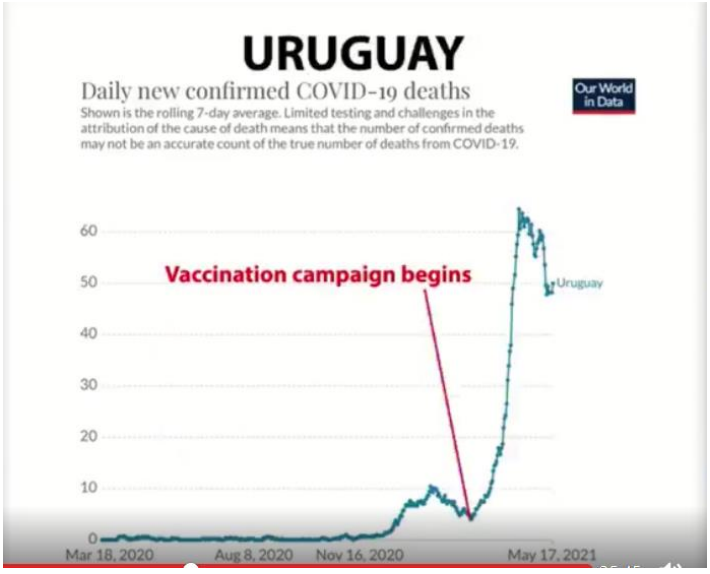
Update July 1st, 2021

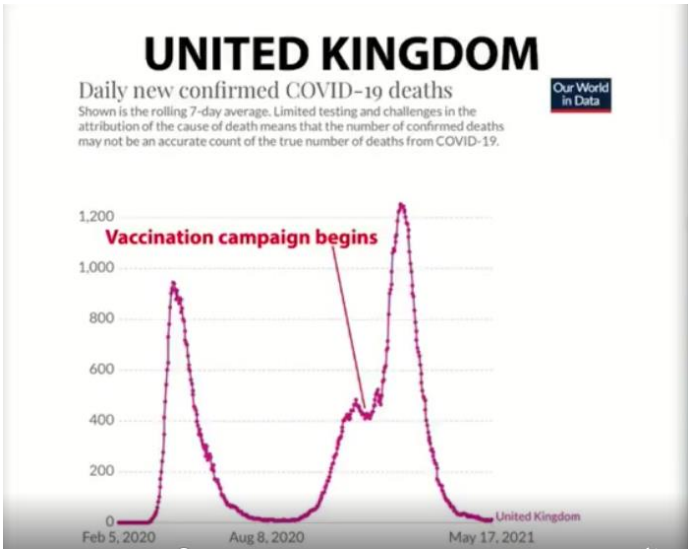
18 countries deaths spike after vaccine campaigns begin- See the Graphs

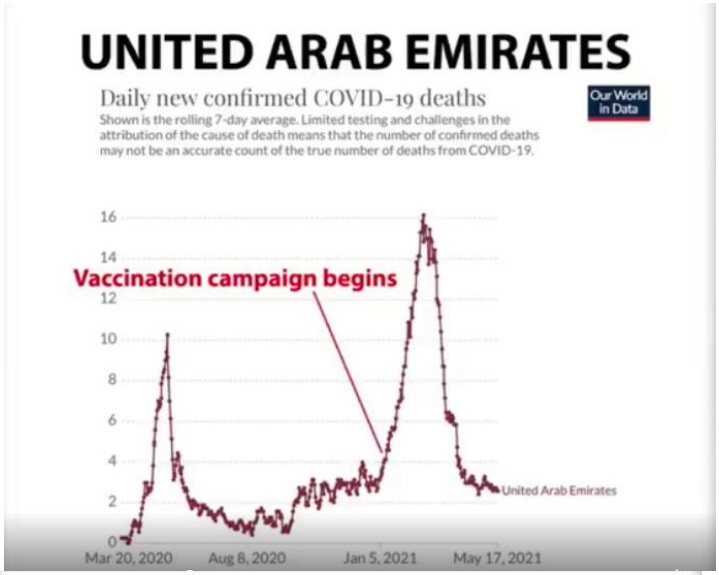
In each of these graphs, look at where the mass vaccination campaigns started and then see what happened with the death rates shortly thereafter. Then ask yourself. Are the vaccines really safe and effective?

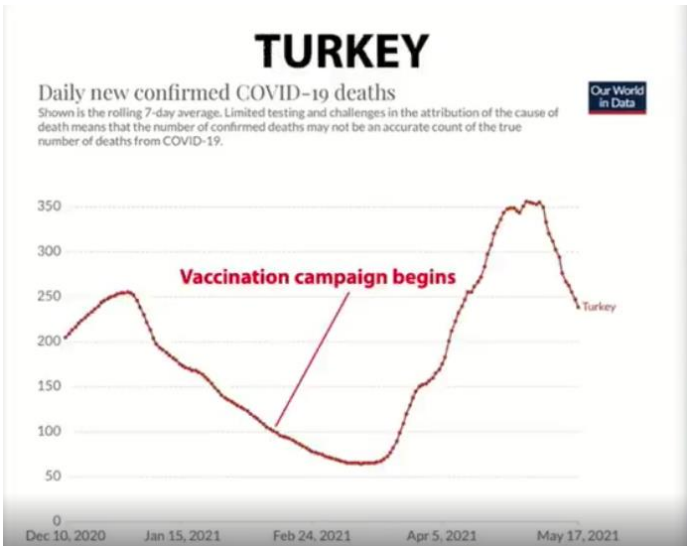
Get ready to have your mind blown!

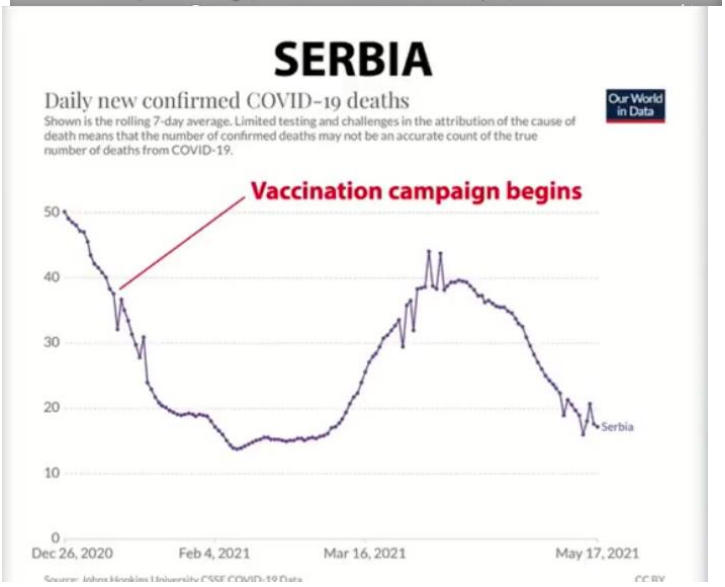


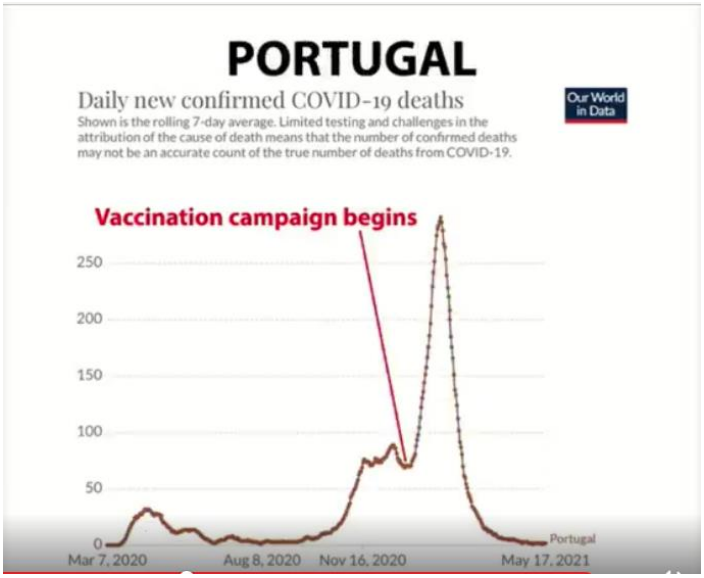



UNITED KINGDOM
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination 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

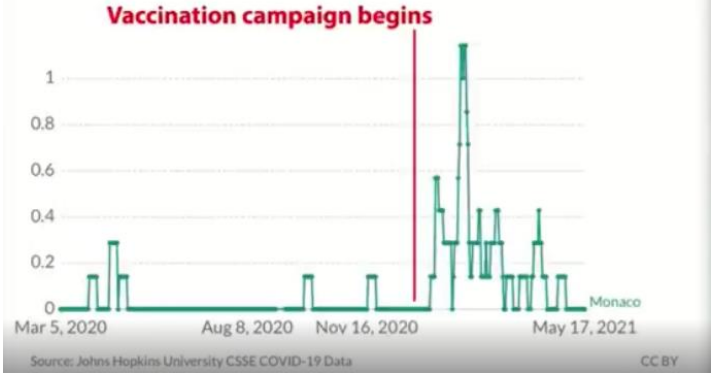

NORTH MACEDONIA
Daily new confirmed COVID-19 deaths
Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.
Our World in Data
Vaccination 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



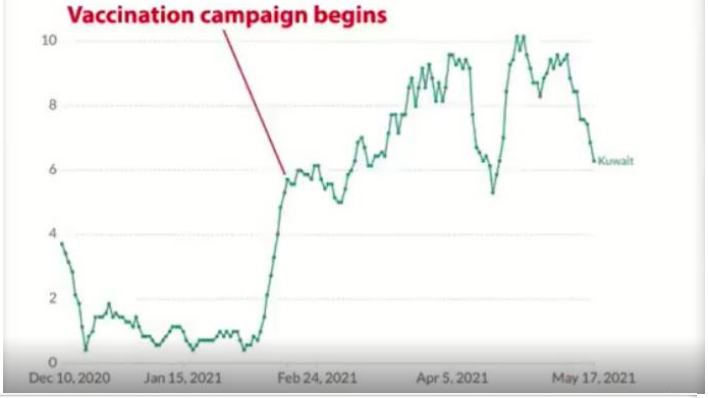
Source: Johns Hopkins University CSSE COVID-19 Data CC BY

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

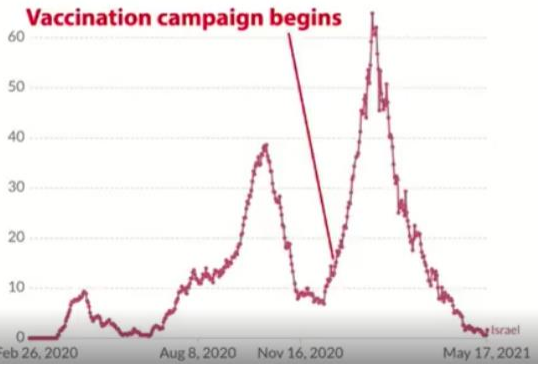


ISRAEL

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

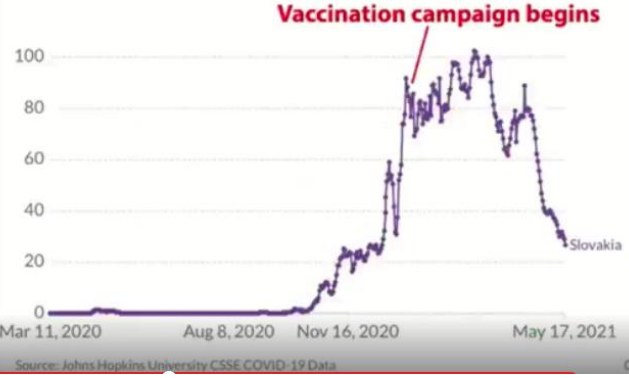


SLOVAKIA

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



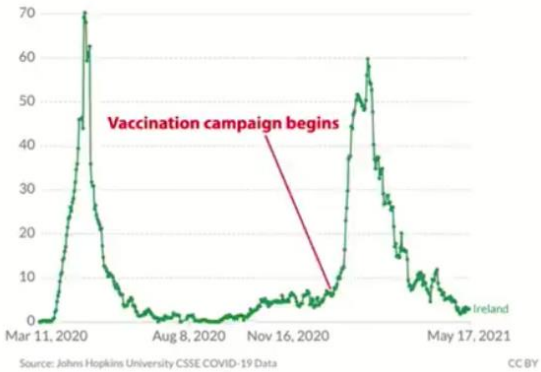
Source: Johns Hopkins University CSSE COVID-19 Data CC BY

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



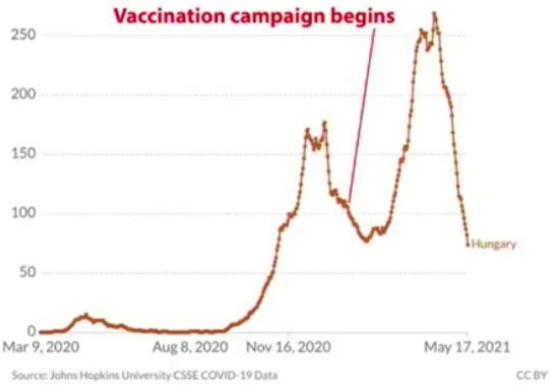
Source: Johns Hopkins University CSSE COVID-19 Data CC BY

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



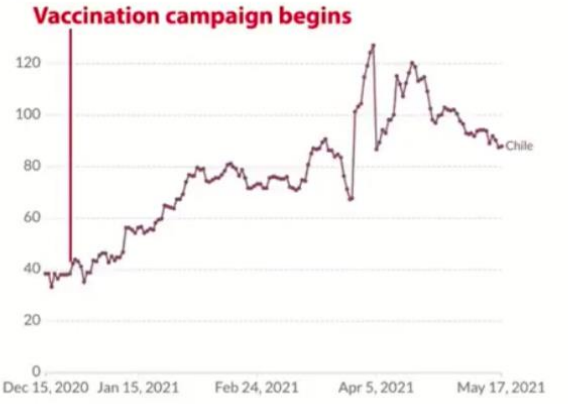
Source: Johns Hopkins University CSSE COVID-19 Data CC BY

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

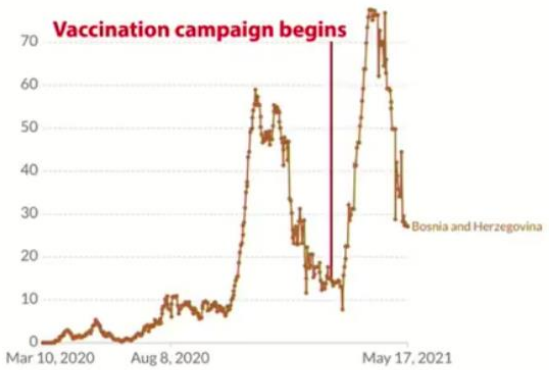
CC BY

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

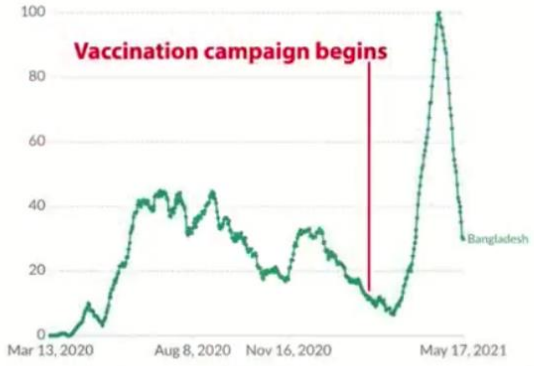
CC BY

BANGLADESH

Daily new confirmed COVID-19 deaths

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

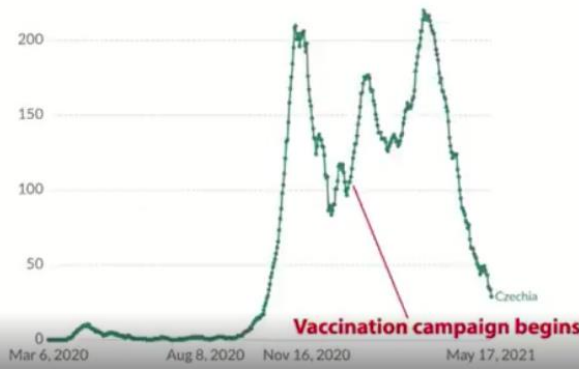
CC BY

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

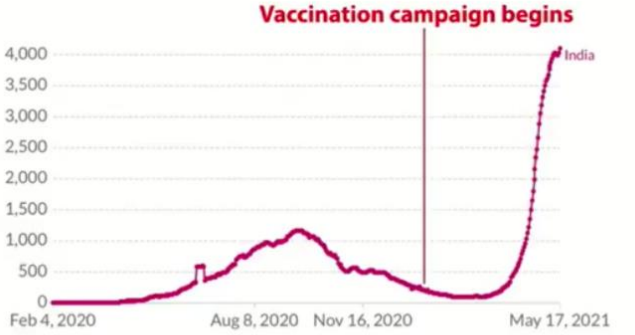


INDIA

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

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%

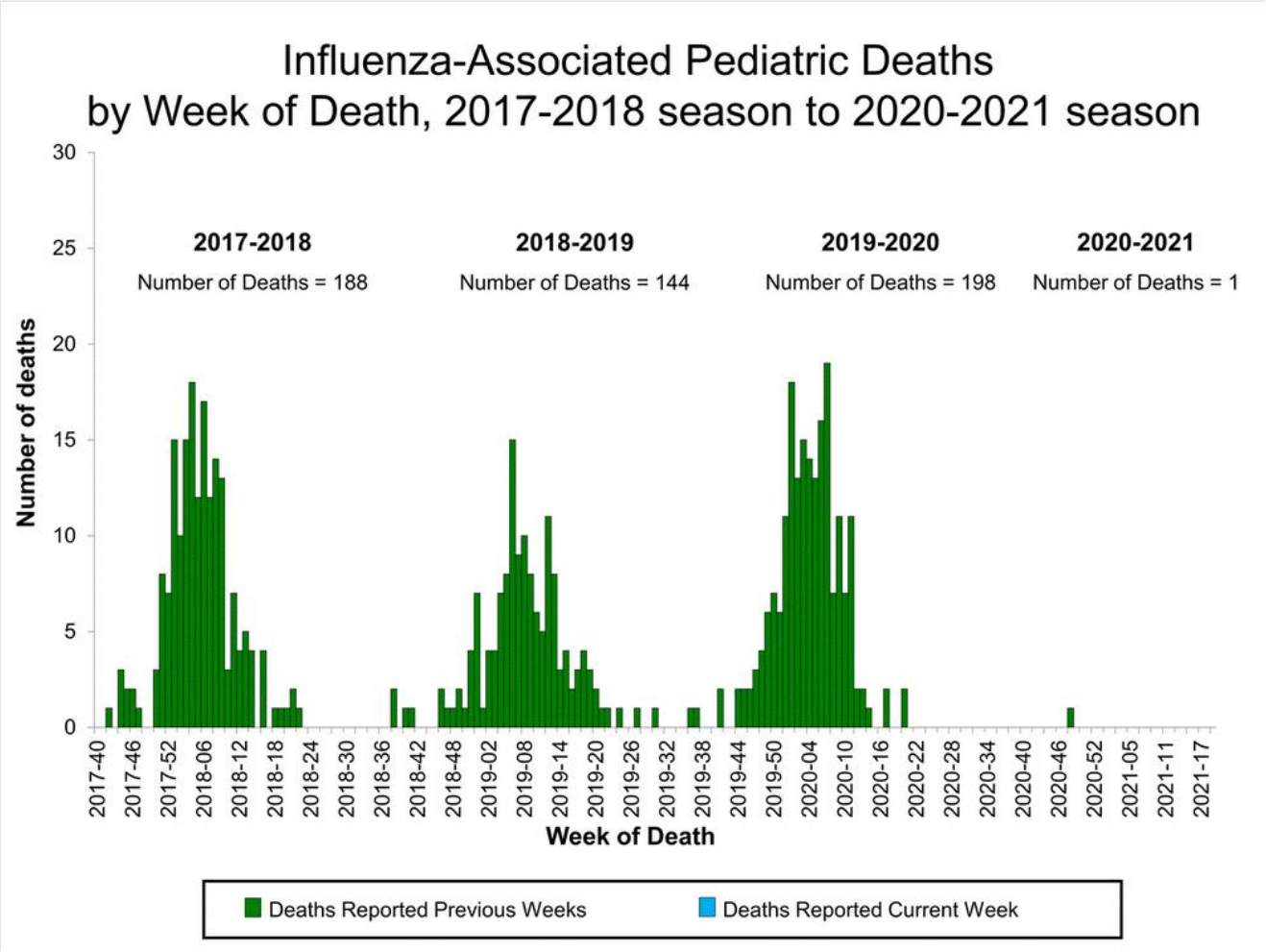
This is critical to understand. COVID-19 appears by all measures to be less deadly to children than the seasonal flu. And, during the 2020-2021 flu season it appears that the flu was almost non-existent, dominated by the SARS-CoV-2 virus. Even so, deaths in children were very low.

The number of pediatric deaths from the flu have dropped 99.5% this year

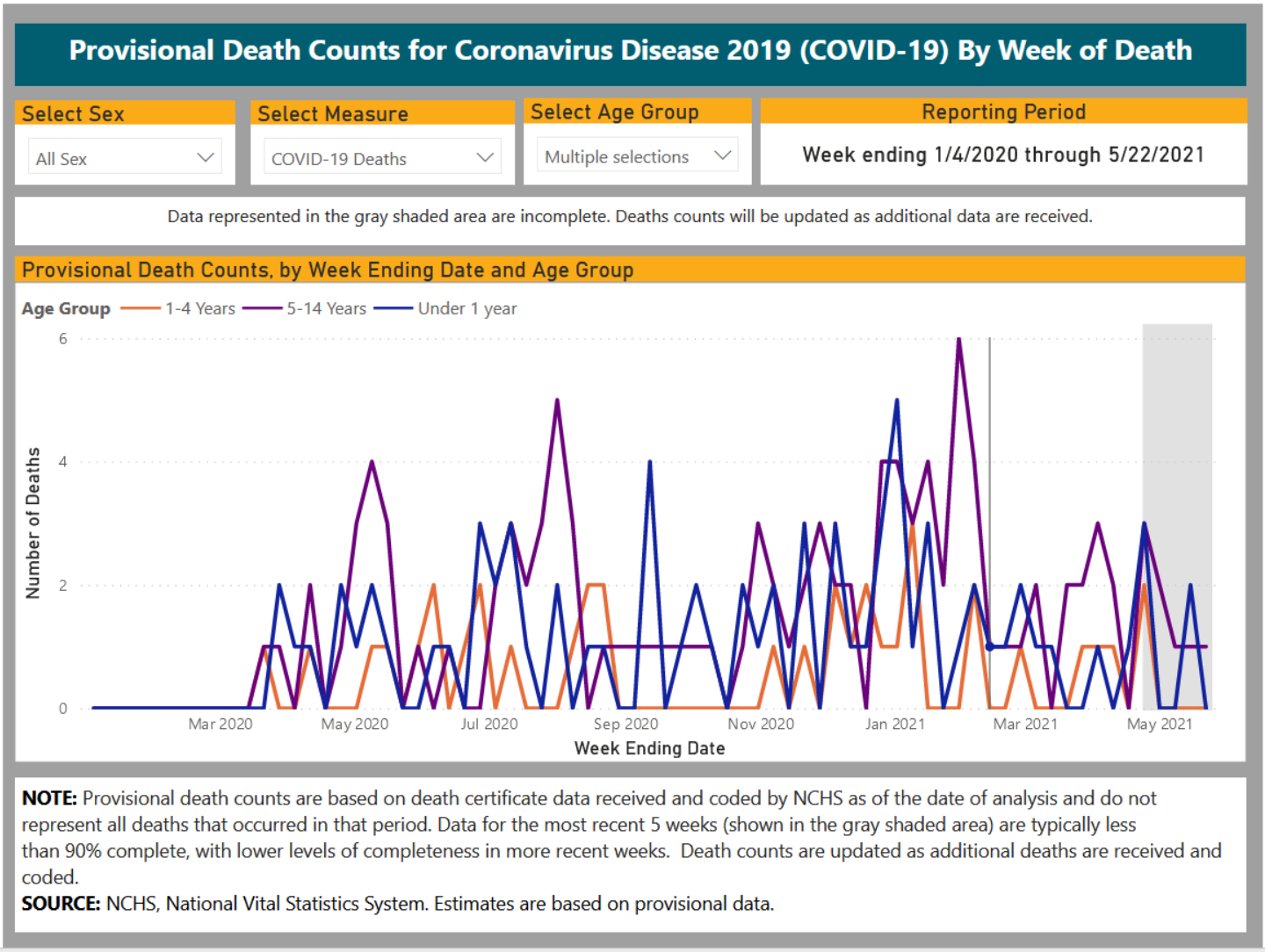
Looking at the chart below it is obvious that just like all flu cases and deaths, pediatric deaths from the flu are at an all-time low. Why is that? Some would claim that it is because of the masks and social distancing. Well, if that were the case, how do you explain the surge of COVID-19 cases and 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.

See graph on the next page…



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.

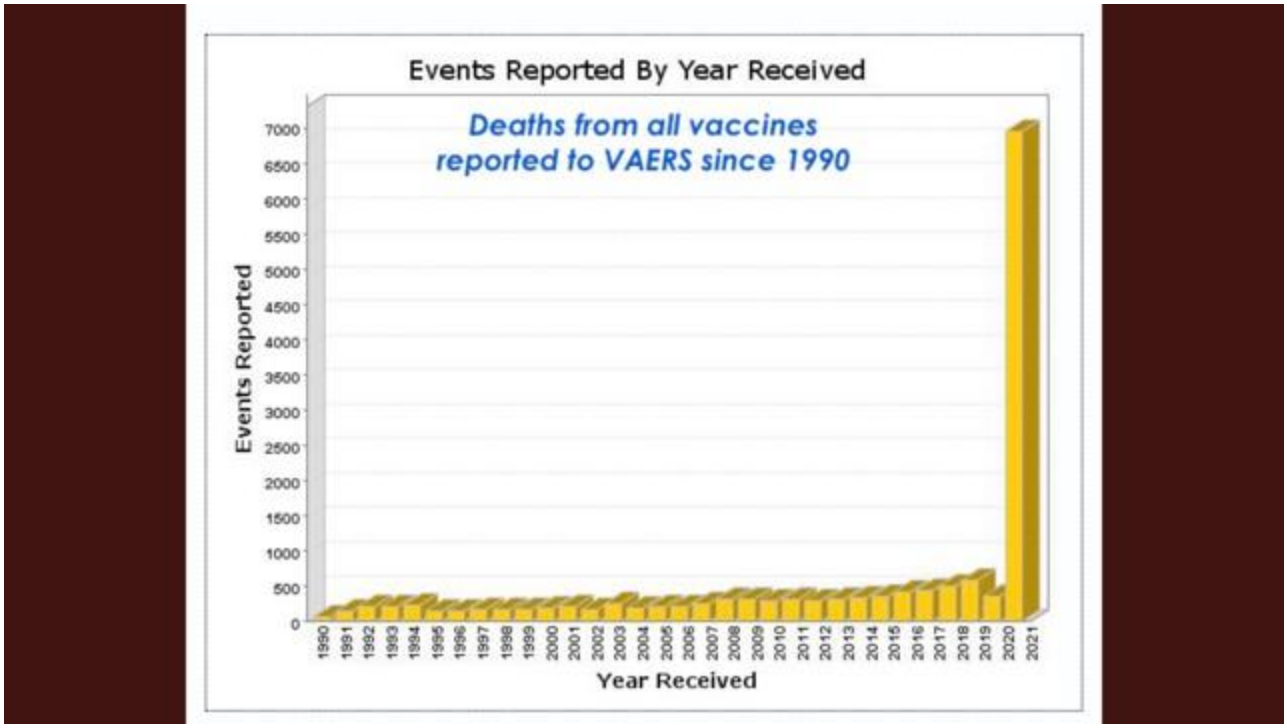
It's an abomination that we are going to subject children in this country with an unknown health risk when they are about as close to zero risk from COVID as it can get. And don't give me the "we have to vaccinate the kids to get to herd immunity" BULL S_ _ _. They are grasping at straws and they know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

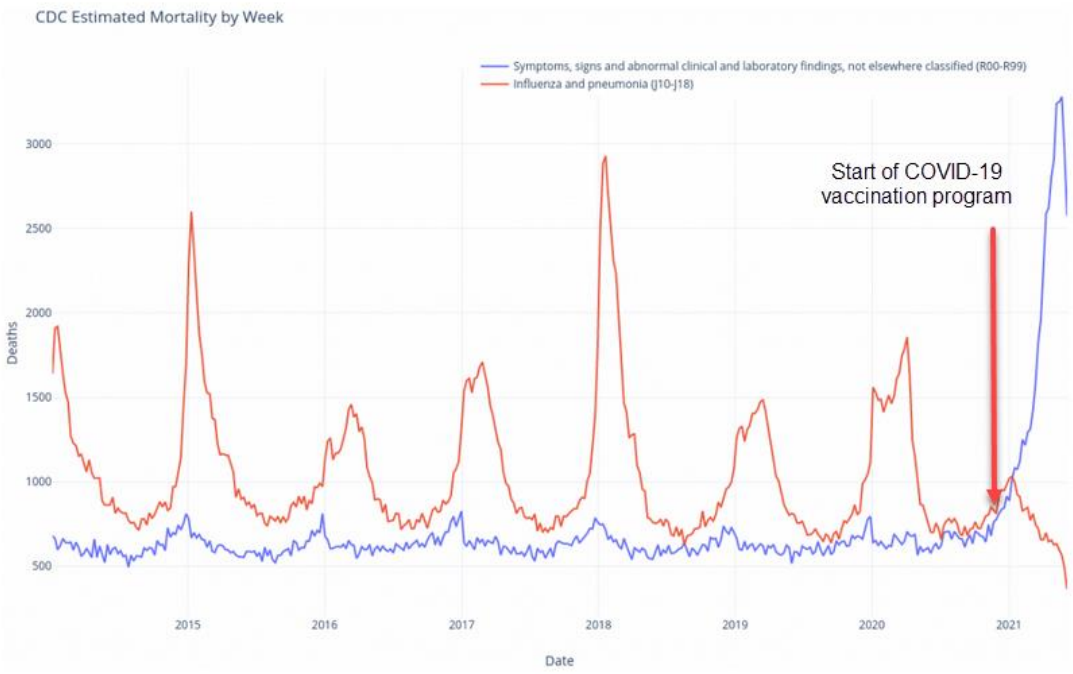
https://data.cdc.gov/NCHS/Weekly-Provisional-Counts-of-Deaths-by-State-and-S/muzy-jte6

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.

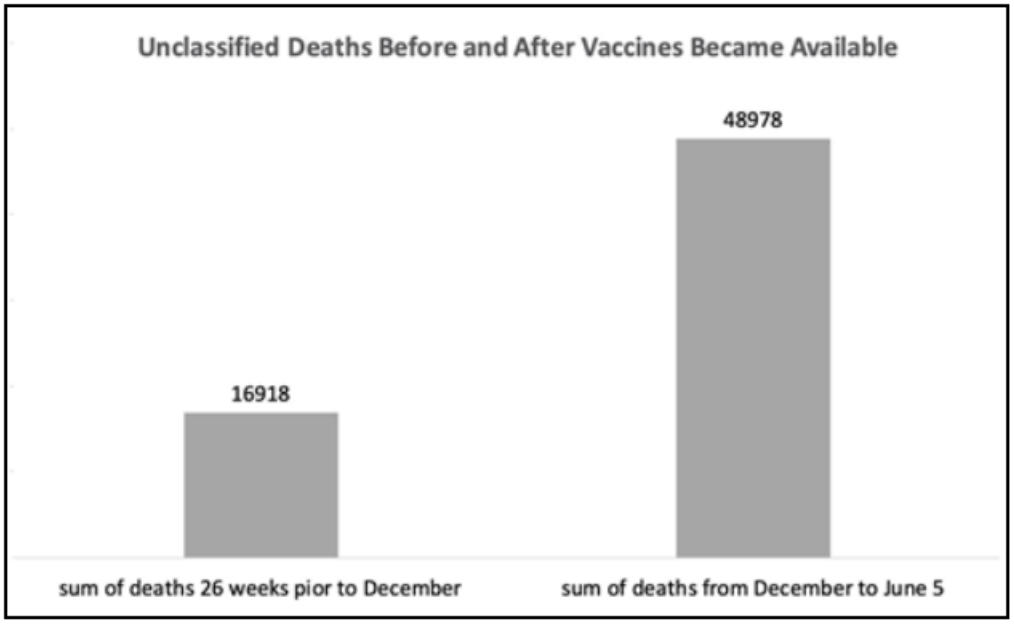


(Addition June 22, 2021) It's important to note the R00-R99 codes will adjust later, i.e. re-attributed to COVID-19 or diseases of heart deaths. I do a bit of an analysis into that topic in a follow up article, Changes in the CDC Counts of Deaths by State and Select Cause. Yes, the R00-R99 are increasing 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.

Signatories

Dr Rosamond Jones, MD, FRCPCH, retired consultant paediatrician
Lord Moonie, MBChB, MRCPsych, MFCM, MSc, House of Lords, former parliamentary undersecretary of state 2001-2003, former consultant in Public Health Medicine
Prof Anthony Fryer, PhD, FRCPath, Professor of Clinical Biochemistry, Keele University
Professor Karol Sikora, MA, MBBChir, PhD, FRCR, FRCP, FFPM, Dean of Medicine, Buckingham University, Professor of Oncology
Professor Angus Dalgleish, MD, FRCP, FRACP, FRCPath, FMed Sci, Professor of Oncology, St Georges Hospital, London
Professor Richard Ennos, MA, PhD. Honorary Professorial Fellow, University of Edinburgh
Professor Anthony J Brookes, Department of Genetics & Genome Biology, University of Leicester
Professor Keith Willison, PhD, Professor of Chemical Biology, Imperial, London
Dr John A Lee, MBBS, PhD, FRCPath, retired Consultant Histopathologist, former Clinical Professor of Pathology at Hull York Medical School
Professor John A Fairclough, BM BS, BMed Sci, FRCS, FFSEM(UK), Professor Emeritus, Honorary Consultant Orthopaedic Surgeon
Dr Alan Mordue, MBChB, FFPH (ret). Retired Consultant in Public Health Medicine & Epidemiology
Dr Elizabeth Evans, MA, MBBS, DRCOG, retired doctor
Mr Malcolm Loudon, MB ChB, MD, FRCSEd, FRCS (Gen Surg). MIHM, VR. Consultant Surgeon
Dr Gerry Quinn, PhD, Microbiologist
Dr C Geoffrey Maidment, MD, FRCP, retired consultant physician
Dr K Singh, MBChB, MRCGP, general practitioner
Dr Pauline Jones MB BS retired general practitioner
Dr Holly Young, BSc, MBChB, MRCP, Consultant physician, Croydon University Hospital
Dr David Critchley, BSc, PhD, 32 years in pharmaceutical R&D as a clinical research scientist.
Dr Padma Kanthan, MBBS, General practitioner
Dr Thomas Carnwath, MBBCh,MA, FRCPsych, FRCGP, consultant psychiatrist
Dr Sam McBride BSc(Hons) Medical Microbiology & Immunobiology, MBBCh BAO, MSc in Clinical Gerontology, MRCP(UK), FRCEM, FRCP(Edinburgh). NHS Emergency Medicine & geriatrics
Dr Helen Westwood MBChB MRCGP DCH DRCOG, general practitioner

Dr M A Bell, MBChB, MRCP(UK), FRCEM, Consultant in Emergency Medicine, UK
Mr Ian F Comaish, MA, BM BCh, FRCOphth, FRANZCO, Consultant ophthalmologist
Dr Jayne LM Donegan MBBS, DRCOG, DCH, DFFP, MRCGP, general practitioner
Dr Dayal Mukherjee, MBBS MSc
Dr Clare Craig, BM,BCh, FRCPath, Pathologist
Mr C P Chilton, MBBS, FRCS, Consultant urologist emeritus
Dr Theresa Lawrie, MBBCh, PhD, Director, Evidence-Based Medicine Consultancy Ltd, Bath
Dr Jason Lester, MRCP, FRCR, Consultant Clinical Oncologist, Rutherford Cancer Centre, Newport
Dr Scott McLachan, FAIDH, MCSE, MCT, DSysEng, LLM, MPhil., Postdoctoral researcher, Risk & Information management Group
Michael Cockayne, MSc, PGDip, SCPHNOH, BA, RN, Occupational health practitioner
Dr John Flack, BPharm, PhD. Retired Director of Safety Evaluation at Beecham Pharmaceuticals 1980-1989 and Senior Vice-president for Drug Discovery 1990-92 SmithKline Beecham
Dr Stephanie Williams, Dermatologist
Dr Greta Mushet, retired Consultant Psychiatrist in Psychotherapy. MBChB, MRCPsych
Dr JE, MBChB, BSc, NHS hospital junior doctor
Mr Anthony Hinton, MBChB, FRCS, Consultant ENT surgeon, London
Dr Elizabeth Corcoran, MBBS,MRCPsych,Psychiatrist,Chair Down's Syndrome Research Foundation UK
Dr Alan Black, MB BS MSc DipPharmMed, retired pharmaceutical physician
Dr Christina Peers, MBBS,DRCOG,DFSRH,FFSRH, Consultant in Contraception & Reproductive Health
Dr Marco Chiesa, MD, FRCPsych, Consultant Psychiatrist & Visiting Professor, UCL
Elizabeth Burton, MB ChB, retired general practitioner
Noel Thomas, MA, MB ChB, DCH, DObsRCOG, DTM&H, MFHom, retired doctor
Malcolm Sadler, MBBS, FRCGP, retired general practitioner with 37 years in Medical Practice
Dr Ian Bridges, MBBS, Retired general practitioner
Mr T James Royle MBChB, FRCS(Ed), MMedEd, Consultant colorectal surgeon
Dr Fiona Martindale, MbChB, MRCGP, GP in out of hours
Dr Karen Horridge, MB ChB(Hons), MSc, MRCP, FRCPCH, Consultant Paediatrician (Disability)
Mr Christian Duncan, Consultant Plastic Surgeon, MB BCh, BAO, MPhil, FRCSI, FRCS (Plast)
Dr David Bramble, MBChB, MRCPsych, MD. Consultant Psychiatrist
Dr Jessica Robinson, BSc(Hons), MBBS, MRCPsych, MFHom, Psychiatrist & Integrative Medicine Doctor
Katherine MacGilchrist, BSc (Hons) Pharmacology, MSc Epidemiology, CEO, Systematic Review Director, Epidemica Ltd
David Halpin MB BS, FRCS, Orthopaedic and trauma surgeon (retired)
Jemma Dale, BSc (Hons), Biomedical Scientist
Dr Helen Macklin, MBBS, DRCOG, MRCGP, general practitioner
Dr Mark Atkinson, MBBS, BSc (Hons), FRSPH. Retired Medical Doctor
Dr Anne Renfrew, MB ChB, MRCOG, MRCGP, DCH, Retired general practitioner
Dr S Allam, MB ChB, FRCA, Consultant Anaesthetist, UK
Dr David Morris, MBChB, MRCP(UK), General Practitioner
Dr. Peter Chan, BM, MRCS, MRCGP, General Practitioner, Functional medicine practitioner
Dr Sam White, MBChB, MRCGP, General Practitioner, Functional medicine practitioner

Endnotes

1. https://www.dailymail.co.uk/news/article-9502227/Coronavirus-UK-Children-young-12-Covid-vaccinesSeptember.html
2. https://www.dailymail.co.uk/news/article-9285157/Sage-member-calls-children-Covid-jab-fast-avoid-riskresurgence.html
3. Critical Thinking Assembly on Vaccines

4. https://www.telegraph.co.uk/news/2021/05/02/schools-back-mass-vaccinations-children-headteachers-saypeer/
5. https://www.hartgroup.org/wp-content/uploads/2021/05/Covid19_Vaccine_in_Children_FULL_document.pdf
6. https://www.narcolepsy.org.uk/resources/pandemrix-narcolepsy
7. https://www.sciencemag.org/news/2019/04/dengue-vaccine-fiasco-leads-criminal-charges-researcherphilippines
8. https://www.ft.com/content/d2e00128-7889-4d5d-84a3-43e51355a751
9. https://gh.bmj.com/content/bmjgh/5/9/e003094.full.pdf
10. https://doi.org/10.1136/bmj.m3249
11. Illness duration and symptom profile in a large cohort of symptomatic UK school-aged children tested for SARS-CoV-2
12. Post-acute COVID-19 outcomes in children with mild and asymptomatic disease
13. https://www.hartgroup.org/wp-content/uploads/2021/05/COV006_Participant-Information-Sheet-16-17-years_V2.0_09Feb2021.pdf
14. https://www.nature.com/articles/s41586-021-03207-w
15. https://science.sciencemag.org/content/370/6522/1339
16. https://www.gov.uk/government/publications/priority-groups-for-coronavirus-covid-19-vaccination-advicefrom-the-jcvi-30-december-2020/joint-committee-on-vaccination-and-immunisation-advice-on-prioritygroups-for-covid-19-vaccination-30-december-2020
17. Vaccinations | Coronavirus in the UK (data.gov.uk)
18.https://www.bmj.com/content/370/bmj.m3563?fbclid=IwAR2v7qLBSWYOv4LdJB6ziwvzPaCvrvoaB1uzLQNRTMeCDkHHDo0a6Tsrto
19. Britain will achieve herd immunity by Monday, according to UCL
20. Sharing a household with children and risk of CO VID-19: a study of over 300,000 adults living in healthcare worker households in Scotland
21. https://publichealthscotland.scot/media/2927/report-of-record-linkage-english-december2020.pdf
22. https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-adverse-reactions
23. https://vaers.hhs.gov/data.html
24. Guidance produced from the Expert Haematology Panel (EHP) focussed on Covid-19 Vaccine induced Thrombosis and Thrombocytopenia
25. https://www.timesofisrael.com/israel-said-probing-link-between-pfizer-shot-and-heart-problem-in-menunder-30/
26. https://www.haaretz.com/israel-news/.premium-women-say-covid-vaccines-affect-their-periods-so-whydon-t-doctors-care-1.9754865
27. https://vaers.hhs.gov/data.html
28. https://www.immunology.org/coronavirus/connect-coronavirus-public-engagement-resources/typesvaccines-for-covid-19
29. https://www.nature.com/articles/s41579-020-00462-y
30. https://scivisionpub.com/pdfs/covid19-rna-based-vaccines-and-the-risk-of-prion-disease-1503.pdf
31. https://www.ohchr.org/en/professionalinterest/pages/crc.aspx
32. https://www.hartgroup.org/open-letter-child-vaccination/

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/

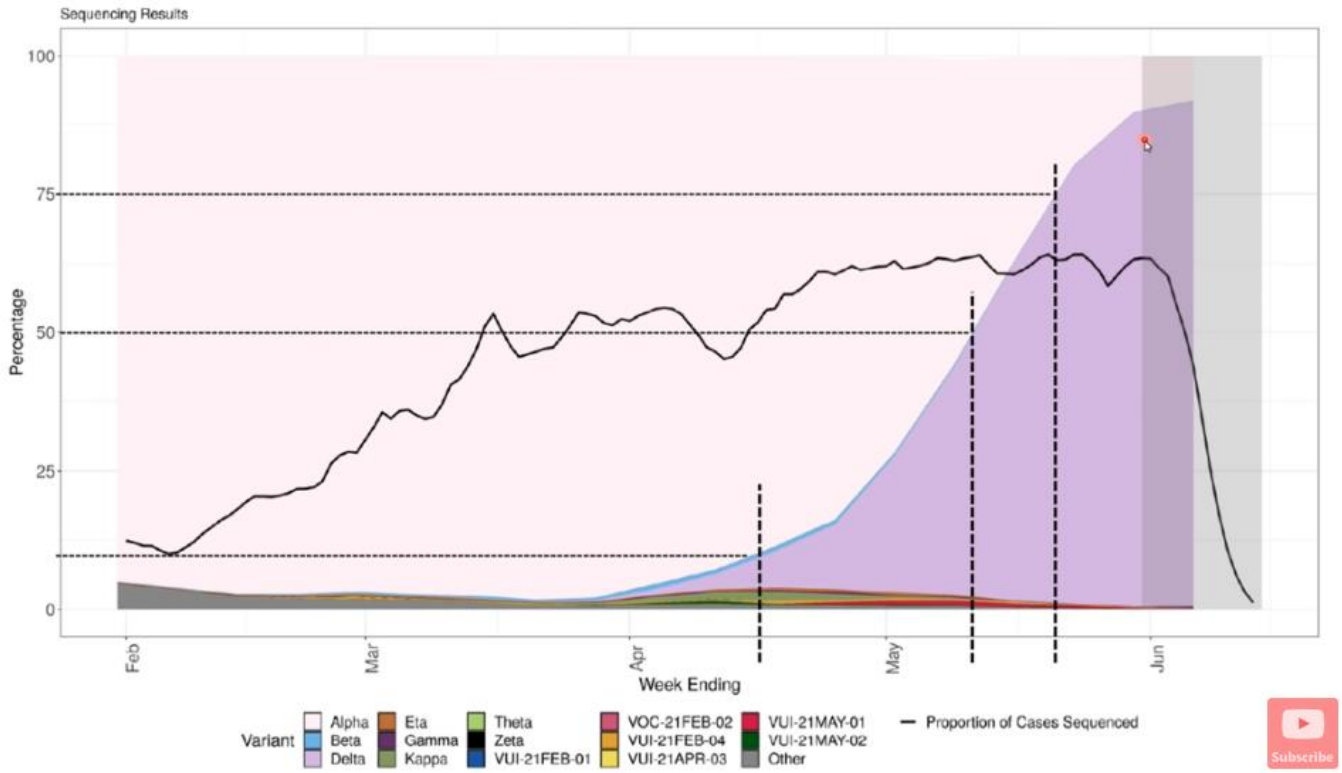
Speaking of variants, is the Delta Variant the scary boogieman that people are being told it is?

In mid-June, the UK announced another 30 days of lockdowns- (at least)

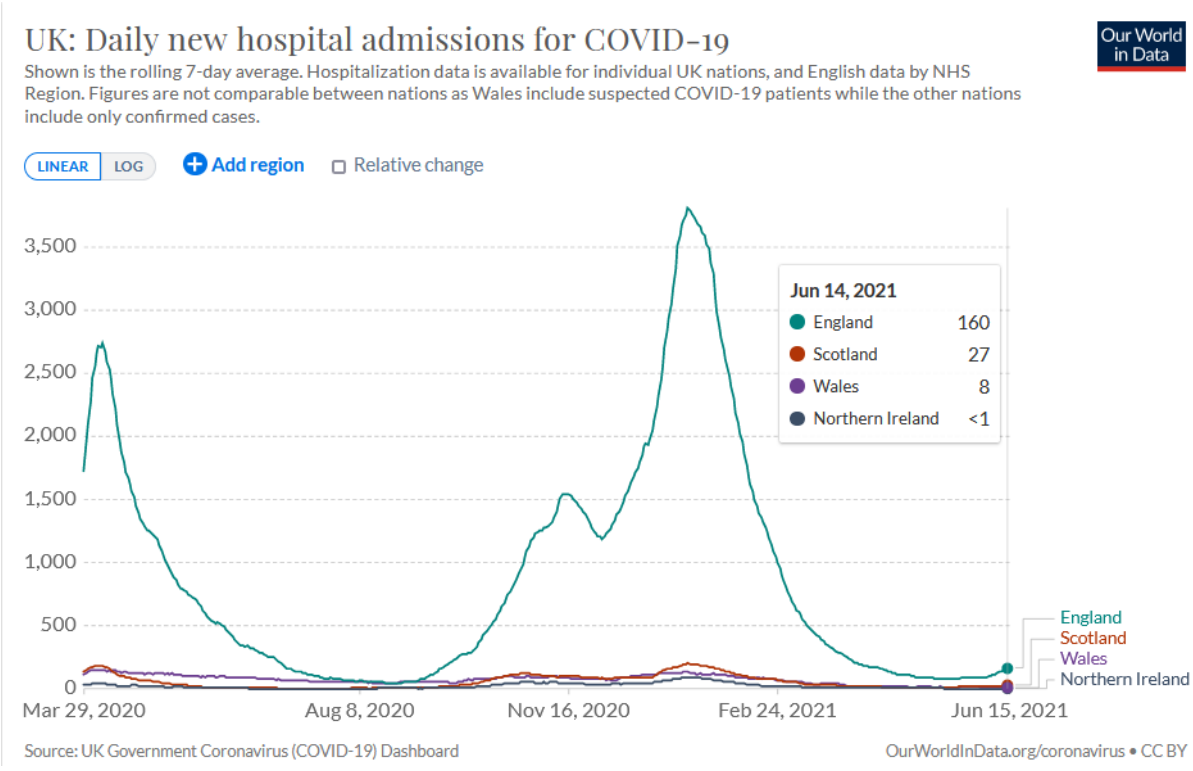
On the next page is the real-world data from England.

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).



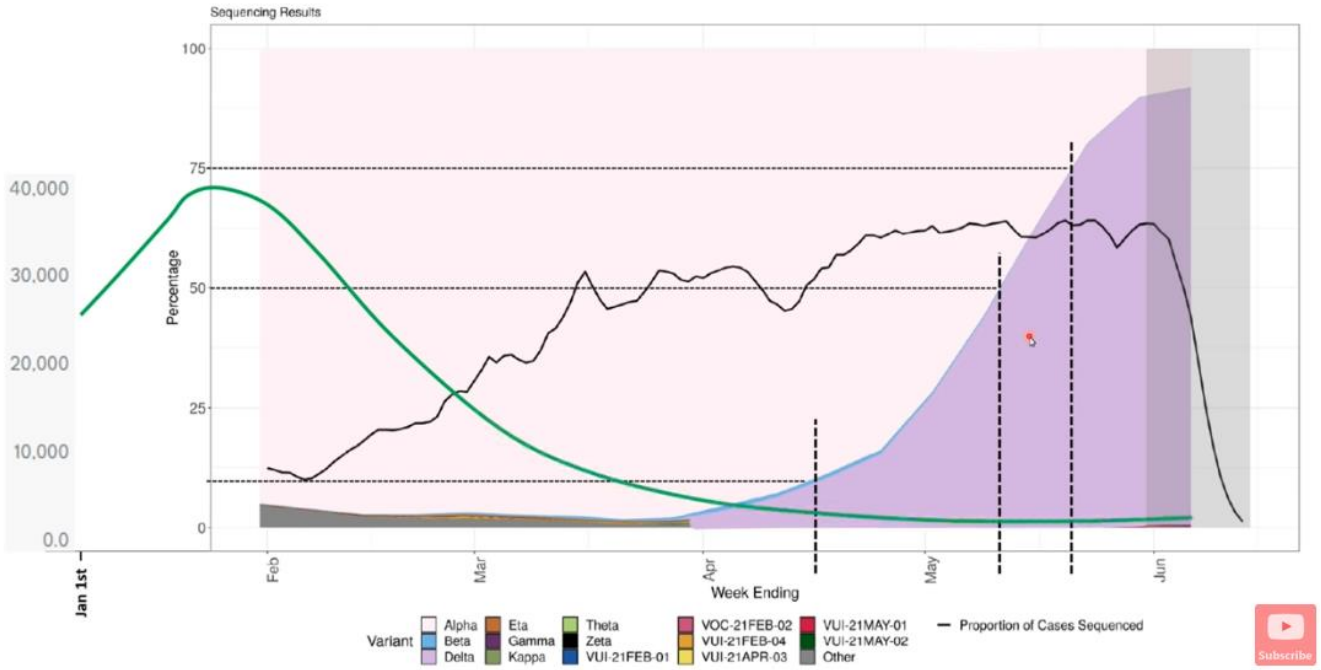
But what are the real-world effects on hospitalizations and deaths? Here is a graph looking at that…



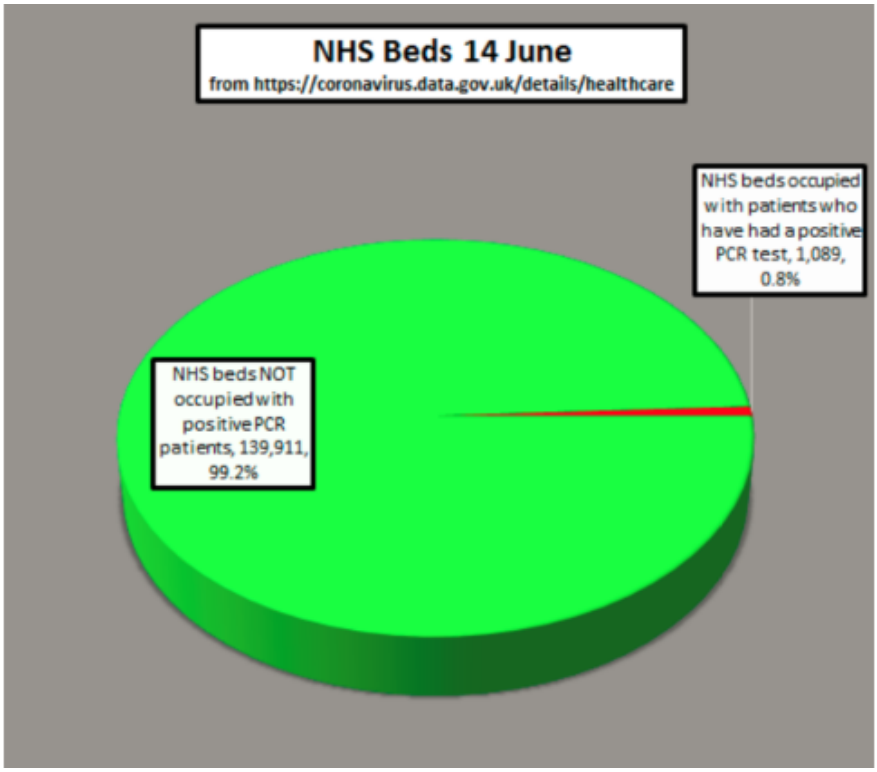
As you can see, zilch, nada, nothing to be panicked about.

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.

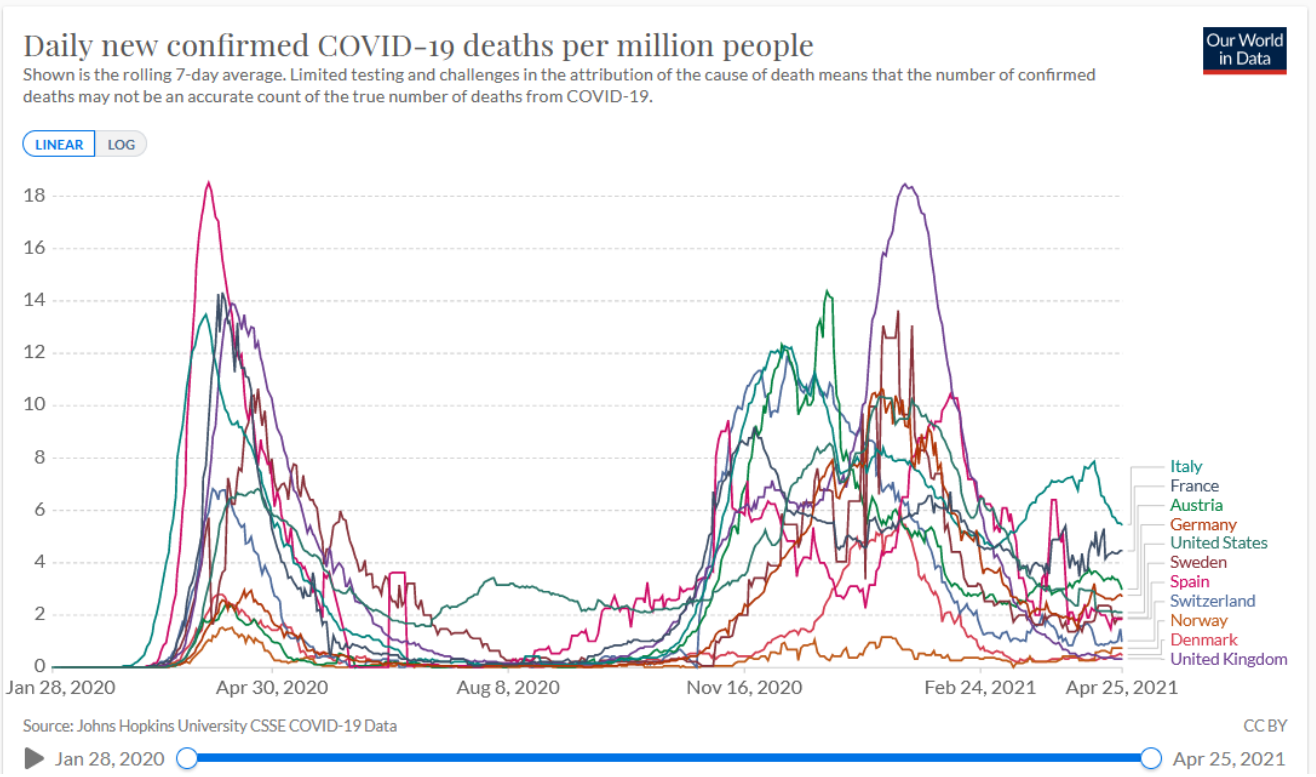
https://www.youtube.com/watch?v=TtOu7jx3snQ

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.

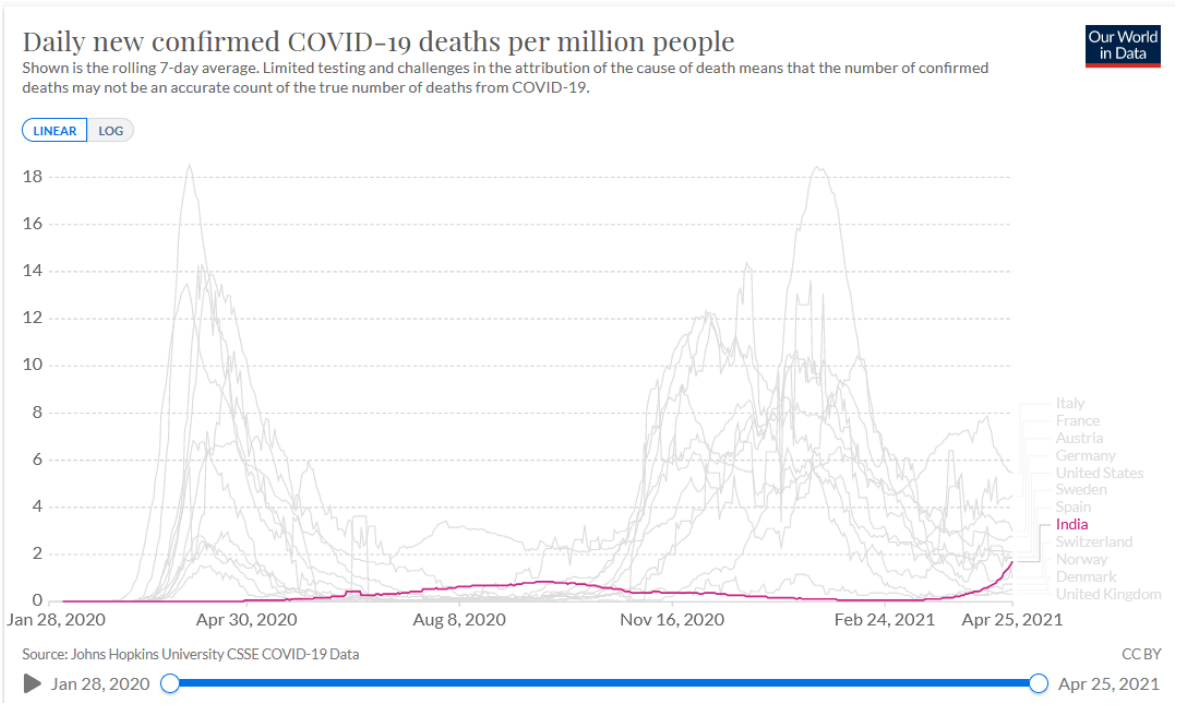
Since Delta IS the Indian Variant and India was hit hard this spring, shouldn't we be concerned?

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.

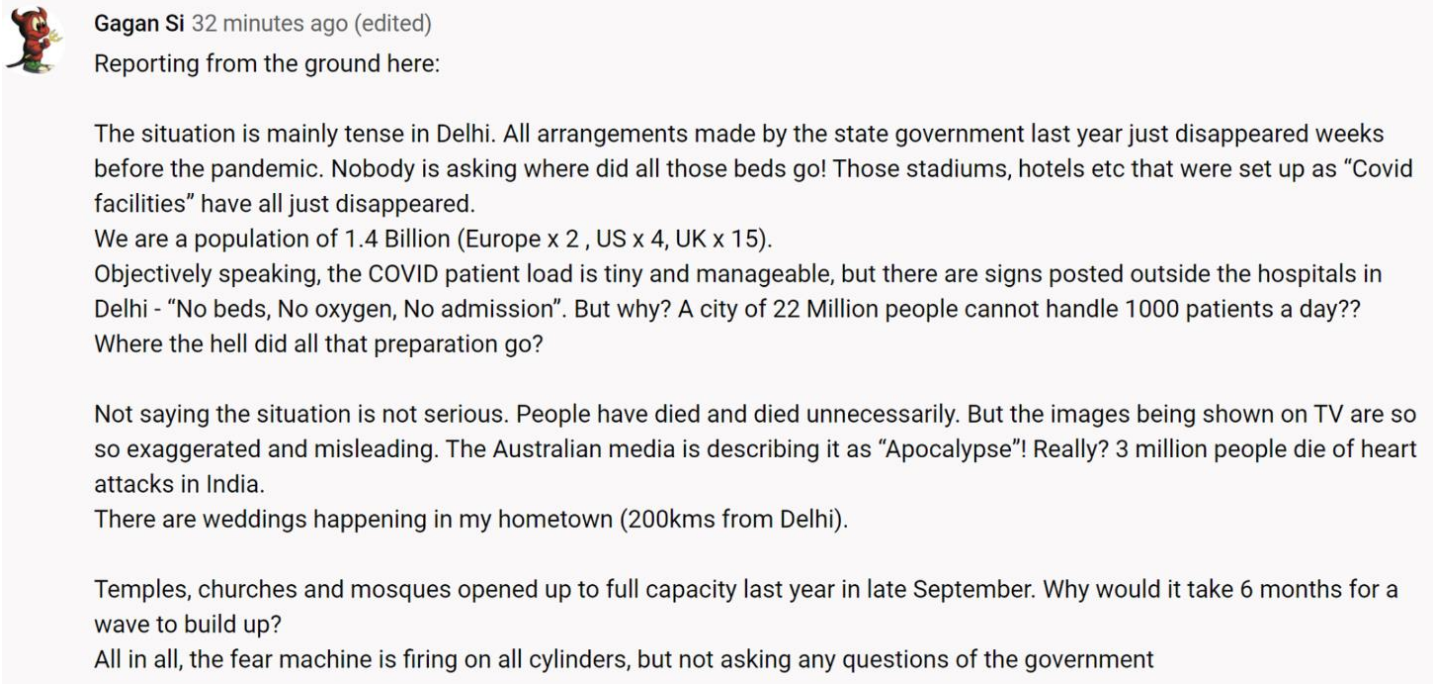


Then I showed India superimposed over the other countries.



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

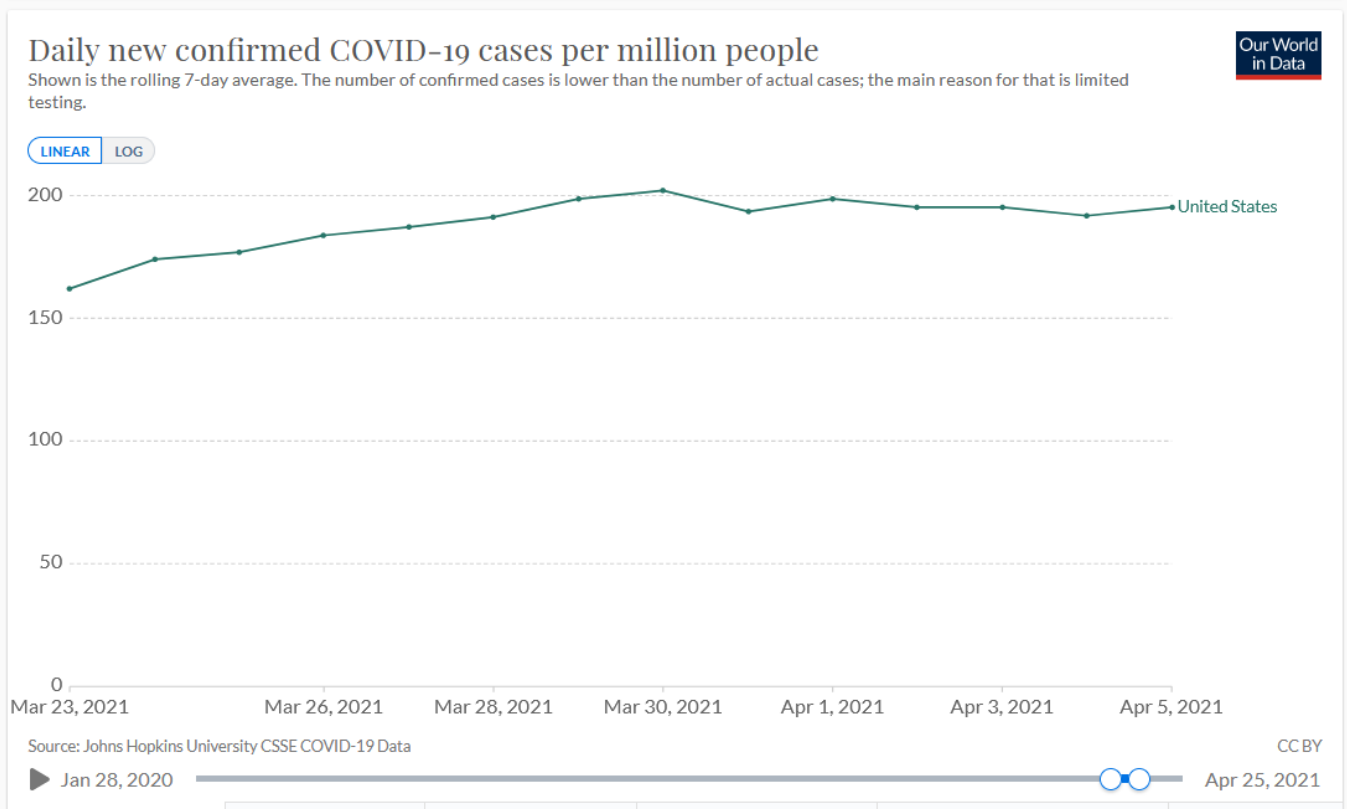
How about the mainstream media's sensationalized reporting? Is there any basis for it? Let's look at how they've handled previous variants.

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.**

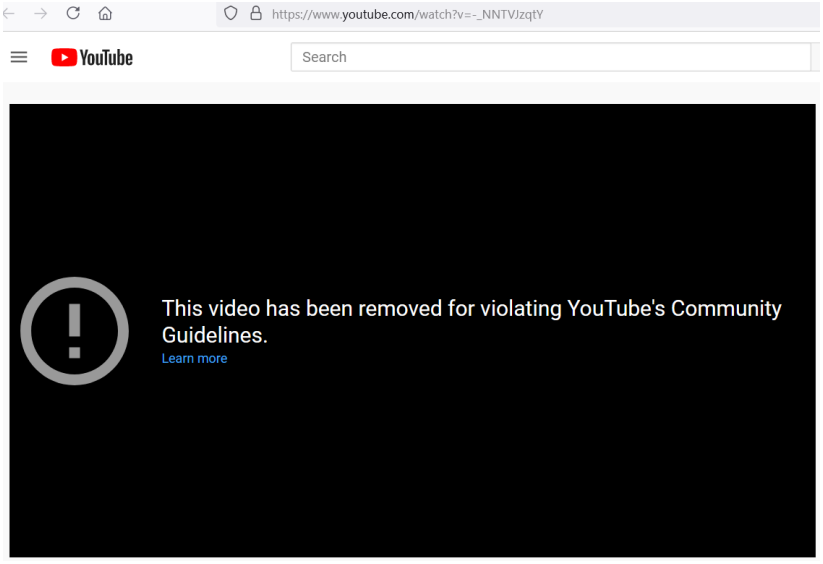
Dr. Malone specializes in clinical research, medical affairs, regulatory affairs, project management, proposal management (large grants and contracts), vaccines and biodefense. This includes writing, developing, reviewing and managing vaccine, bio-threat and biologics clinical trials and clinical development 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.**

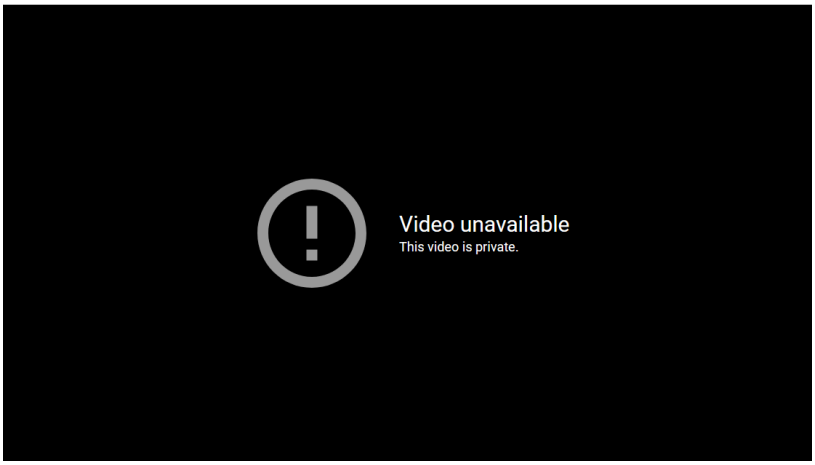
He received his medical training at Northwestern University (MD) and Harvard University (Clinical Research Post Graduate) medical school, and in Pathology at UC Davis.

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.

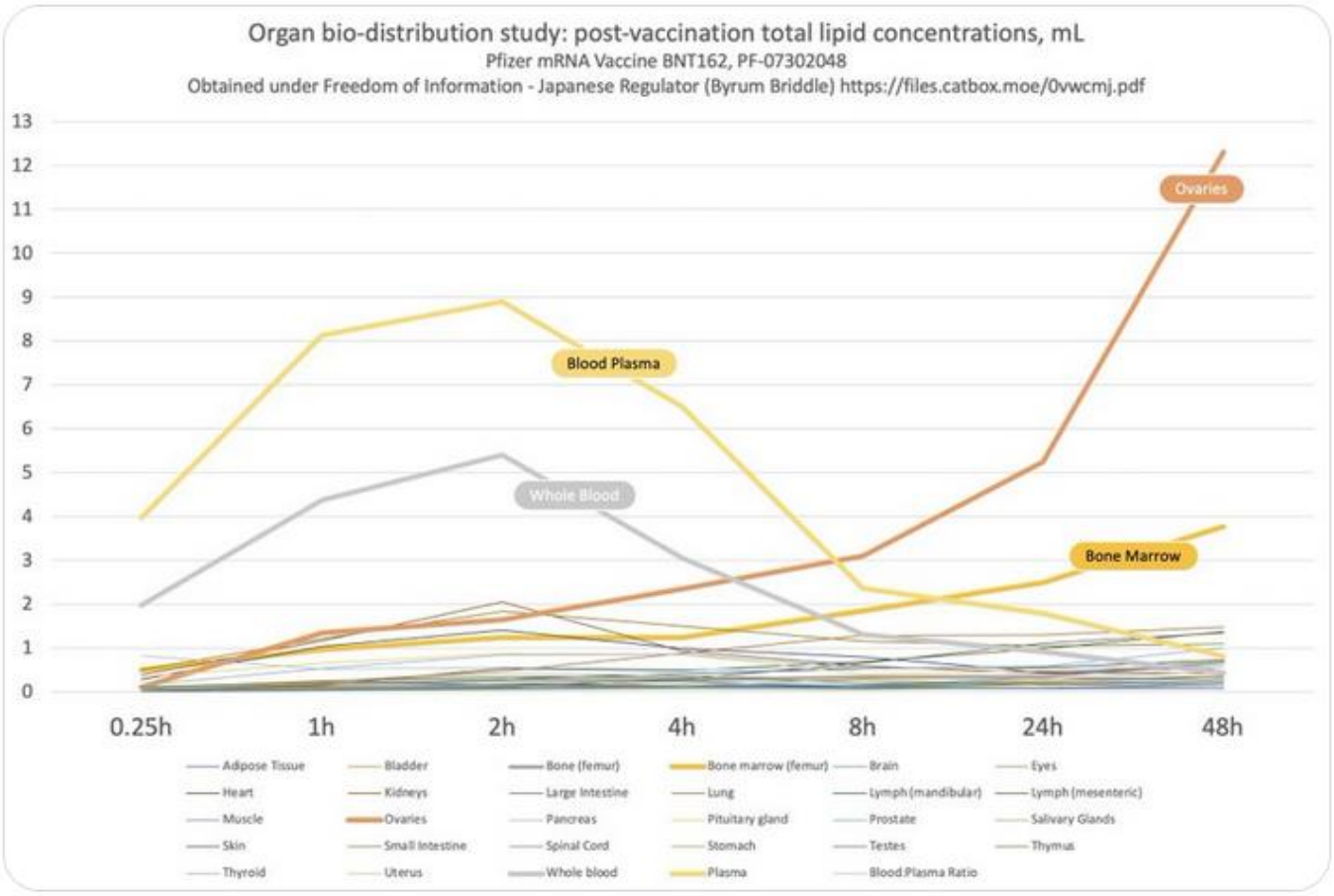
The virus will effectively outsmart the highly specific antigen-based vaccines being used and tweaked, depending on the circulating variants. All of this could lead to a hockey stick-like increase in serious and potentially lethal cases — in effect, an out-of-control pandemic.

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.

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/≤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,

Deanna, McLeod, HBSc, Principal at Kaleidoscope Strategic Inc, Toronto, ON deanna@kstrategic.com

Ira Bernstein, MD, CCFP, FCFP, University of Toronto, Toronto, ON, irabernstein@bell.net

Sanja Jovanovic, MD, MSc, Kwantlen Polytechnic University, Surrey, BC, sanja.jovanovic@Dal.Ca

No potential conflict of interest relevant to this letter was reported.

1. Shimabukuro TT, Kim SY, Myers TR, Moro PL, Oduyebo T, Panagiotakopoulos L, Marquez PL, Olson CK, Liu R, Chang KT. Preliminary Findings of mRNA Covid-19 Vaccine Safety in Pregnant Persons. *New England Journal of Medicine* 2021.

2. Devis P, Knuttinen MG. Deep venous thrombosis in pregnancy: incidence, pathogenesis and endovascular management. *Cardiovascular diagnosis and therapy* 2017;7:S309.

3. Dugas C, Slane VH. Miscarriage. *StatPearls [Internet]* 2020.

4. Obstetricians ACo, Gynecologists. ACOG practice bulletin no. 200: Early pregnancy loss. *Obstetrics and gynecology* 2018;132:e197-e207.

5. Medicine PCotASfR. Evaluation and treatment of recurrent pregnancy loss: a committee opinion. *Fertility and sterility* 2012;98:1103-11.

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

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

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

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

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

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

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

From the story

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

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

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

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

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

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

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

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

1. "We don't have any data that suggests that COVID-19 vaccines affects fertility."

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

2. "It's not a live vaccine."

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

3. "The sort of proteins that are used in the vaccine do not alter anyone's DNA or genetic material."

That is still up for debate, but one thing that isn't, is that they do instruct your cells to manufacture a genetically modified spike protein that has now shown in several studies to act as a toxin in the body and is now thought to be responsible for the catastrophic numbers of casualties in vaccinated people.

4. "So, we don't have any evidence that makes us worry that this vaccine could affect fertility."

Could that be because these vaccines weren't studied as they should have been and tested in a small number of women who were then followed for two to three years to see if they were able to conceive as compared to the rest of the population? And, based on the previous report it would be logical to suggest that the possibility exists.

5. "And we know, we have lots of vaccines in the past, that we give out, you know, to people that desire to get pregnant as a way to protect them in pregnancy."

The only two vaccines that the CDC recommends in pregnant women are the flu vaccine and the T-dap. What she means by "lots of vaccines" I'm not exactly sure. And even these two vaccines have been shown in many

studies to be problematic. Download and read my **1200 Studies- Truth Will Prevail** (https://1200studies.com) and you will see extensive evidence to support that statement.

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

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

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

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

Conclusion from the abstract

The novel COVID-19 has an affinity for ACE-2 receptors. Since ACE-2 receptor expression is high in the testes,

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

From the study

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

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

RNA-seq studies, we believe the high androgen environment of the testes will allow for viral entry [16].

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

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

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

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

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

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

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

From the Abstract

Here, we tested the antibody response developed after the first dose of the mRNA-based vaccine encoding the SARS-CoV-2 full-length spike protein (BNT162b2) in 124 healthcare professionals of which 57 had a previous history of COVID-19 (ExCOVID). Post-vaccine antibodies in ExCOVID individuals increase exponentially within 7-15 days after the first dose compared to naïve subjects (p<0.0001). We developed a multivariate Linear Regression (LR) model with l2 regularization to predict the IgG response for SARS-COV-2 vaccine. We found that the antibody response of ExCOVID patients depends on the IgG pre-vaccine titer and on the symptoms that they developed during the disorder, with anosmia/dysgeusia and gastrointestinal disorders being the most significantly positively correlated in the LR. Thus, one vaccine dose is sufficient to induce a good antibody response in ExCOVID subjects. **On the contrary, a second dose might switch-off the immune**

response due to antigen exhaustion, which occurs in response to several viruses or drive the development of low-affinity antibodies for SARS-CoV-2 which may foster an antibody dependent enhancement (ADE) reaction when re-exposed to the virus. These results question whether a second shot in ExCOVID subjects is indeed required and suggest to post-pone it while monitoring antibody response longevity.

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

At least some of the mainstream media is finally catching on

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

Recently they have reported on the lab origins…

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

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

and now this from the WSJ…

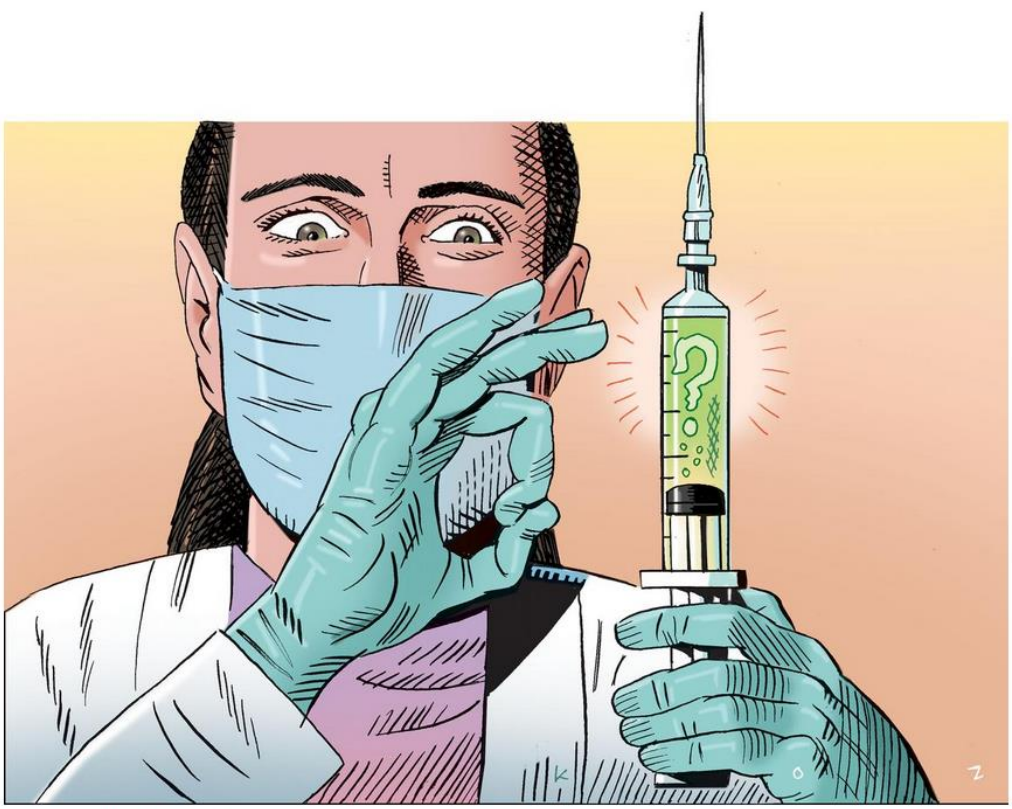


ILLUSTRATION: MARTIN KOZLOWSKI

The op-ed featured in the WSJ June 22nd, 2021 titled **Are Covid Vaccines Riskier Than Advertised?** - **There are concerning trends on blood clots and low platelets, not that the authorities will tell you** was submitted by

Joseph Ladapo, M.D., Ph.D., associate professor of medicine at ***UCLA's David Geffen School of Medicine***, and Harvey Risch, M.D., Ph.D., a professor of epidemiology at ***Yale School of Public Health*** wrote while "some scientists have raised concerns that the safety risks of Covid-19 vaccines have been underestimated … the politics of vaccination has relegated their concerns to the outskirts of scientific thinking."

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

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

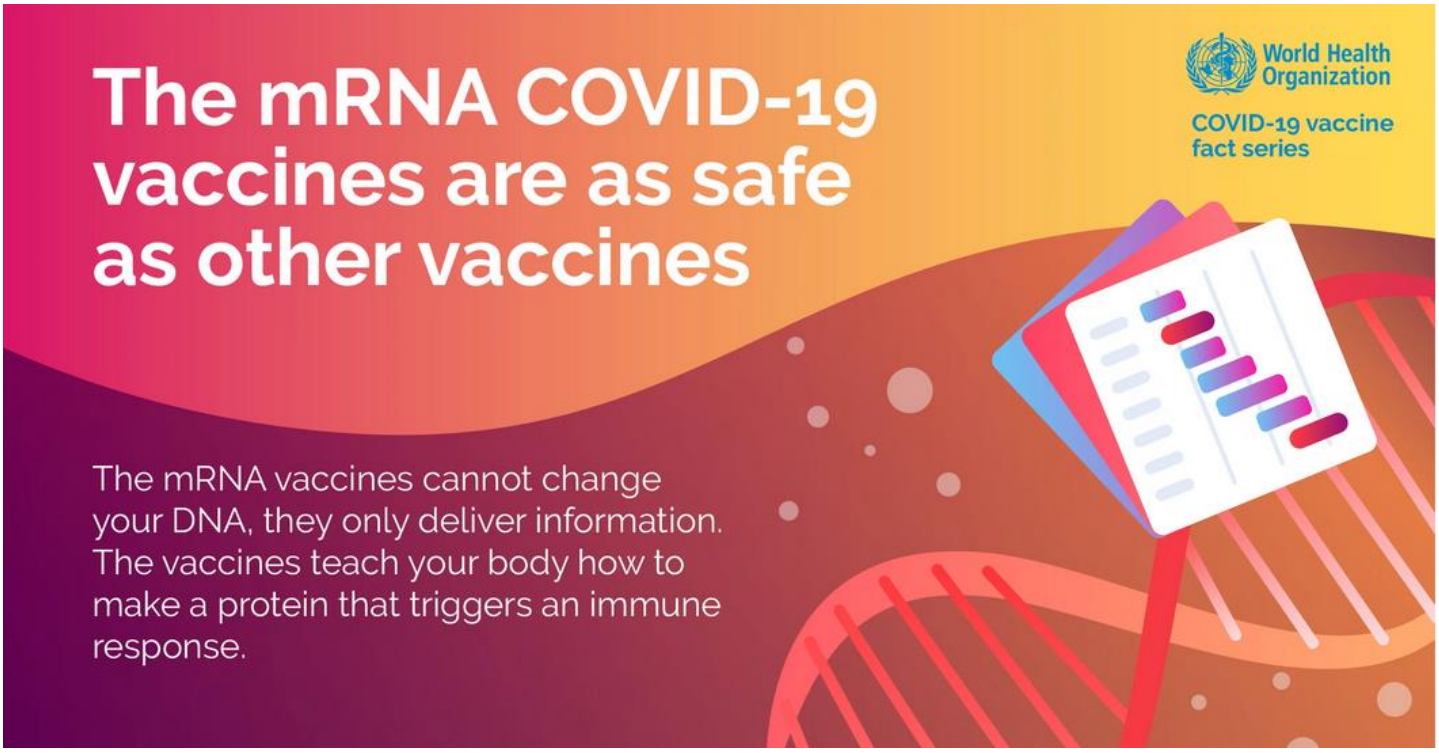
"Analyses to confirm or dismiss these findings should be performed using large data sets of health-insurance companies and healthcare organizations. The CDC and FDA are surely aware of these data patterns, yet neither agency has acknowledged the trend."

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

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….



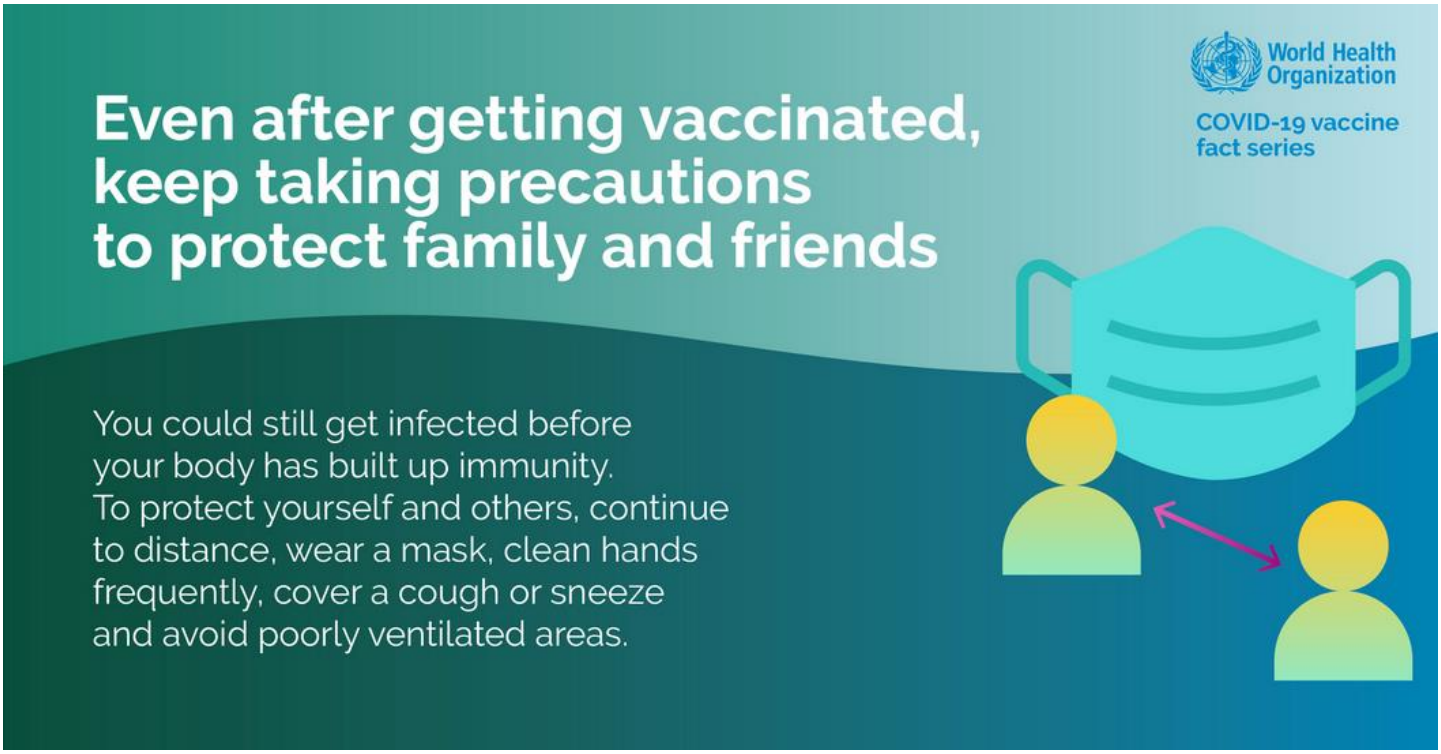
As safe as other vaccines? Just check the VAERS reports (which we know are highly under-reported) and read the MedScape medical professional comments from the link found in this newsletter. Then tell me what you think about this egregious statement.

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.

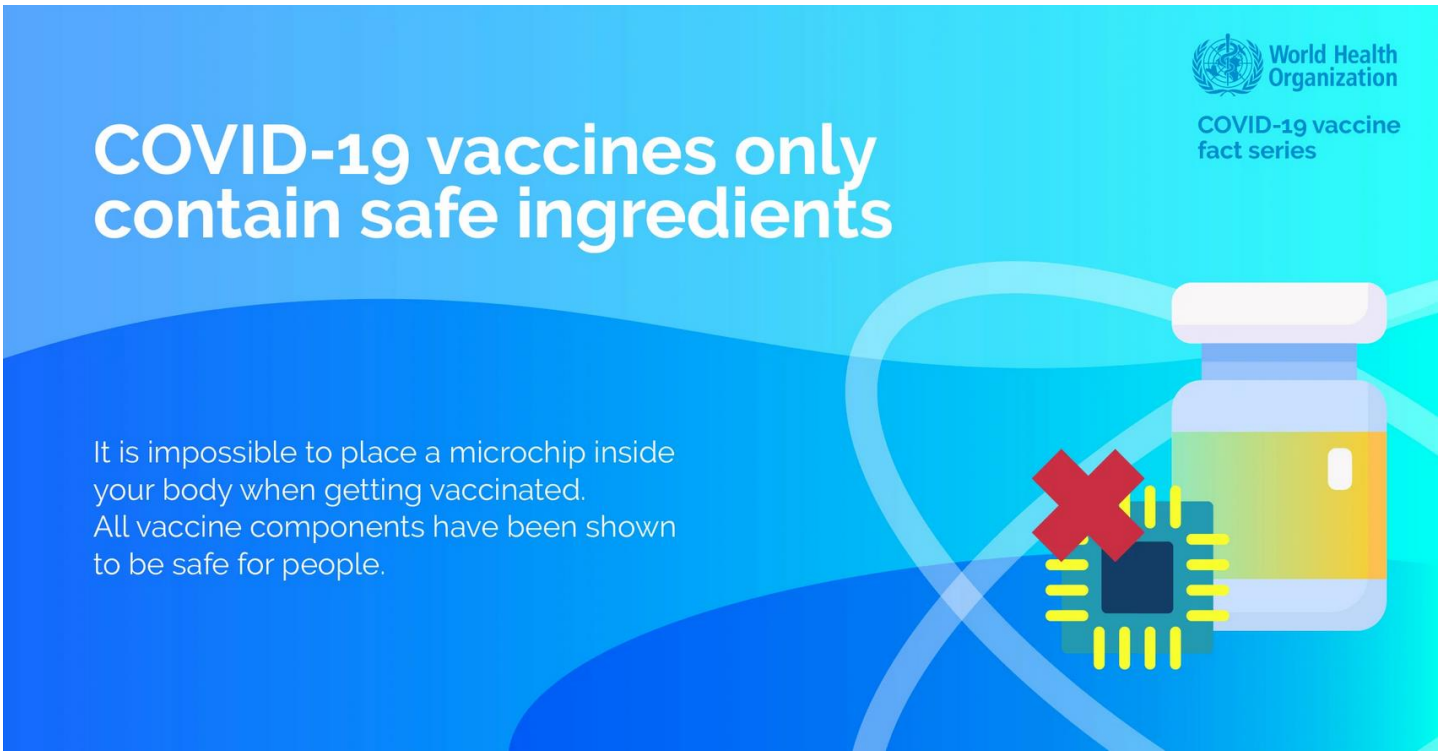
The statement above is a joke! We know from numerous studies many of which I've covered in previous newsletters and some of them in this newsletter, that natural immunity is far superior to vaccine immunity. Those who have been vaccinated are at far greater risk of becoming infected by mutant strains. 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

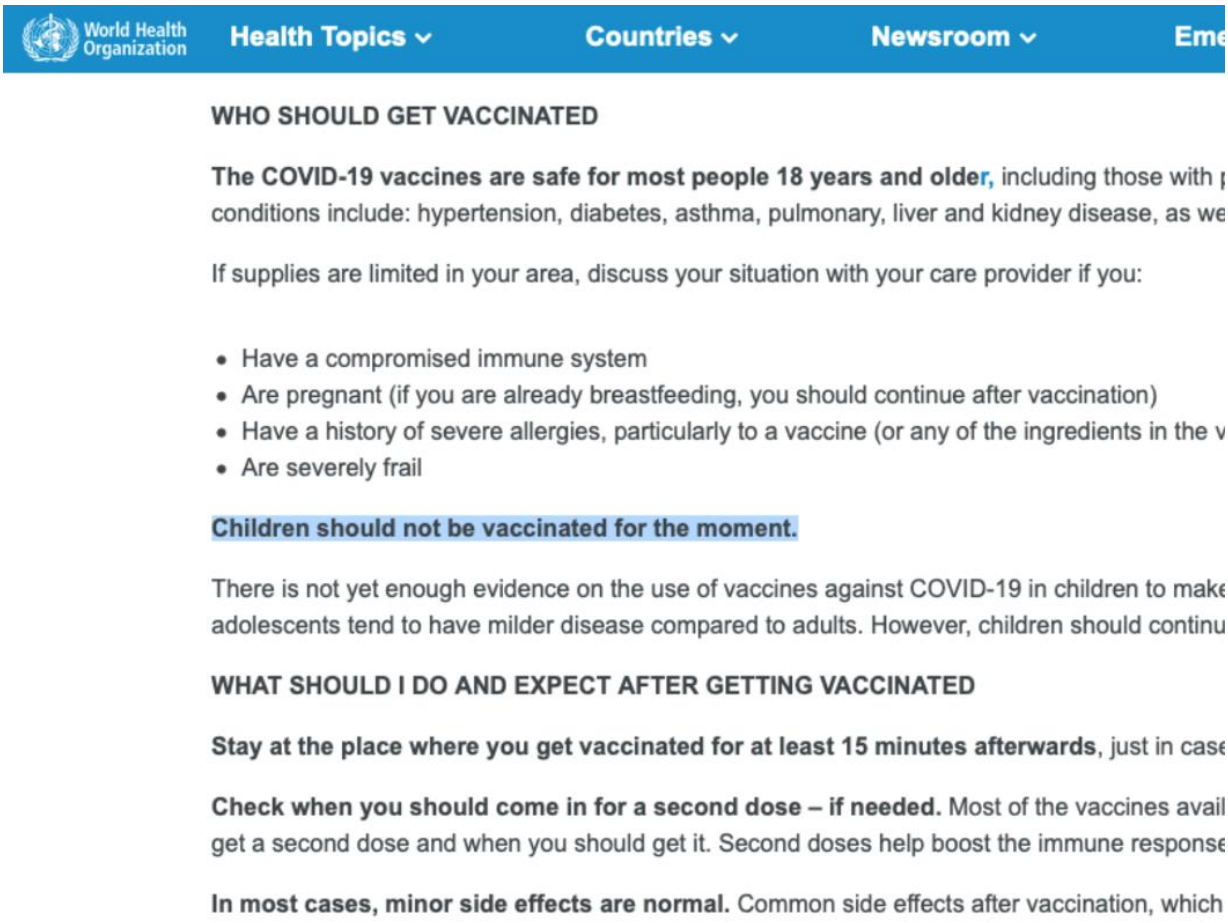
https://www.who.int/emergencies/diseases/novel-coronavirus-2019/covid-19-vaccines/advice

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.



World Health Organization | Health Topics | Countries | Newsroom | Eme

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

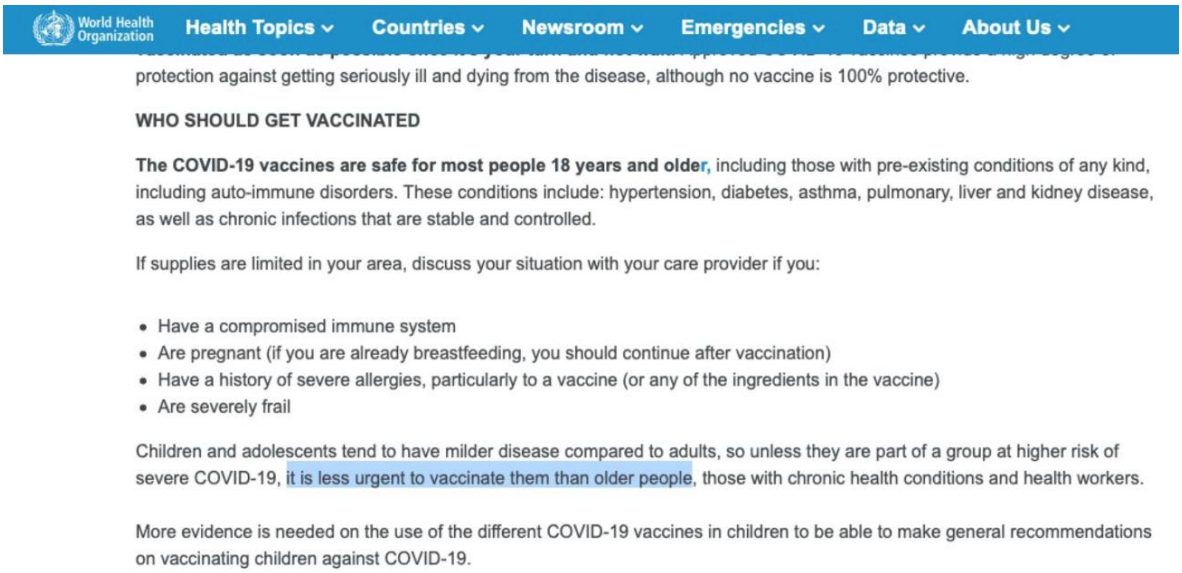
WHAT SHOULD I DO AND EXPECT AFTER GETTING VACCINATED

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…



World Health Organization | Health Topics | Countries | Newsroom | Emergencies | Data | About Us

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

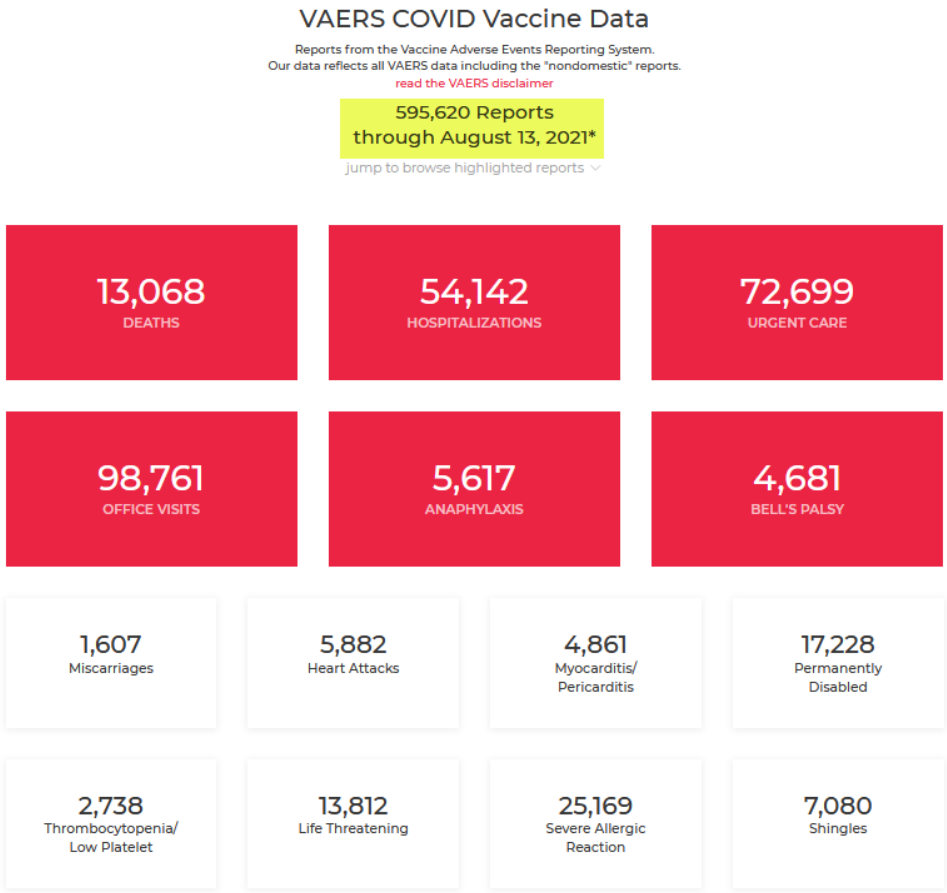
Children and adolescents tend to have milder disease compared to adults, so unless they are part of a group at higher risk of severe COVID-19, it is less urgent to vaccinate them than older people, those with chronic health conditions and health workers.

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.

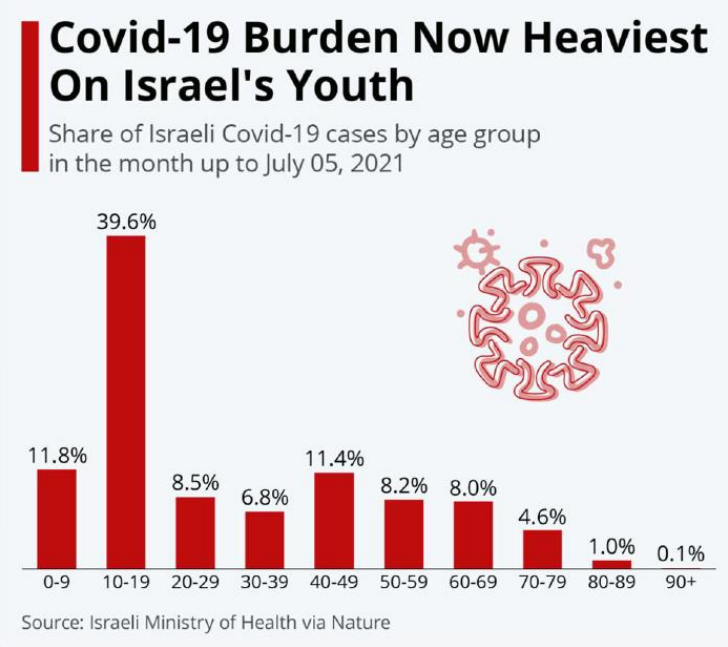
The article also said the following: "The reproduction rate (R), the number of people a sick person infects, stood at 1.37 – meaning that Covid-19 is spreading again." Parts of my brain perked up when I read this. A reproduction number (R0 for R-naught) above 1 means that there is spread of a pathogen 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

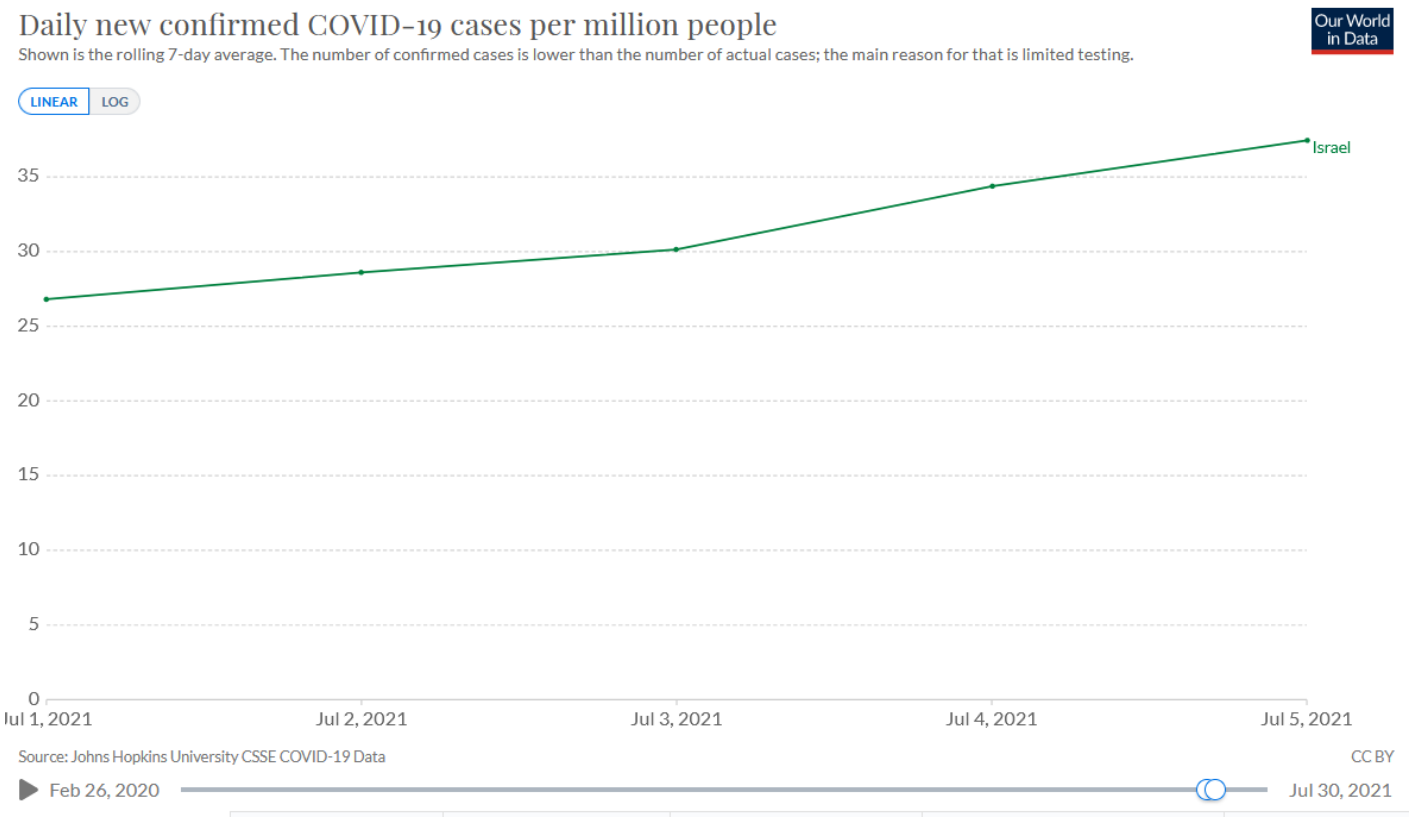
What about an increased number of cases in young people as we are hearing about?

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).

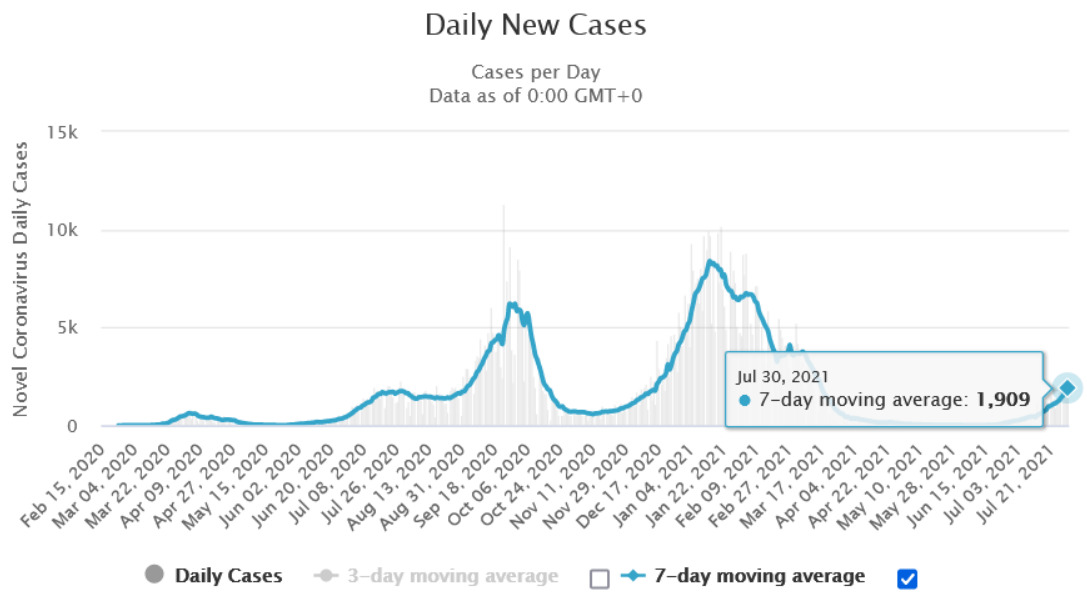


The reality is that young people are still doing extremely well against this virus and it is not only irrational to use scare tactics like this in reporting, it is corrupt and disingenuous. We will talk a lot more about all of that kind of reporting and behavior in this issue of 1200 Studies newsletter.

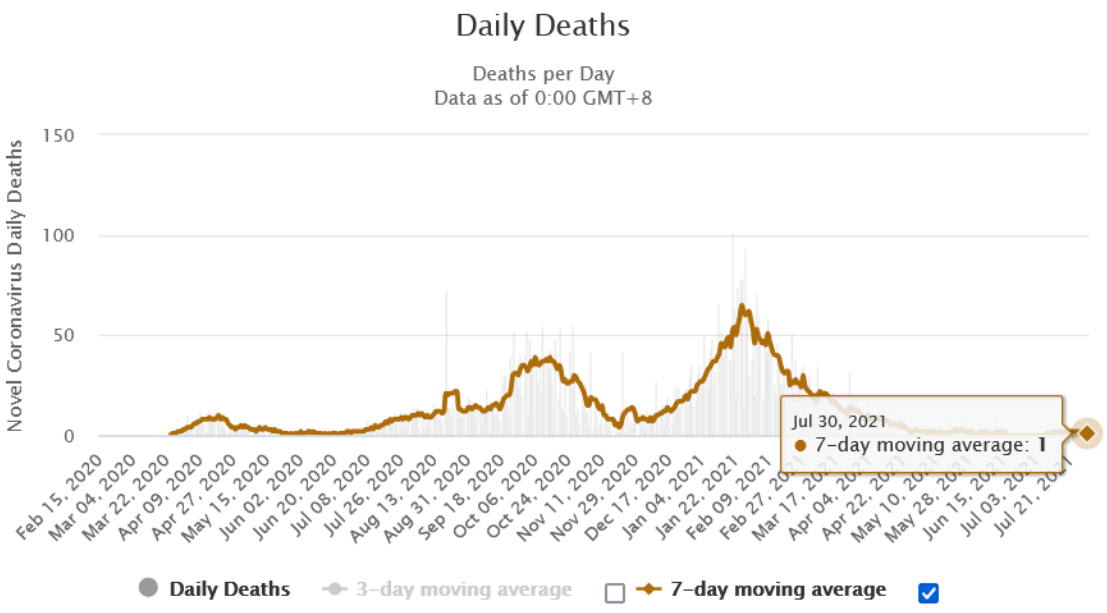
On the next page…As an example of the non-story that the image showing cases by age is presenting, let's look at what is really happening with case and death rates in Israel?

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.

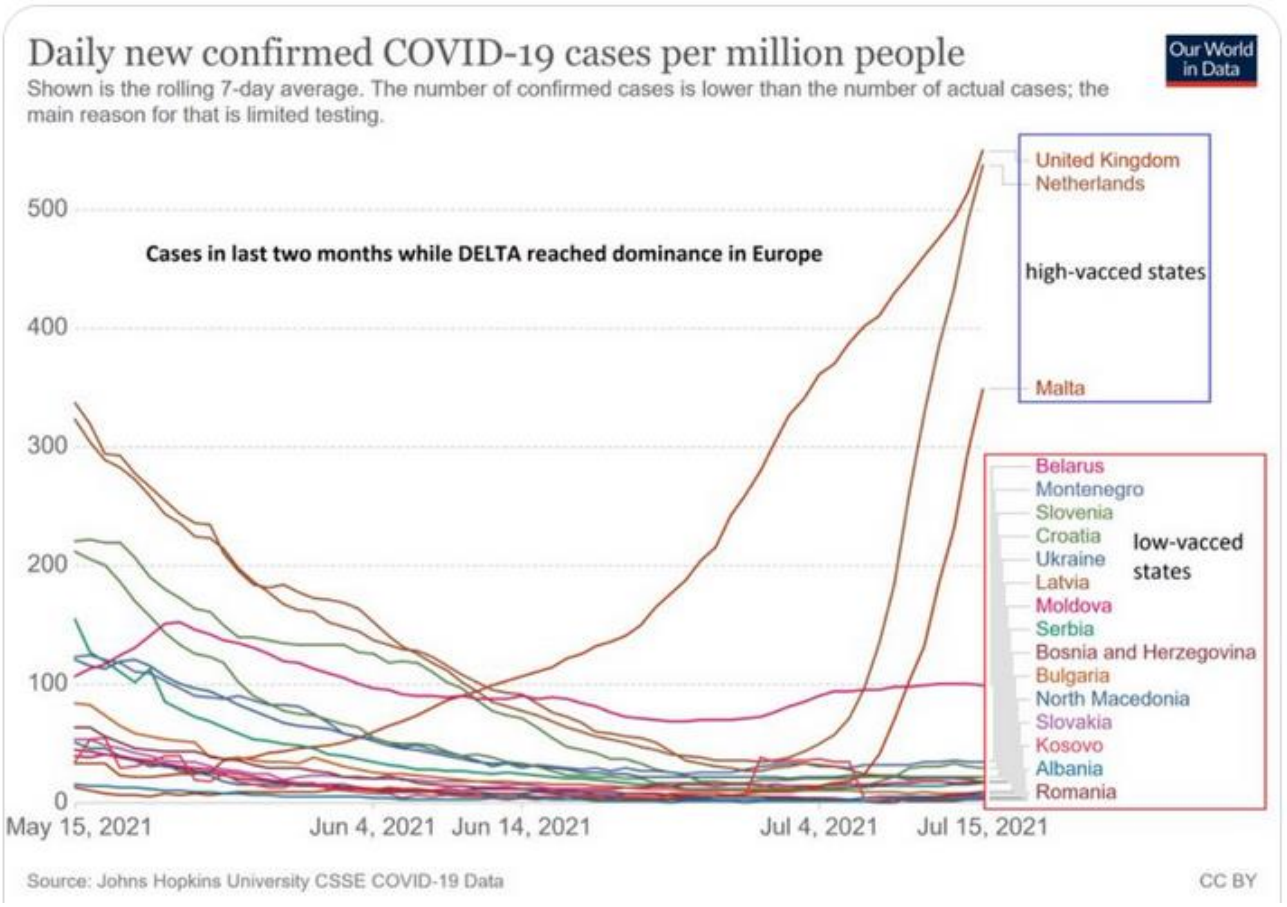
Corona Realism
@holmenkollin

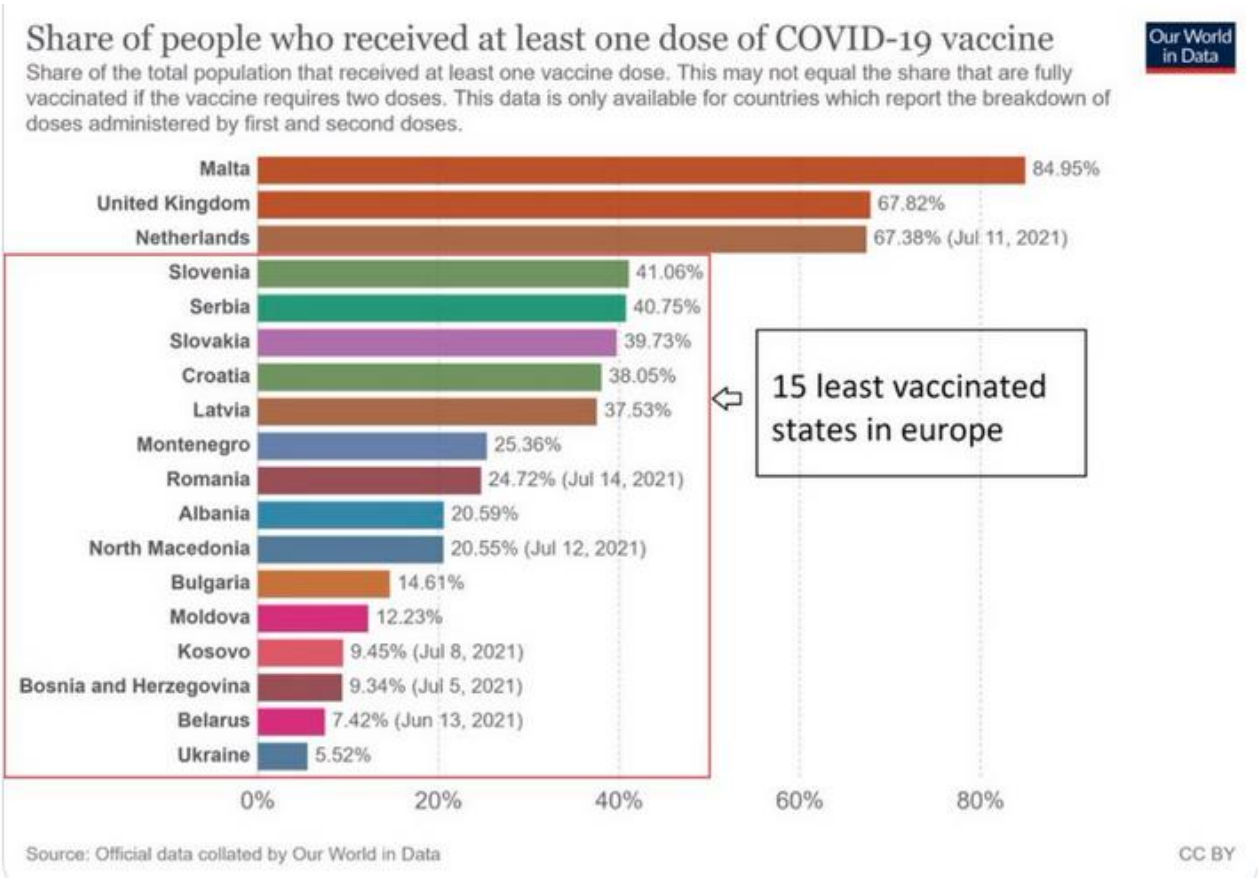
Something really odd is going on:

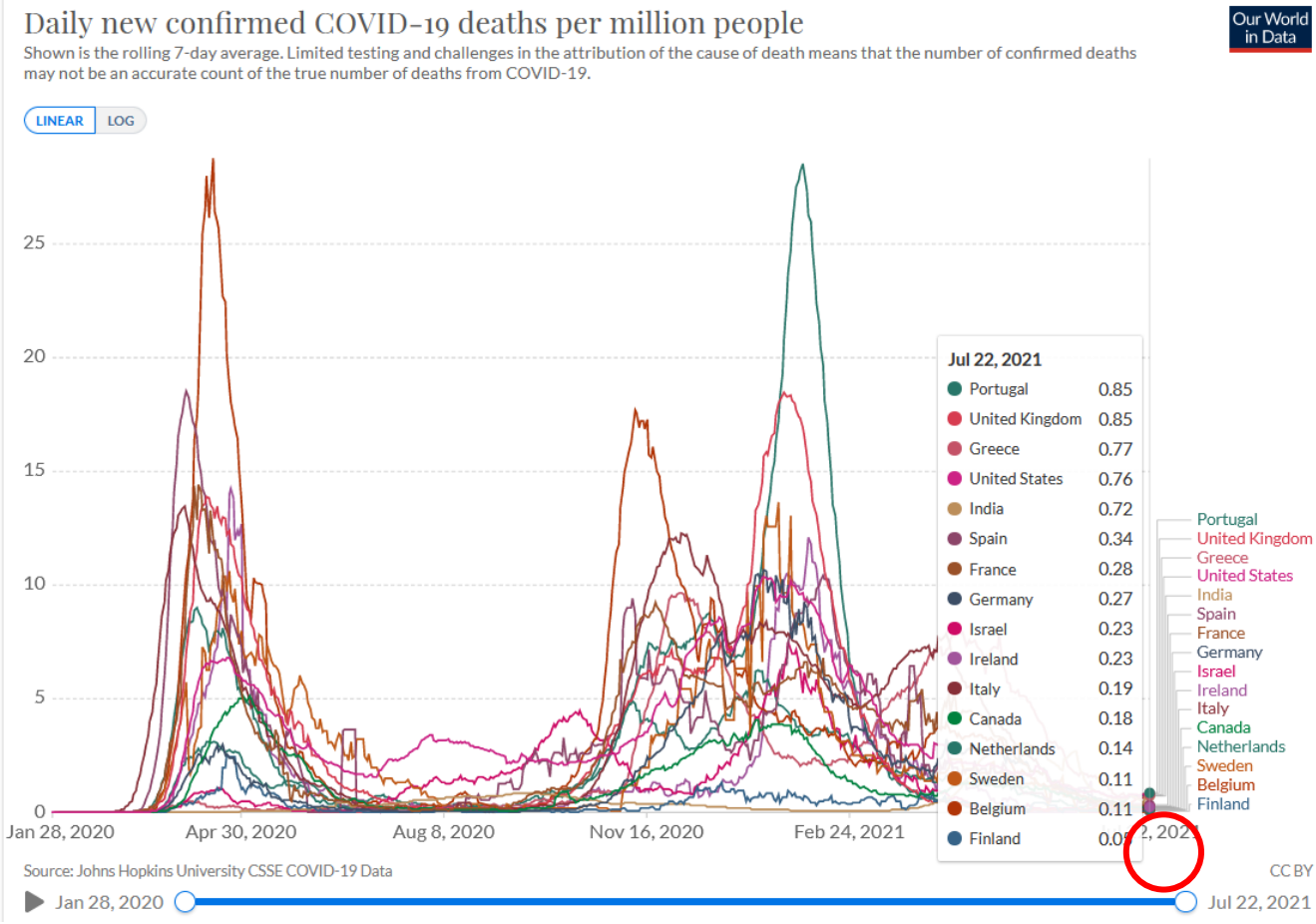
In Europe we are seeing surges at many places where most of the population has already been vaccinated.

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.

TABLE OF CONTENTS

(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.

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.[10]

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

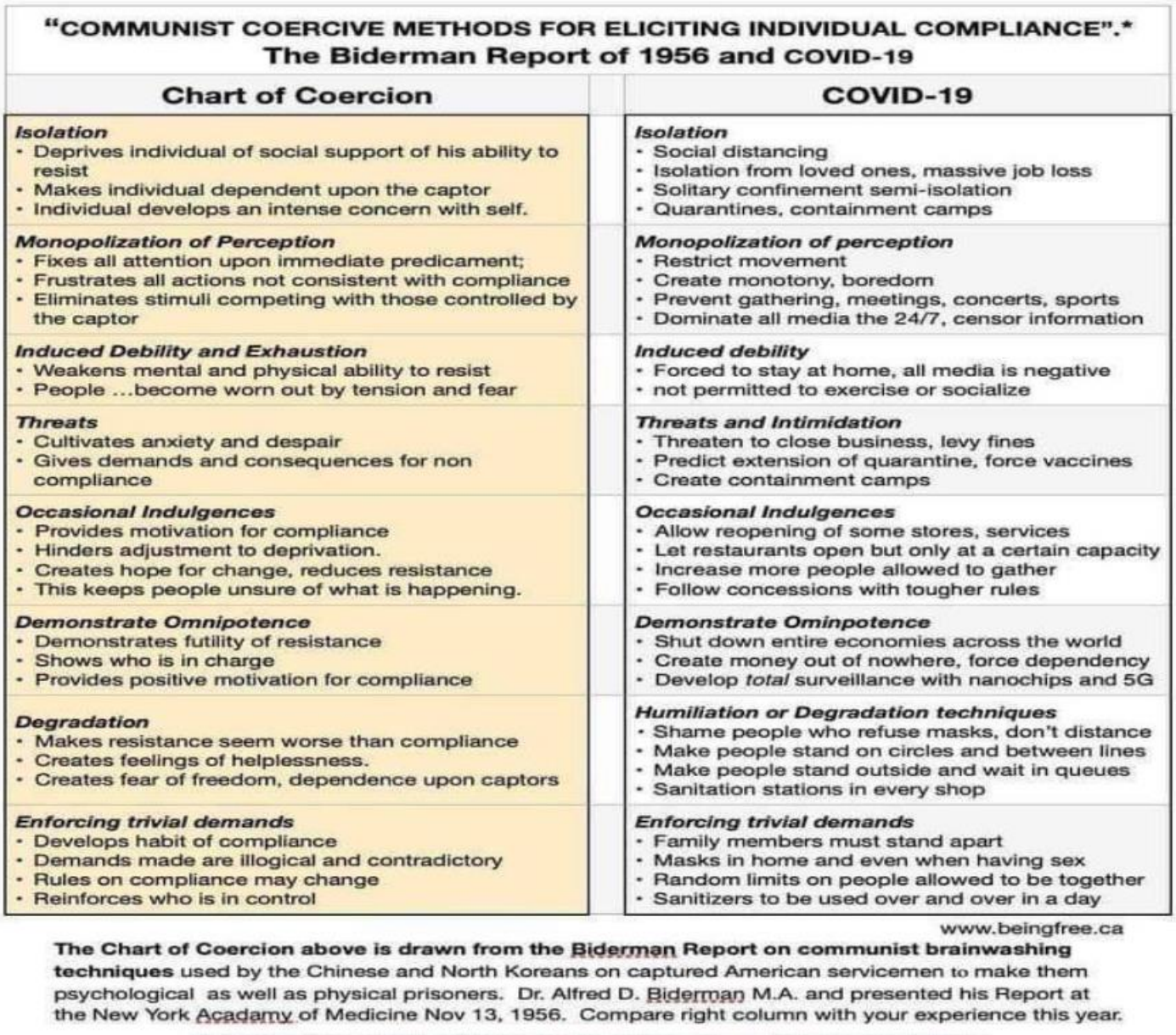
Information regarding available alternatives to the Vaccines has been suppressed and censored equally with information regarding the risks of the Vaccines, as aforesaid.

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

www.beingfree.ca

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.

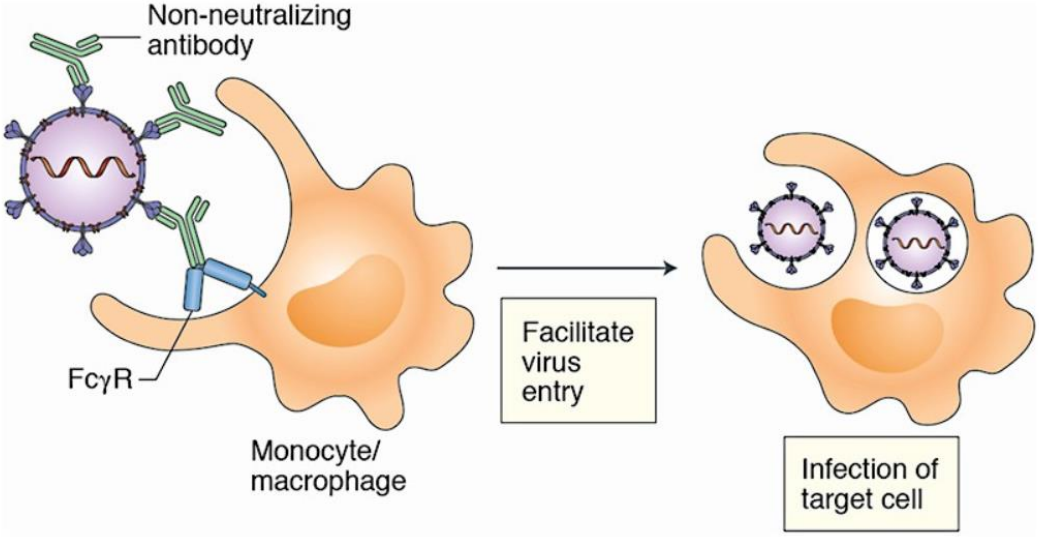
A non-neutralizing antibody is one that can bind to the virus, but for some reason, the antibody fails to neutralize the infectivity of the virus. This can occur, for example, if the antibody doesn't bind tightly enough to the virus, or the percentage of the surface area of the virus covered by the antibody 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/

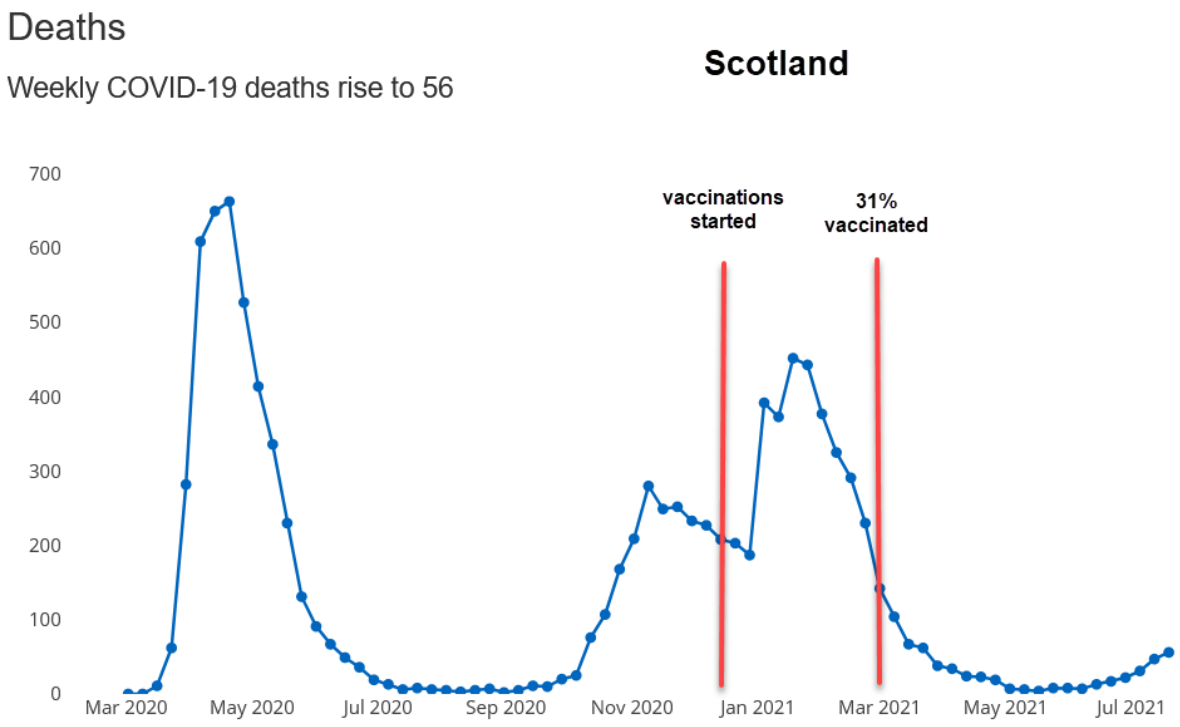
This is an example of how statistics can be deceptive.

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.

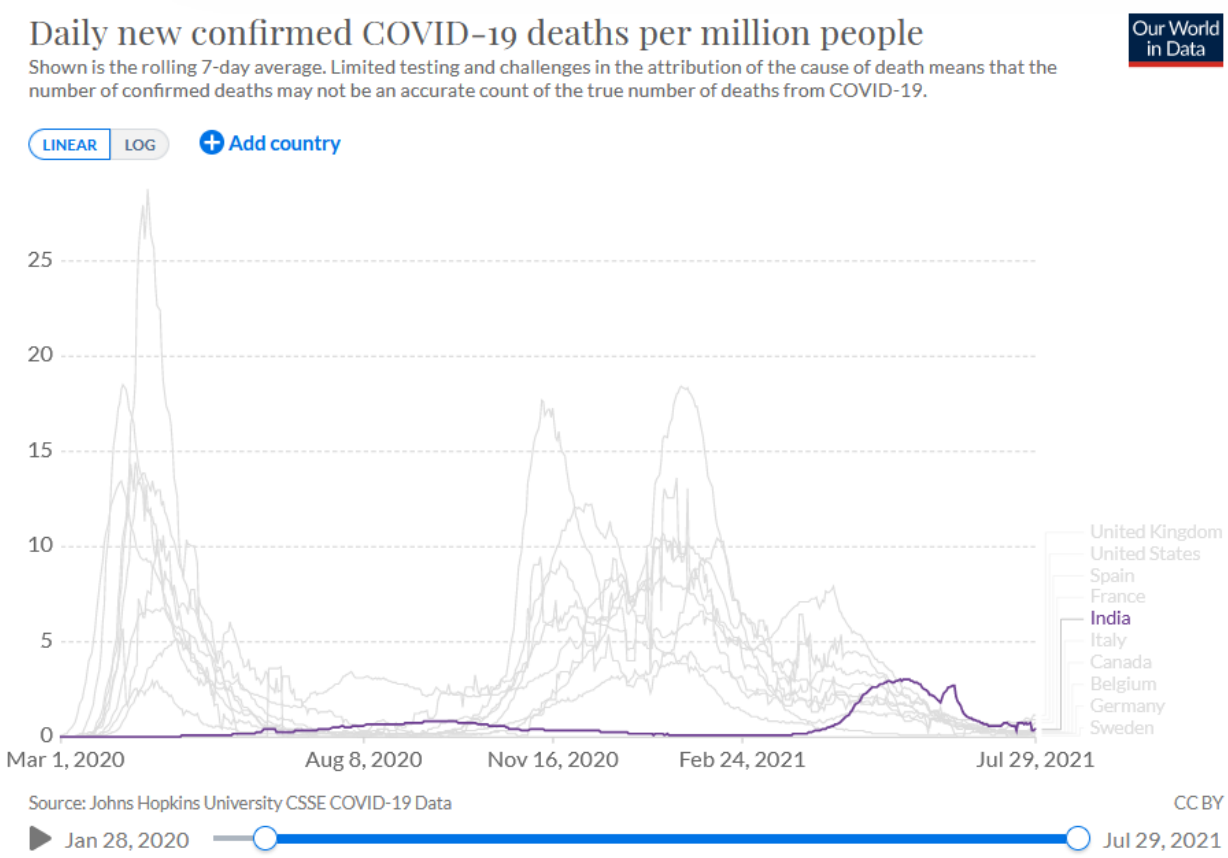
Two-thirds of Indians have coronavirus antibodies, survey shows

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.

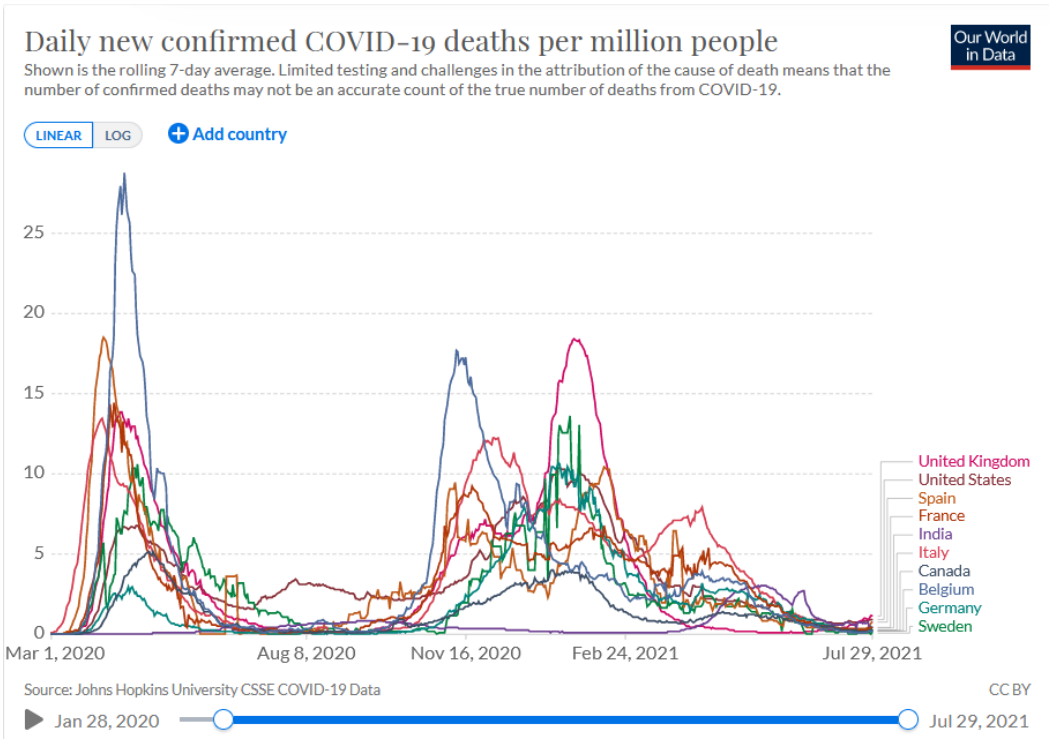
The fourth national blood serum survey which tests for antibodies, known as a sero survey, included 8,691 children aged 6-17 years for the first time. Half of them were seropositive.

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.

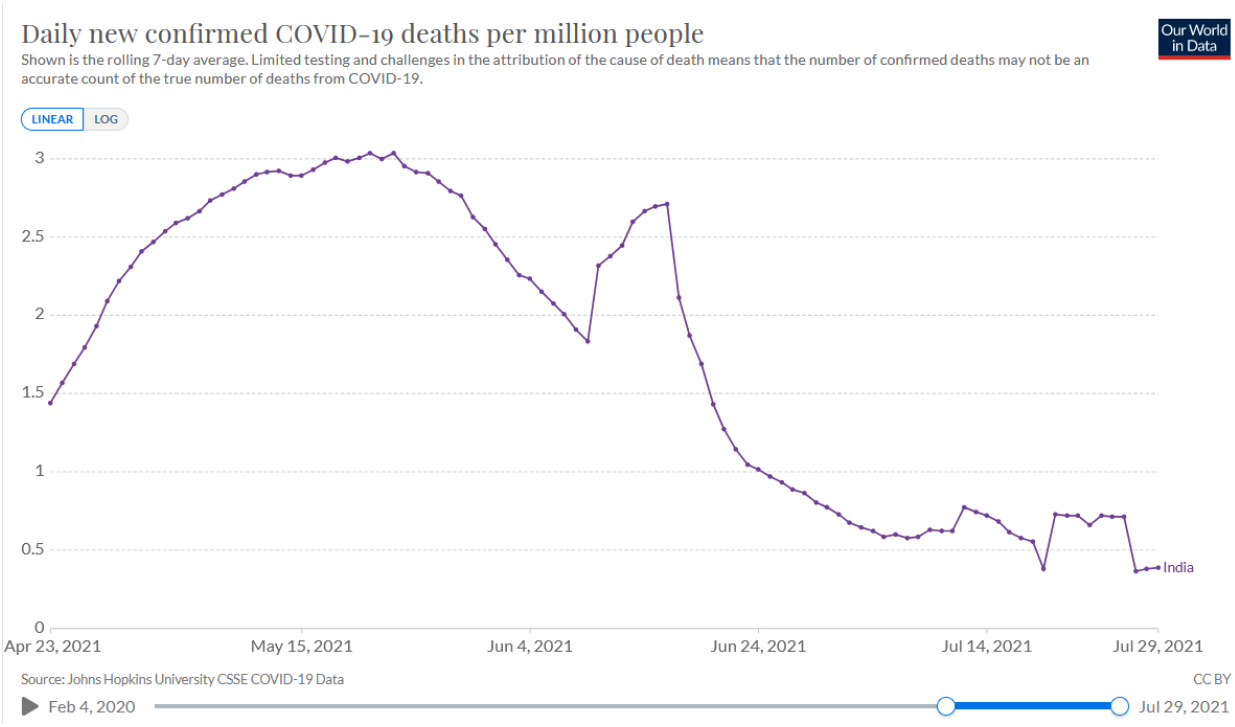
https://www.reuters.com/world/india/india-govt-survey-shows-two-thirds-have-coronavirus-antibodies-2021-07-20/



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.

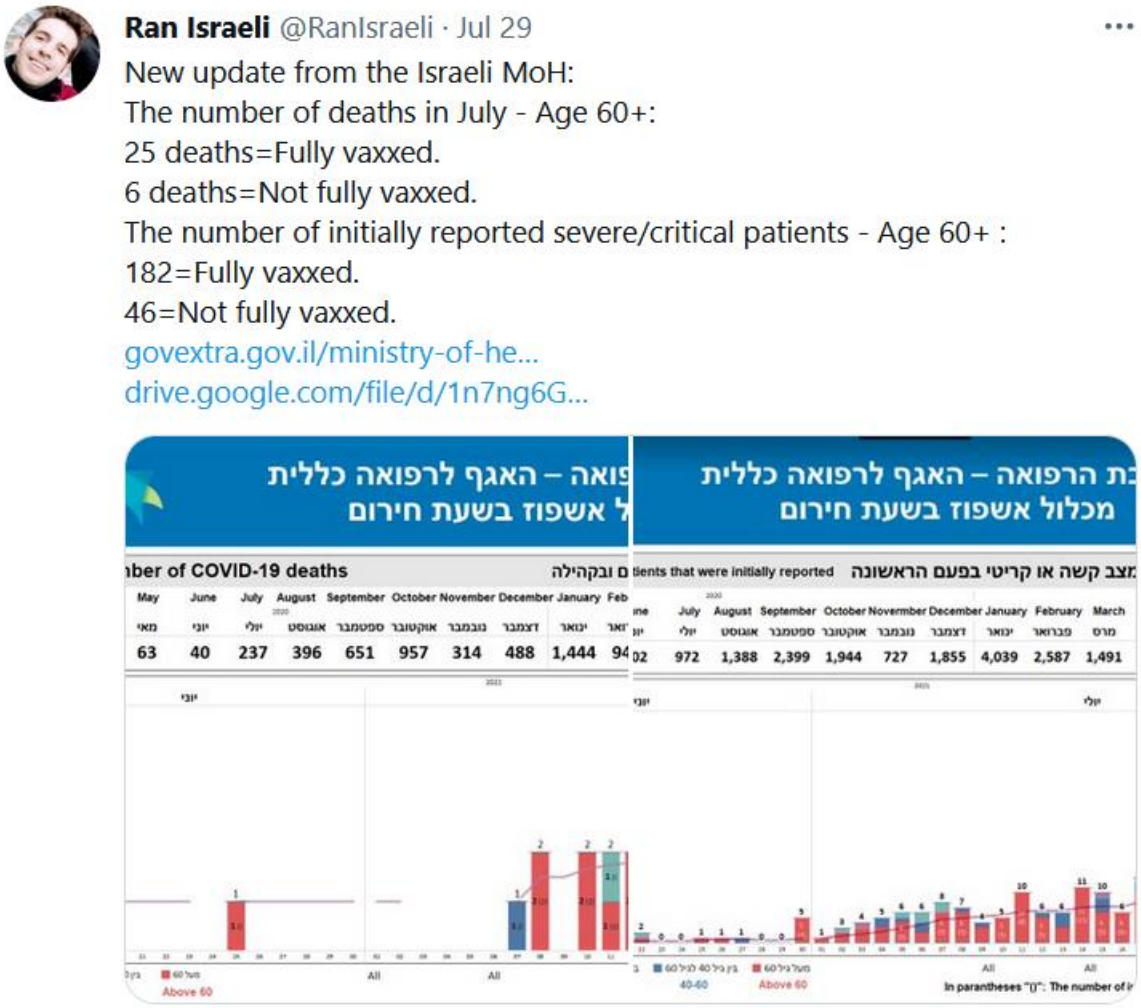
Israel Confirmed Cases, July 4th – July 10th, Vaccinated* vs. Unvaccinated**

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.



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%)

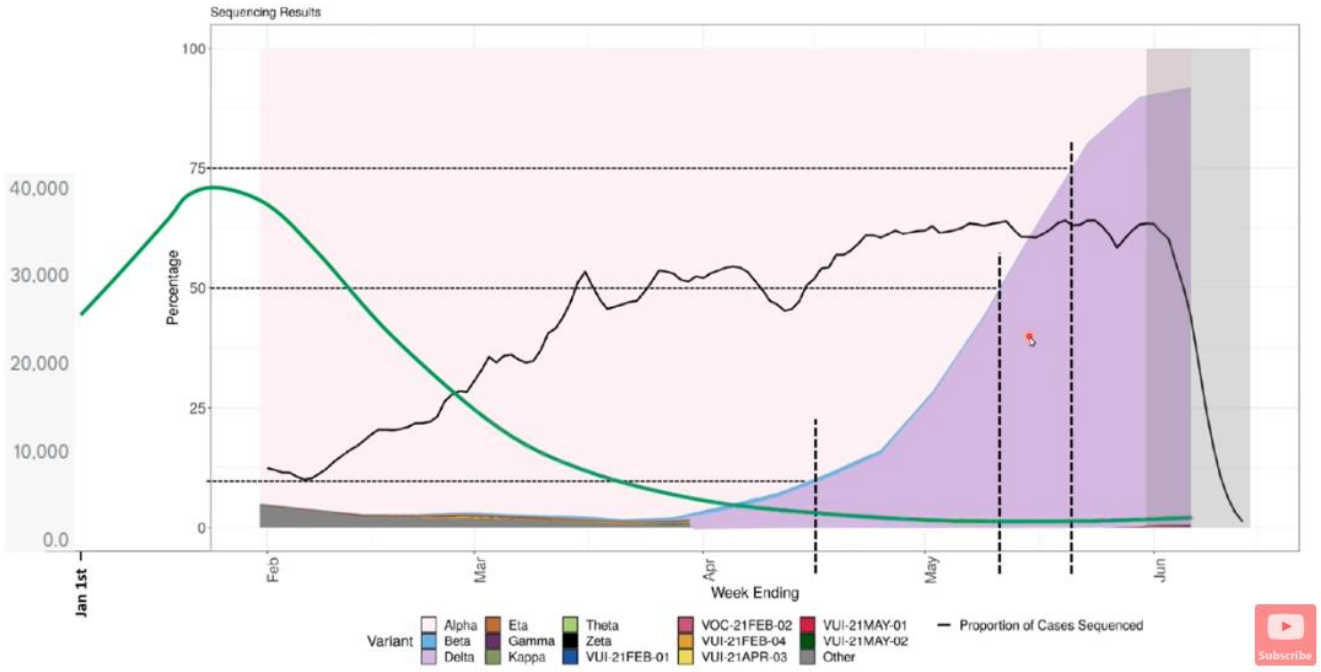
Compare the Delta (Indian) Variant statistics to the Alpha (UK), Beta (South African) or Eta Variants and you will see that it is far less lethal. But you would never know that by listening to the hysterical “misinformation media”.

Want more evidence of the disconnect with what we hear in the media in the U.S. and what they are experiencing elsewhere?

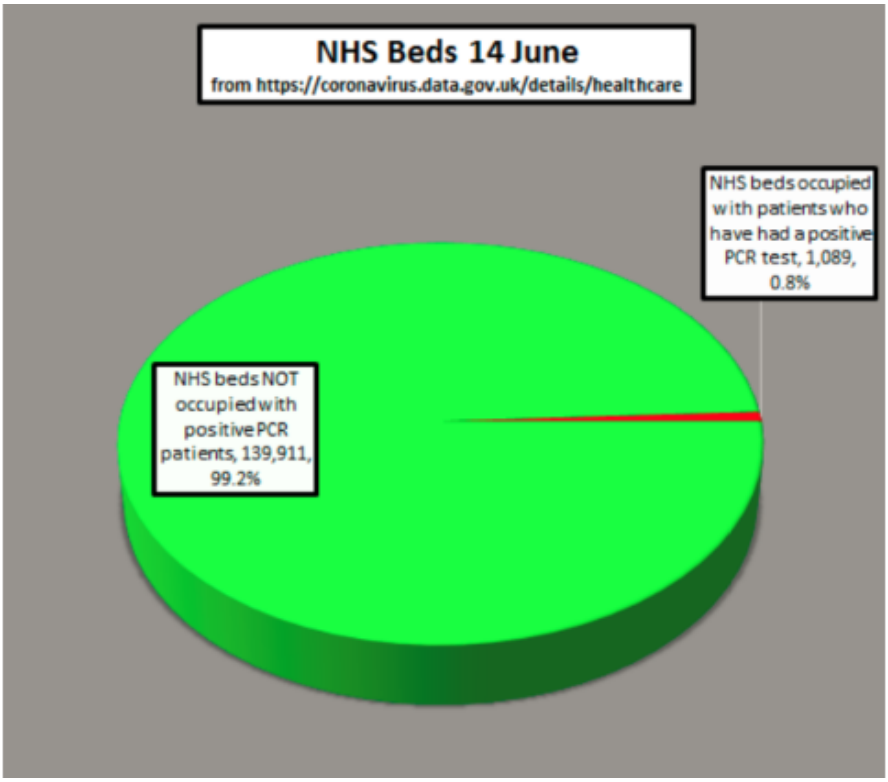
See next page…

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/

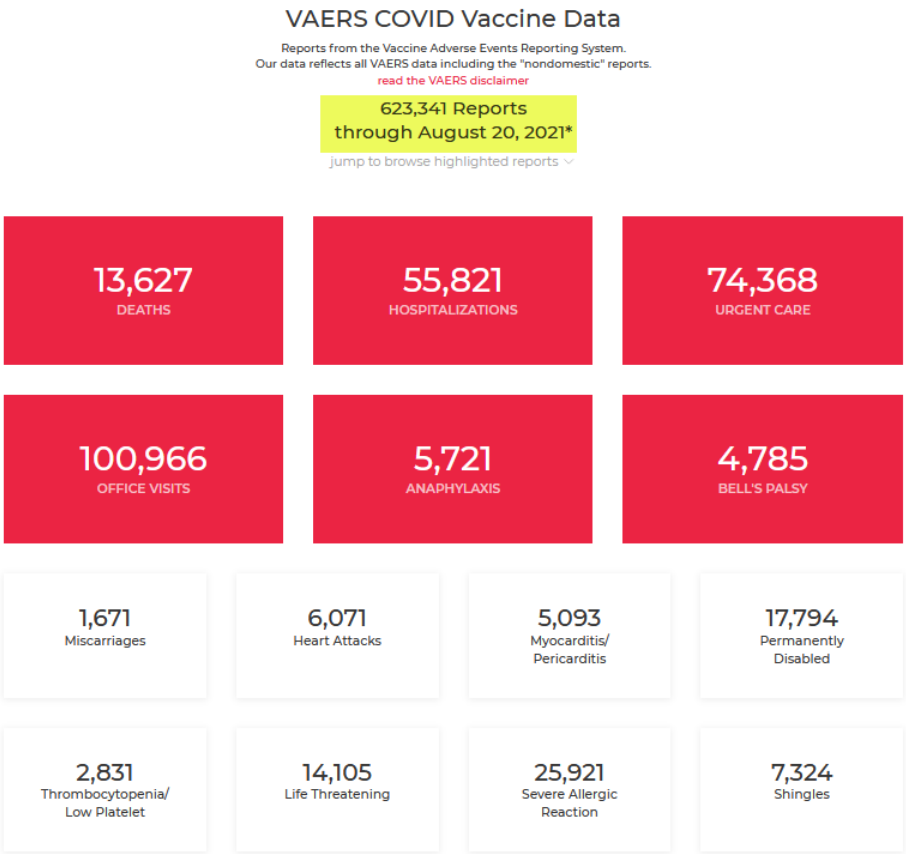
Not only that, but it has been proven time and time again that children are not vectors for spreading the virus, because we all know that one of the sales pitches is we need to vaccinate the children to protect grandma and grandpa. First of all, why don't we do a survey of all of the grandmas and grandpas 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

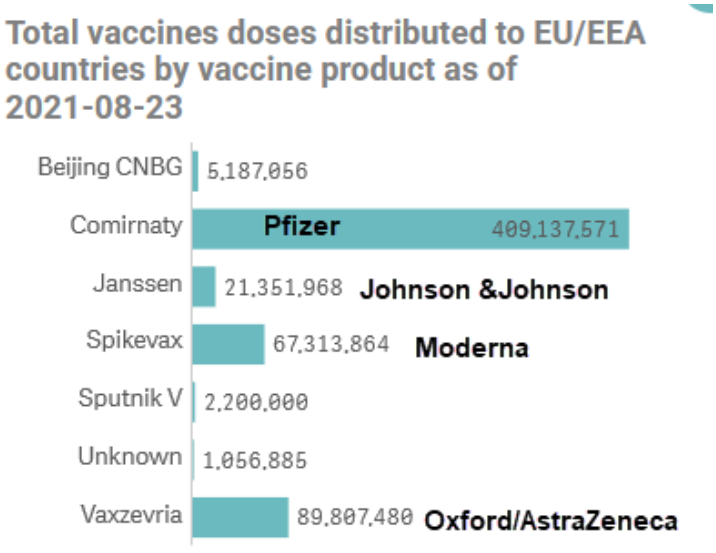
EudraVigilance - European database of suspected adverse drug reaction reports

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

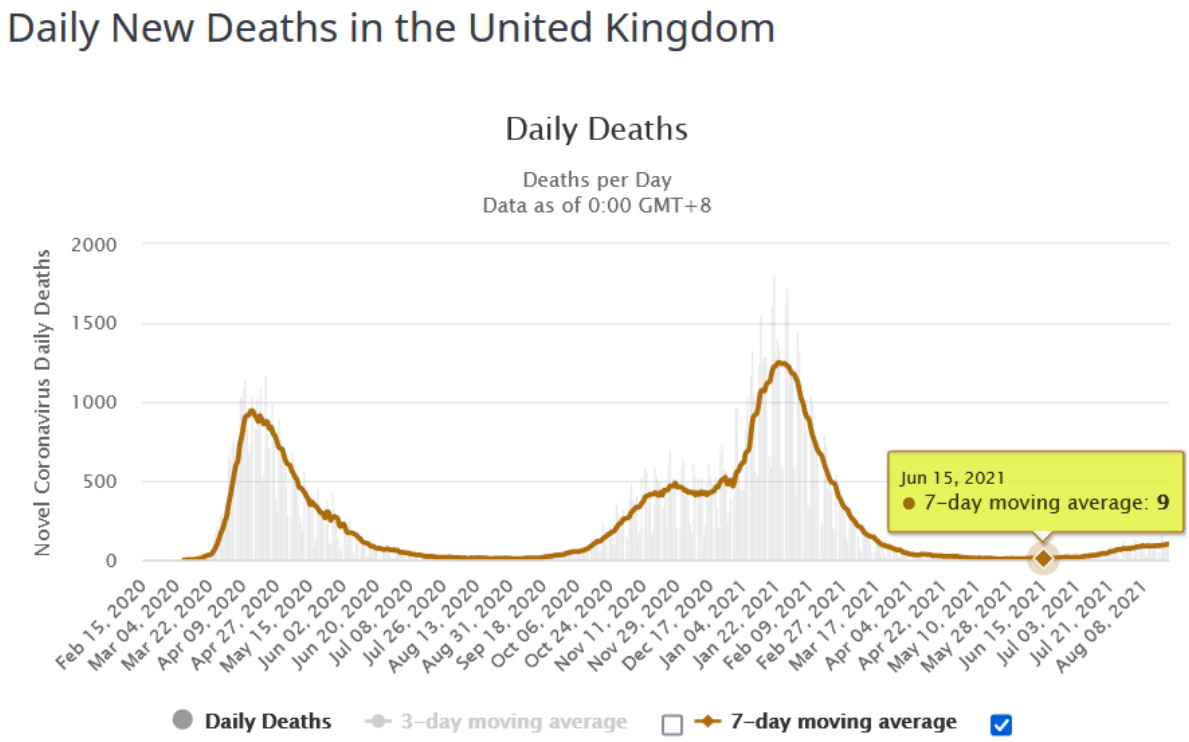
Table 4. Attendance to emergency care and deaths by vaccination status among Delta confirmed cases (sequencing and genotyping) in England, 1 February 2021 to 14 June 2021.

	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%

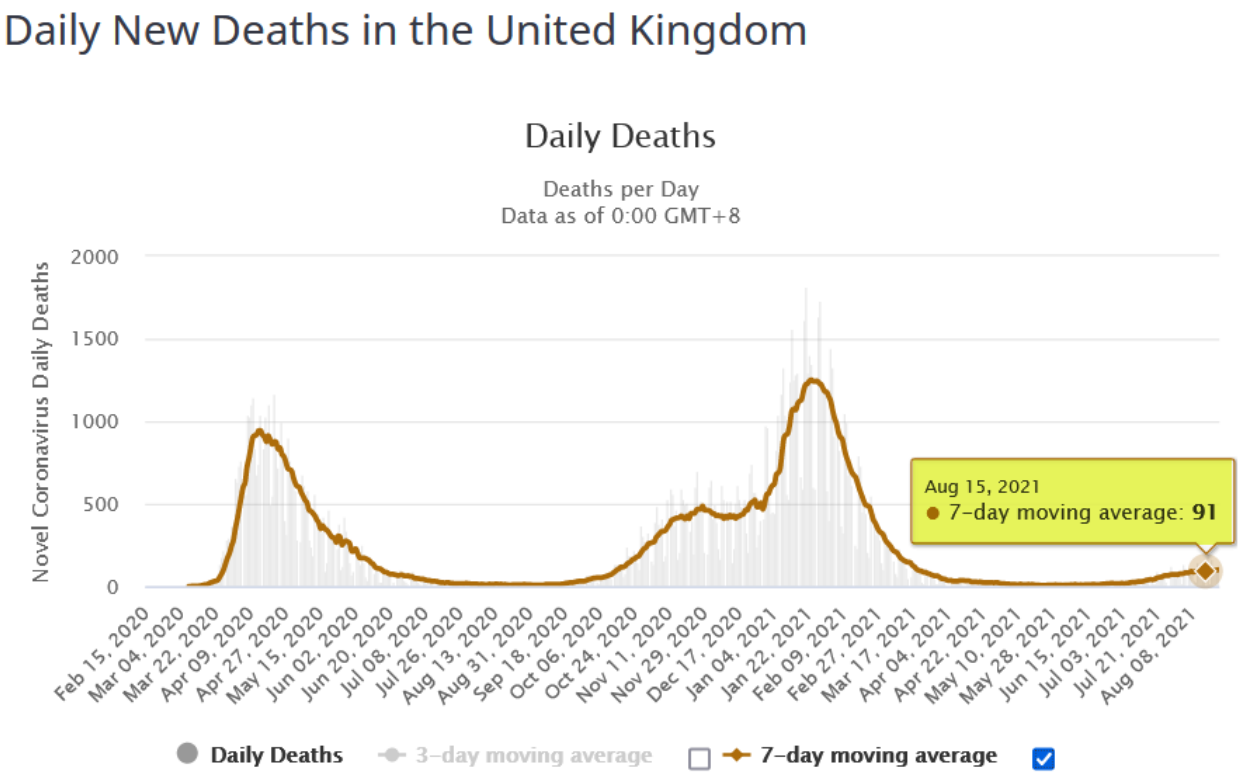
Data sources: Emergency care attendance and admissions from Emergency Care Dataset (ECDS), deaths from PHE daily death data series (deaths within 28 days)

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



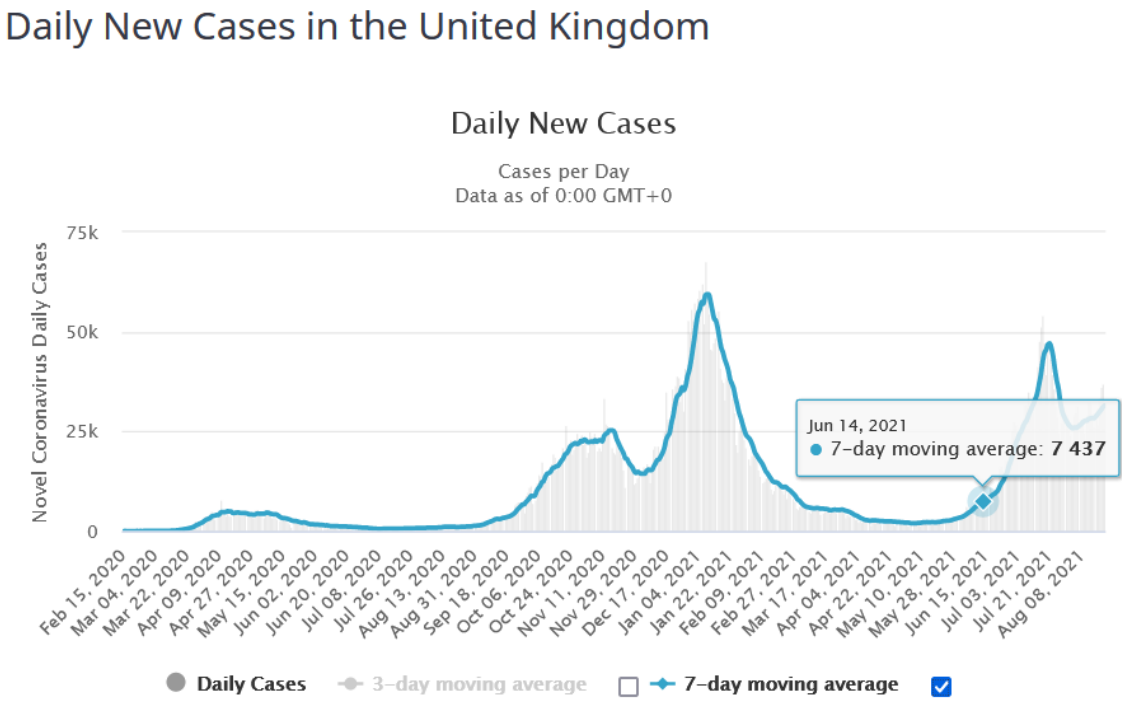
This was the 7-day average for deaths in the UK on August 15th, the date of the PHE report.



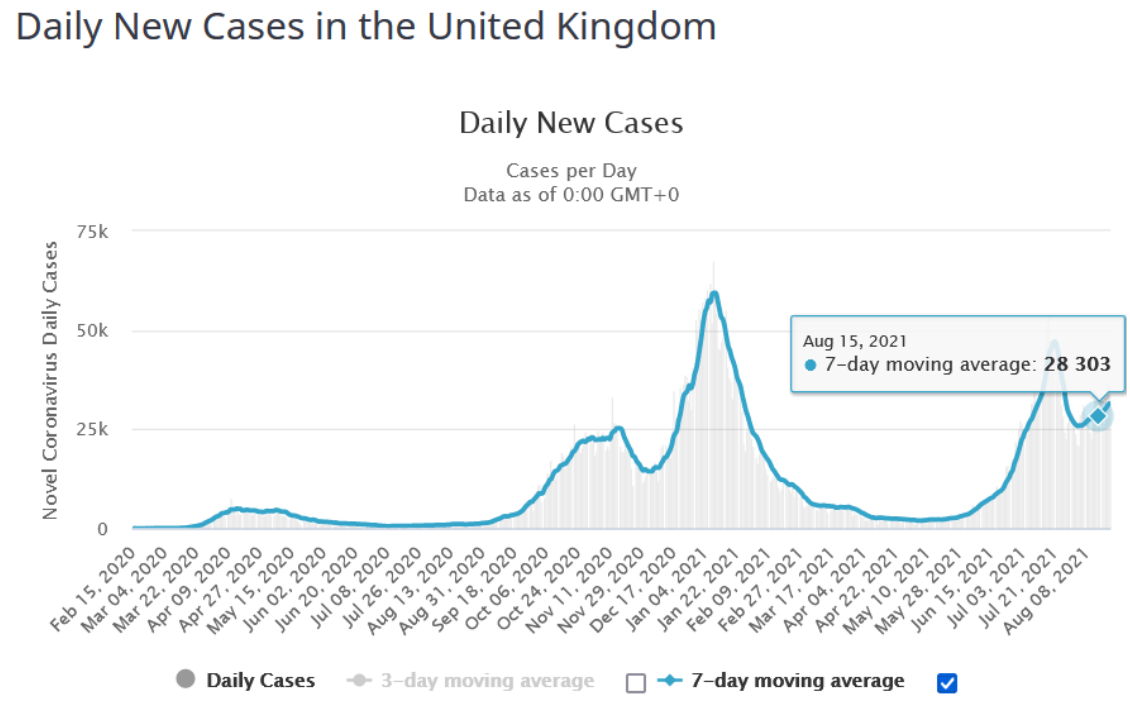
As you can see, the 7-day average for daily deaths is 10-fold higher as of August 15th (91) as compared to June 14th (9).

Case comparison for June 14th and August 15th

June 14th



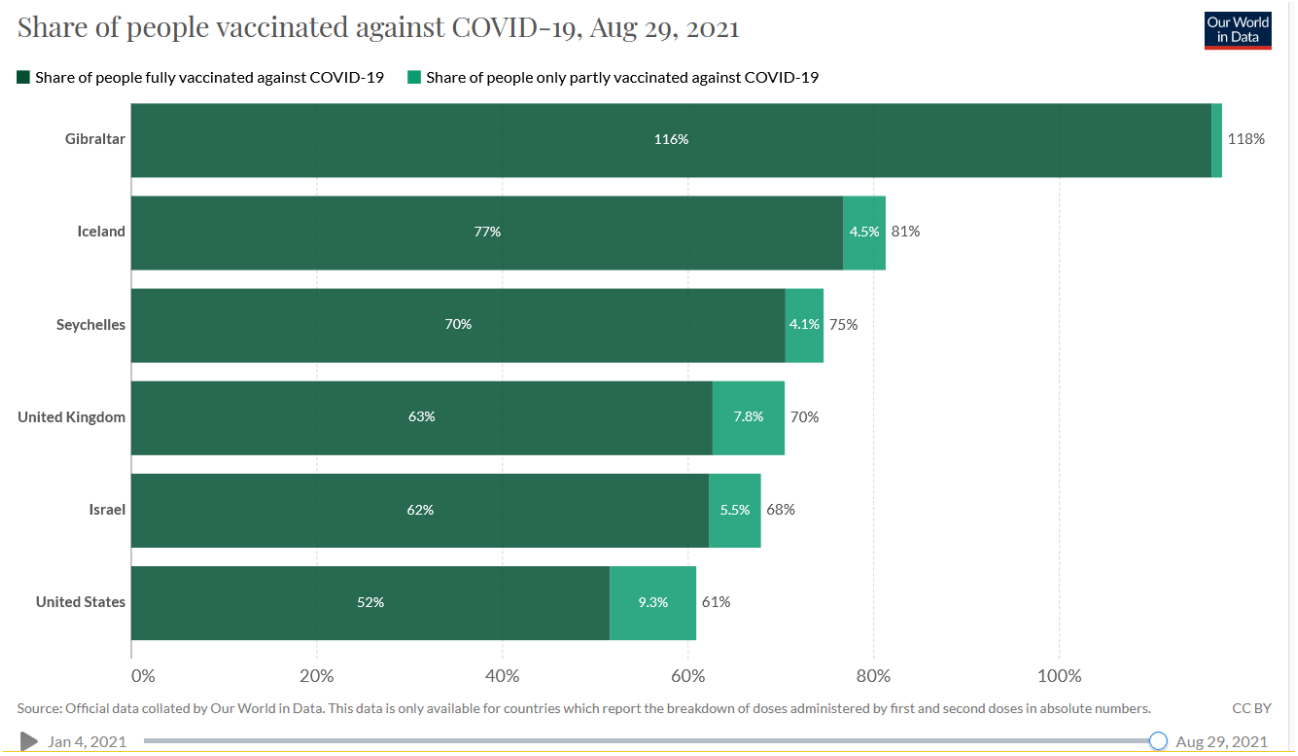
August 15th



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



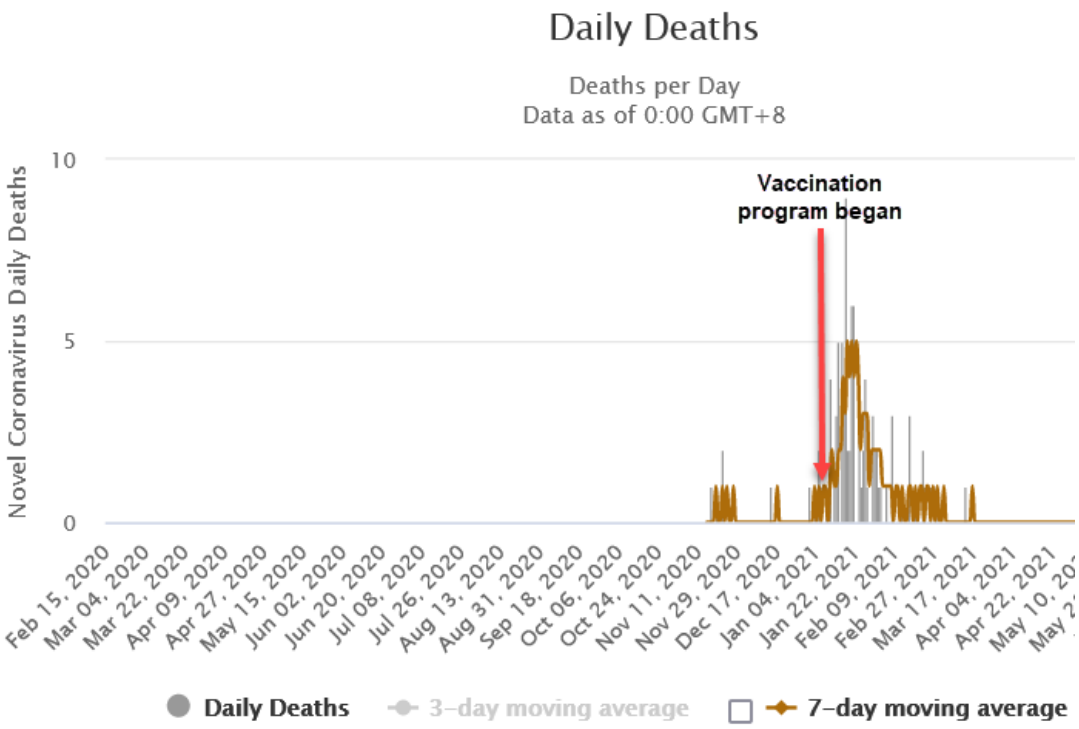
How Gibraltar has a 116% vaccination rate is a mystery to me. But that is what *Our World in Data* is reporting. Regardless, let's starts there.

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.

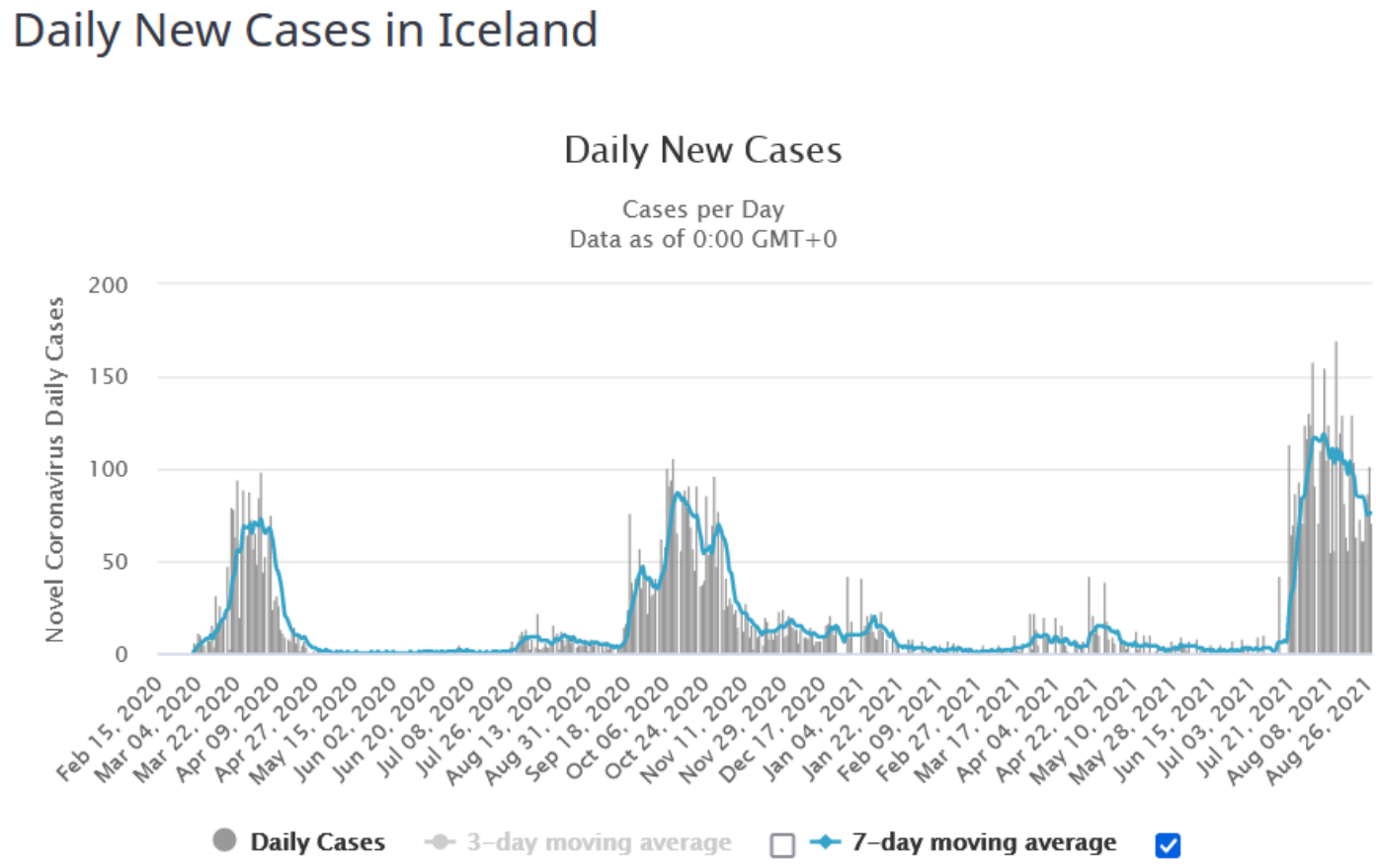
After the first week of vaccination, Chief Minister Fabian Picardo said, "This is now the worst loss of life of Gibraltarians in over 100 years. Even in war, we have never lost so many in such a short time."

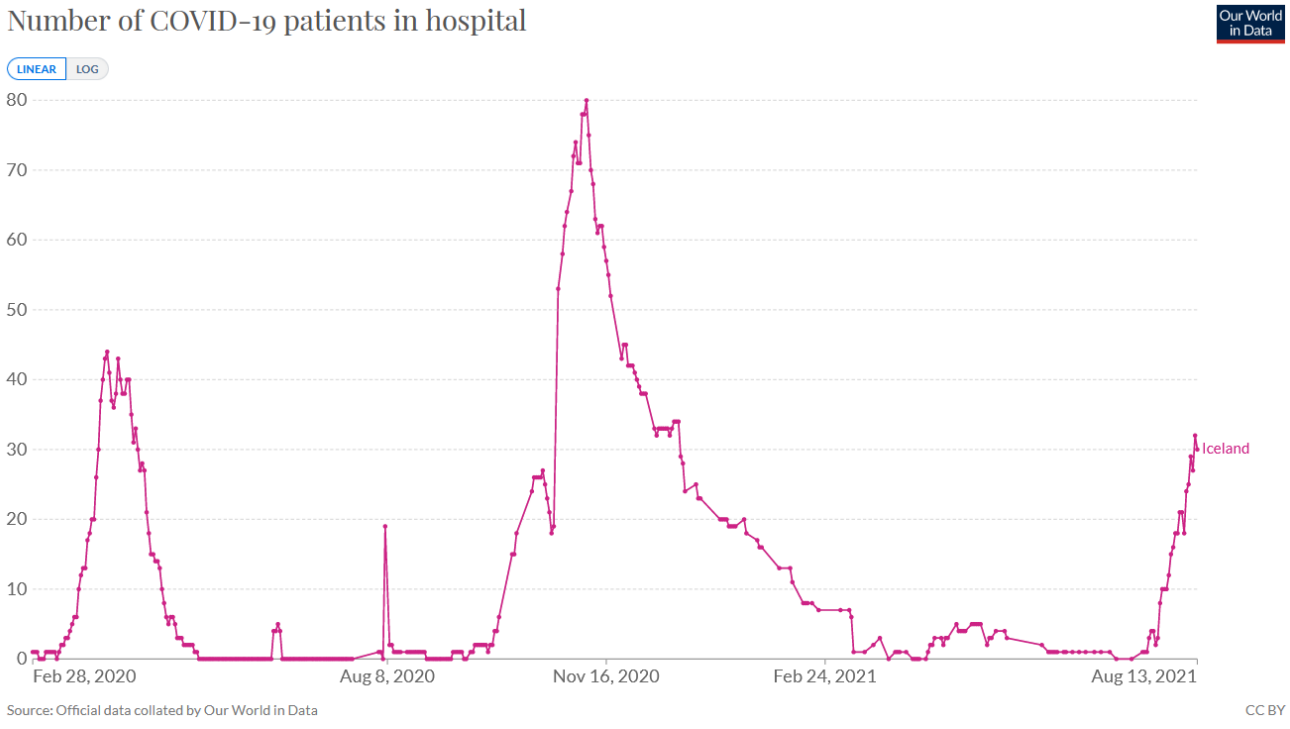
Vaccine-induced deaths to be blamed on new "covid-variant"

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.

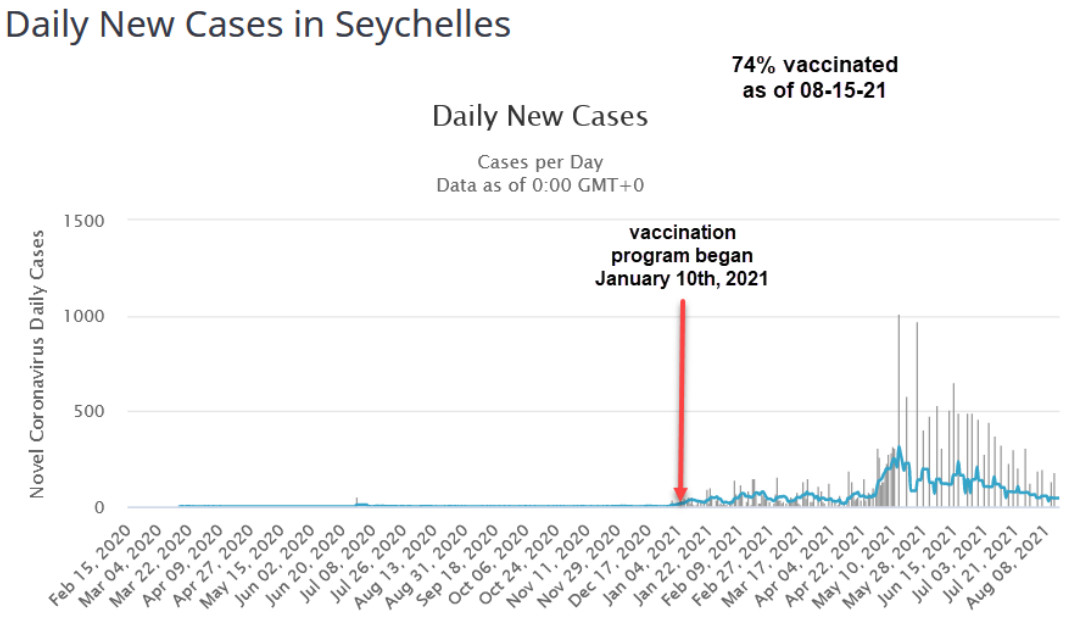




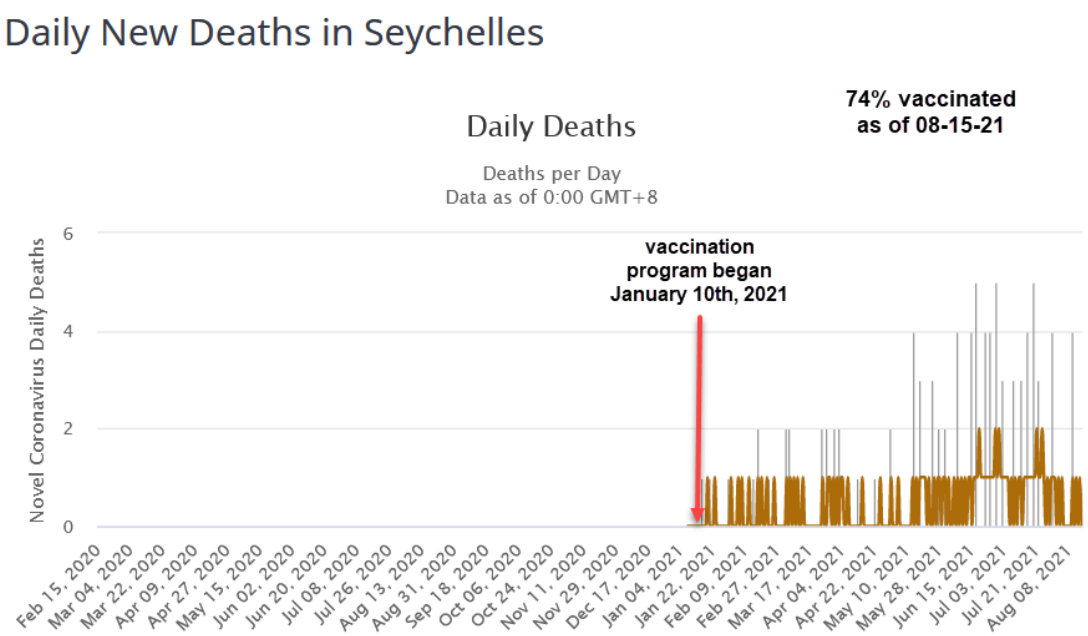
Seychelles

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.

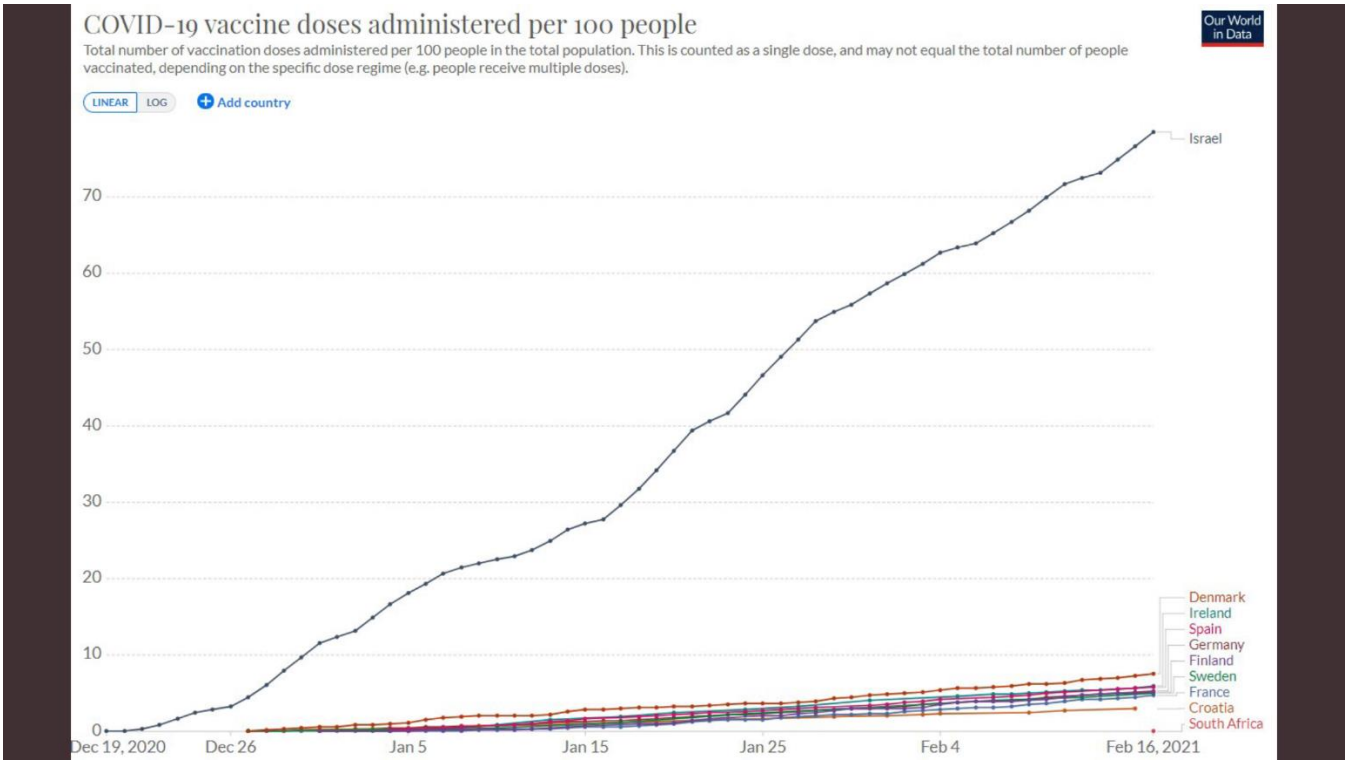
The United Kingdom

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

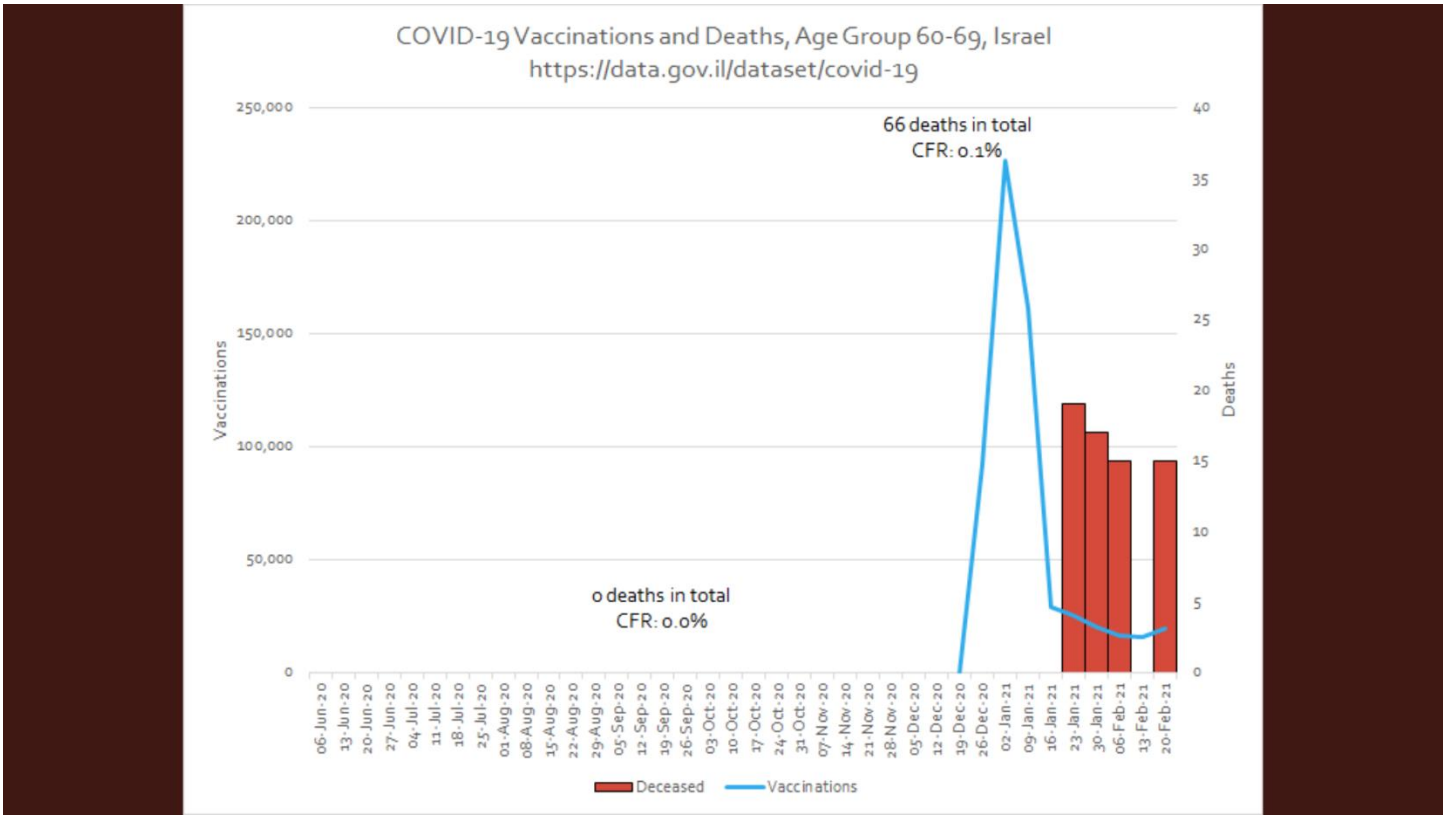
Let's look first at what happened in Israel after the rollout of their mass vaccination program.

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!

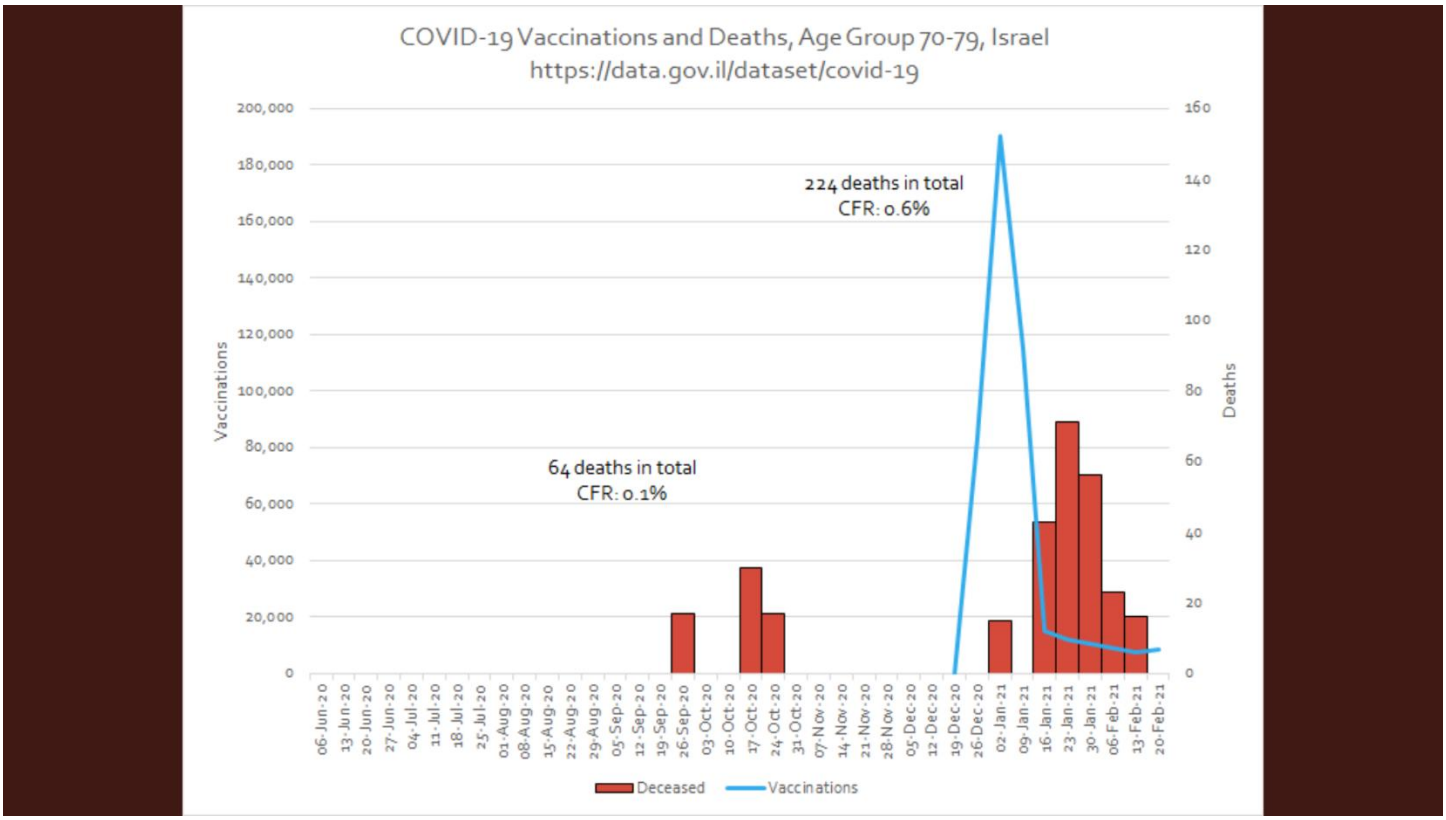


See the next page…

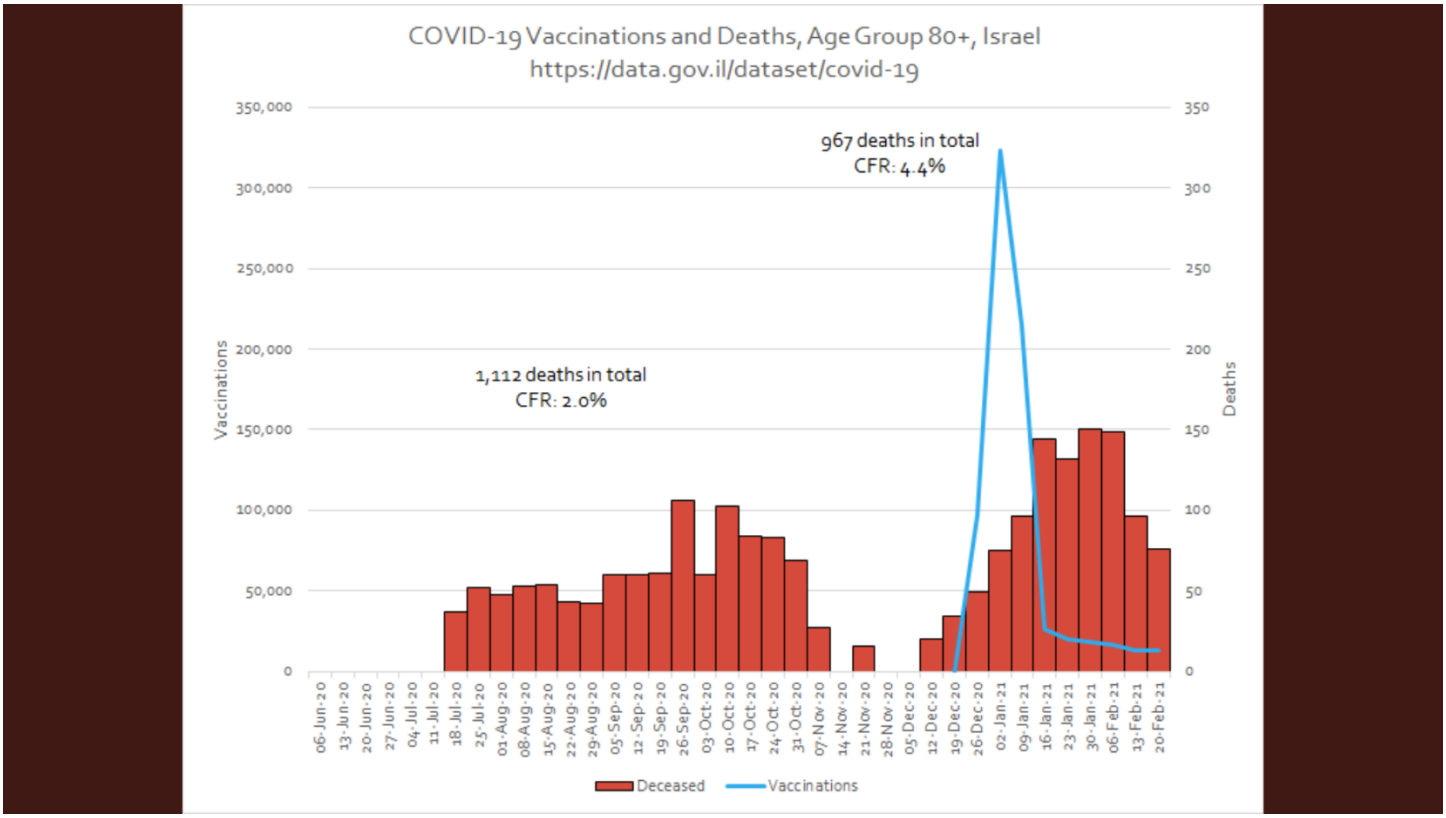
Deaths in the 60- to 69-year-old age group- Vaccination campaign is the blue line



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.

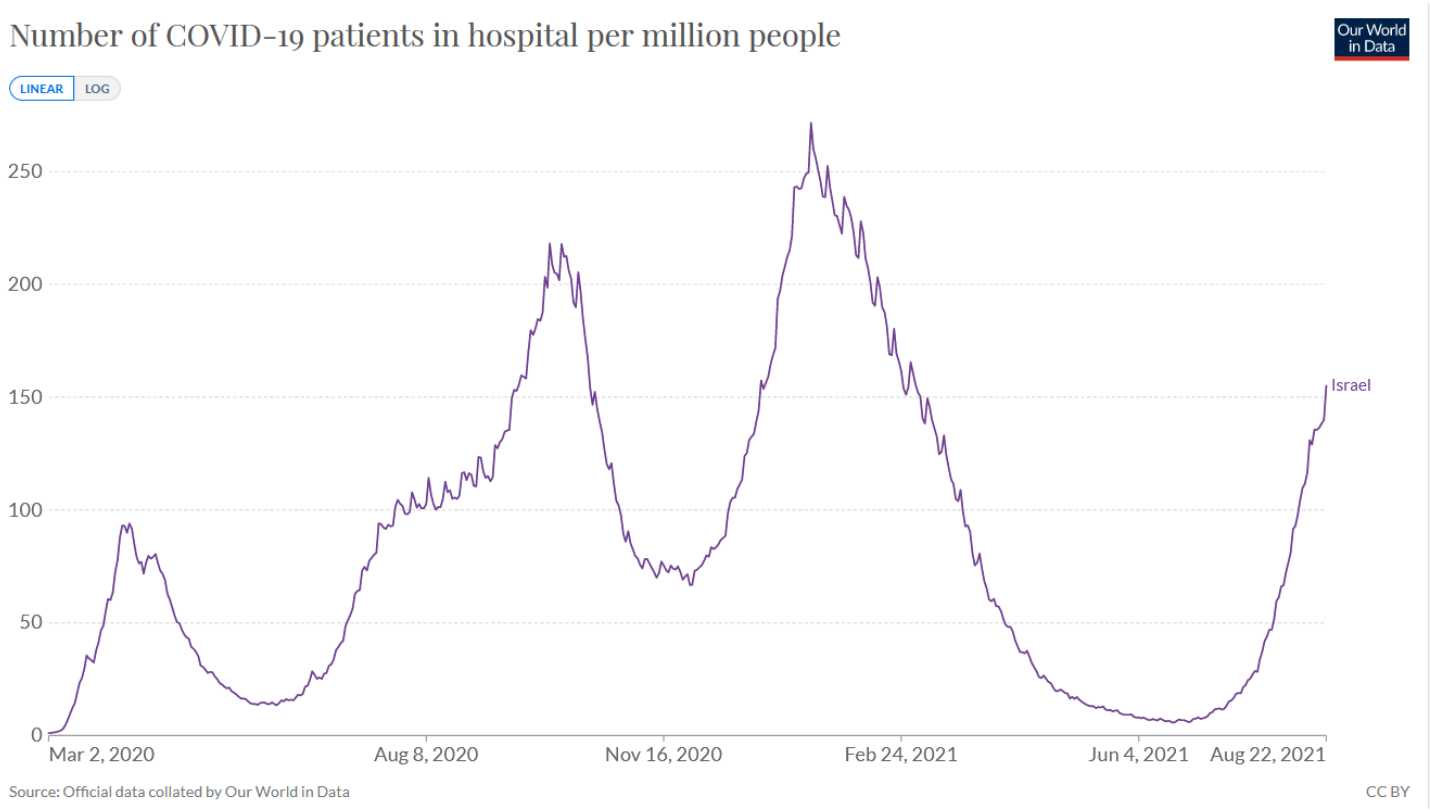
A full course of the Pfizer-BioNTech vaccine was just 39% effective at preventing infections and 41% effective at preventing symptomatic infections caused by the Delta Covid-19 variant, according to Israel's health ministry, **down from early estimates of 64% two weeks ago.** (Emphasis mine)

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

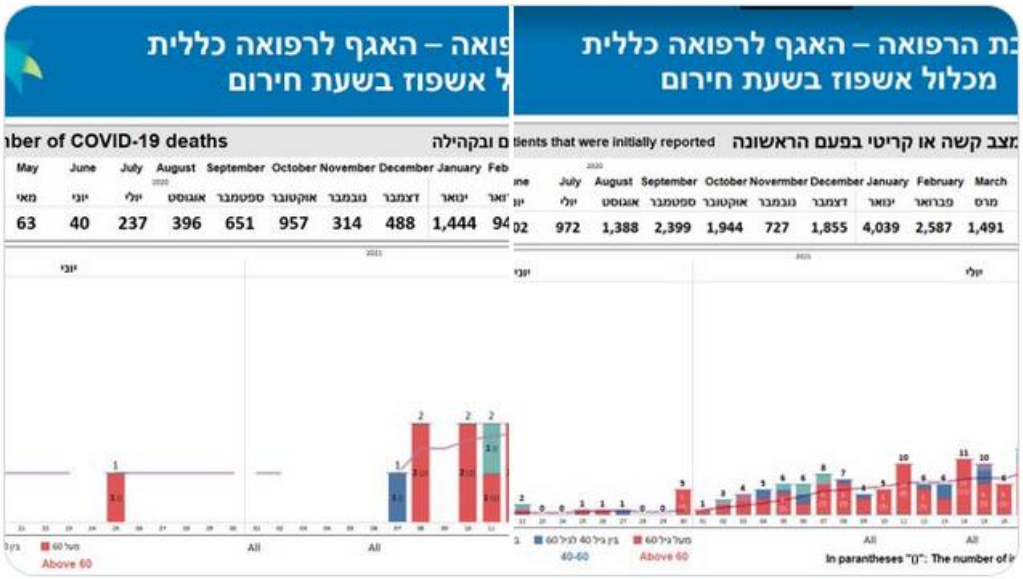
Health Ministry Data- (sorry it's in Hebrew). https://www.gov.il/BlobFolder/reports/vaccine-efficacy-safety-follow-up-committee/he/files_publications_corona_two-dose-vaccination-data.pdf



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.

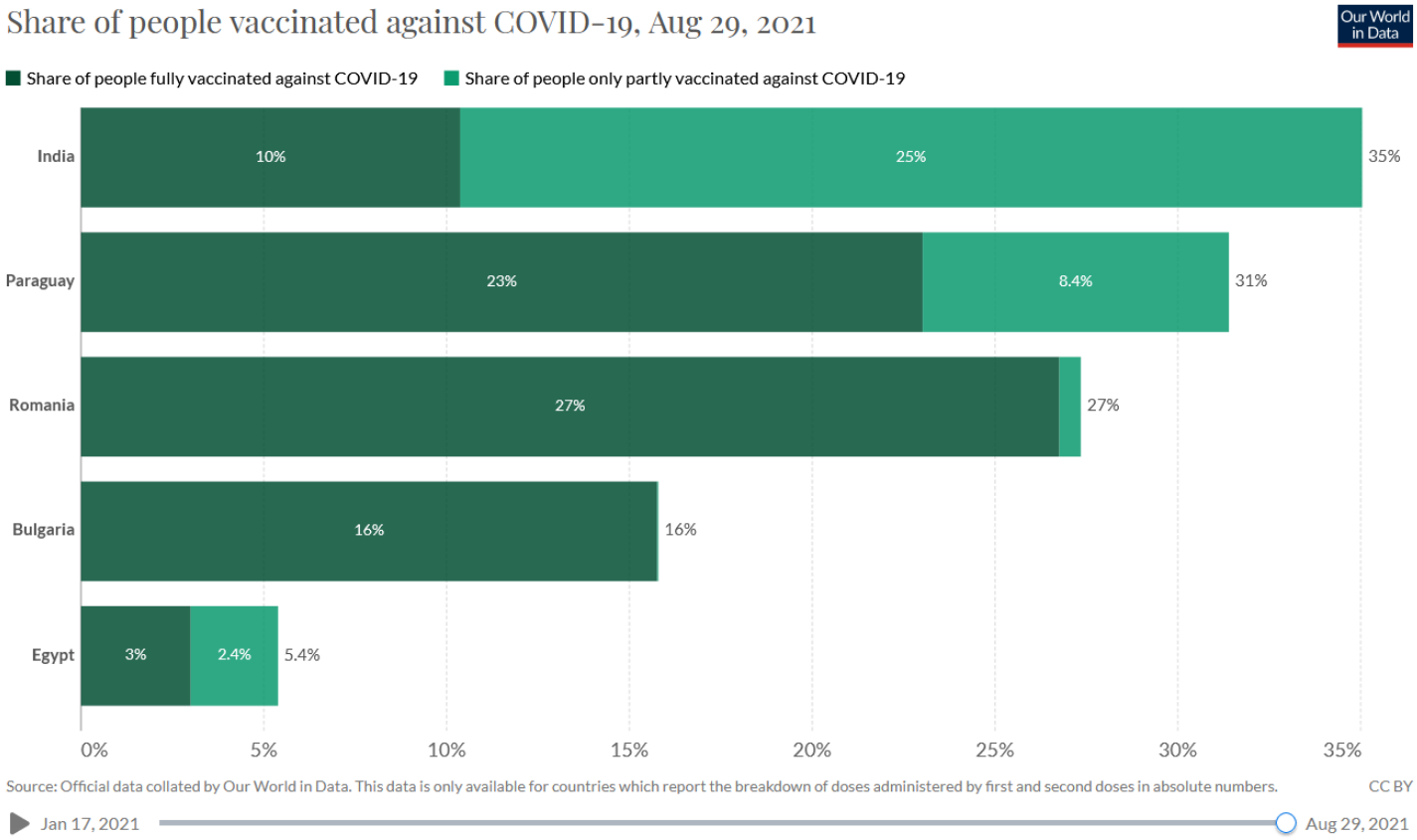
Fast forward two months later: Israel reported 9,831 new diagnosed cases on Tuesday, a hairbreadth away from the worst daily figure ever recorded in the country—10,000—at the peak of the third wave. More than 350 people have died of the disease in the first three weeks of August. In a Sunday press conference, 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.



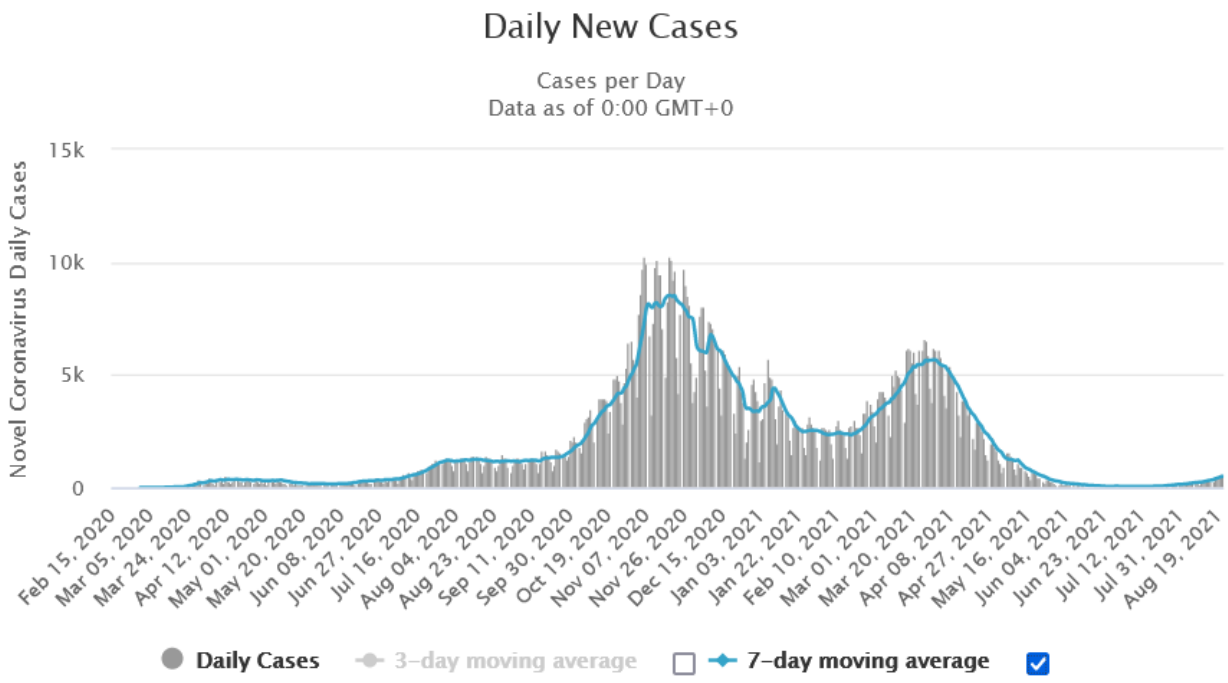
So, let's look at these five countries starting with the one that has the most fully vaccinated people at 27% and finishing with the one that is the least fully vaccinated at 3%.

Continued next page…

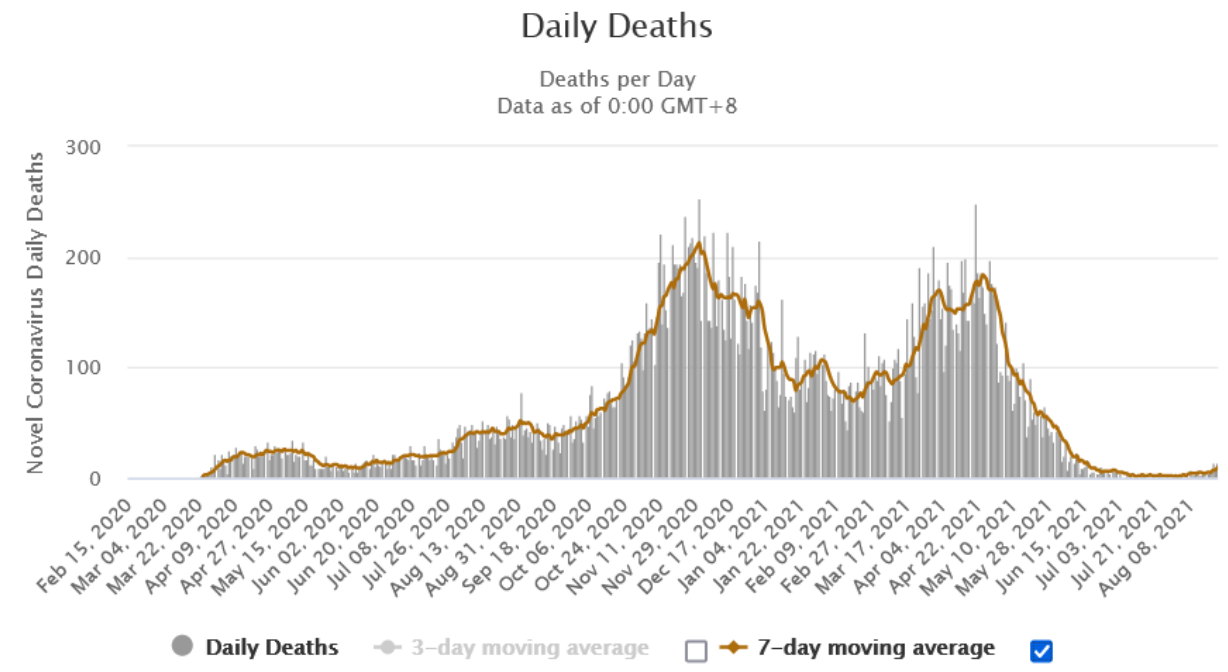
Romania

As of August 29th, just 27% of the population is fully vaccinated.

Daily New Cases in Romania



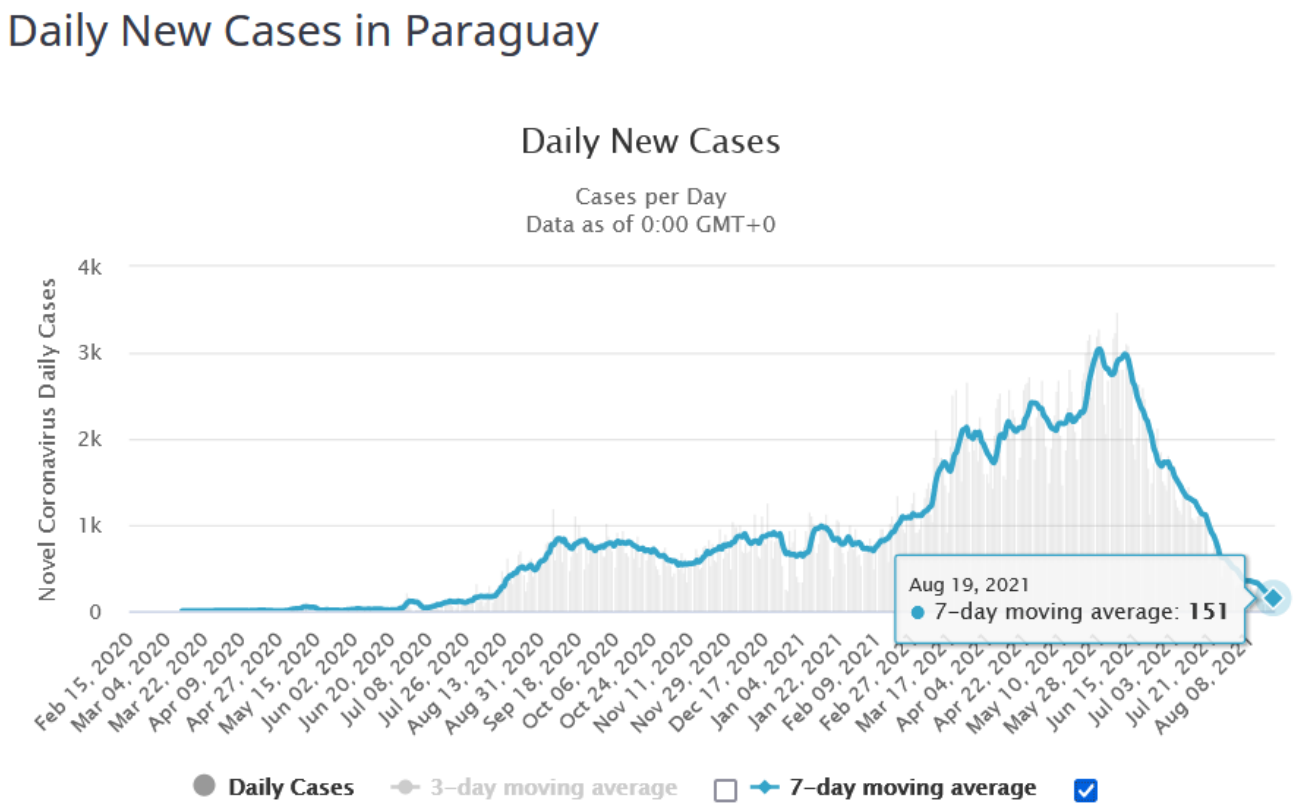
Daily New Deaths in Romania



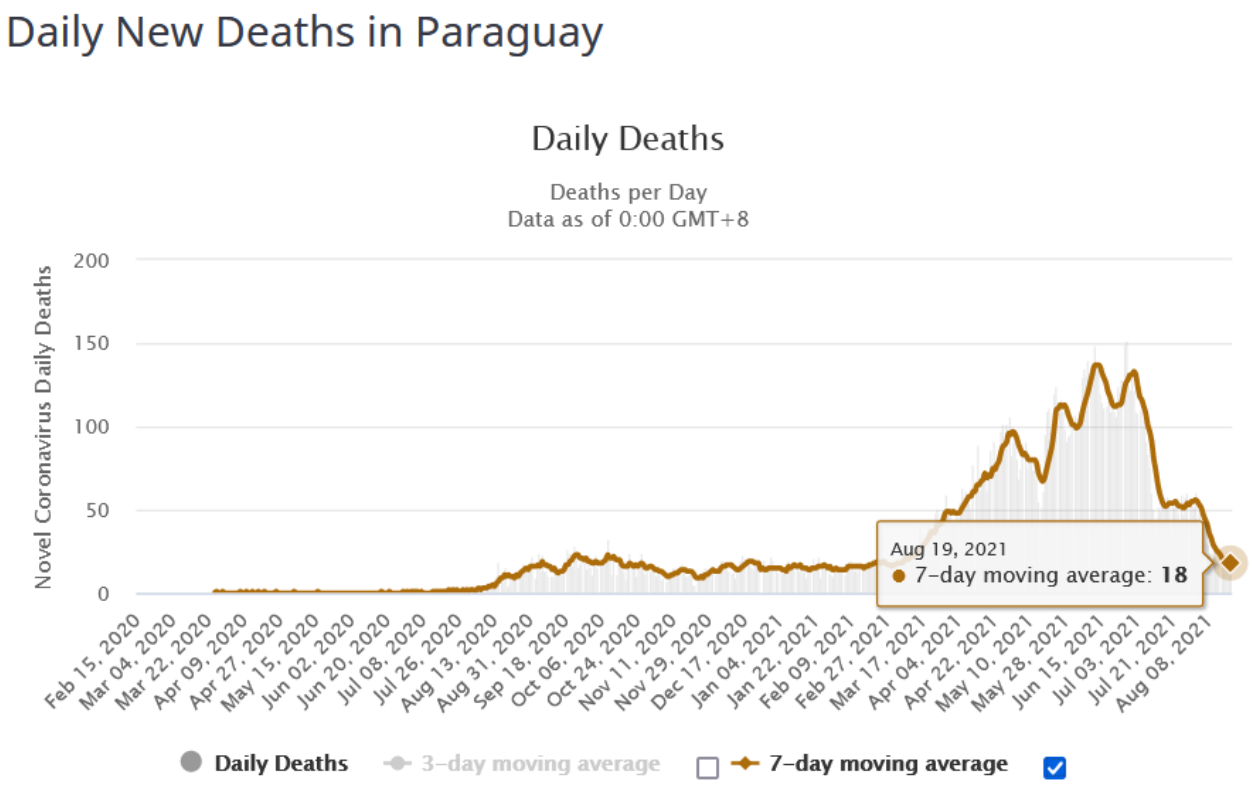
All with only one fourth of the population fully vaccinated they are doing just fine. This could be a case of decrease due to seasonality, or are they possibly nearing natural herd immunity?

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



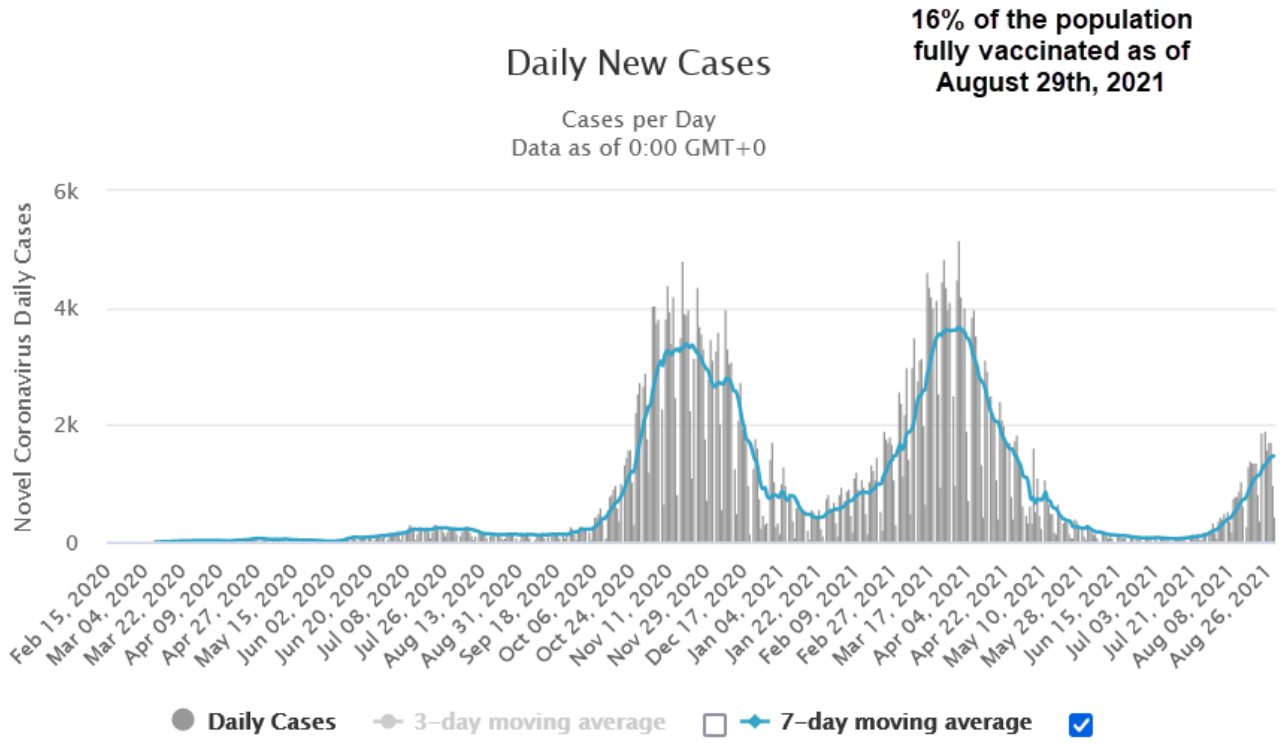
While you can see that Paraguay had a rise in cases and deaths just like so many countries around the world despite vaccination rates, the rates of both have dropped precipitously. This is what happens with viral outbreaks. They have rises and falls based on many factors including seasonality, percentage 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.

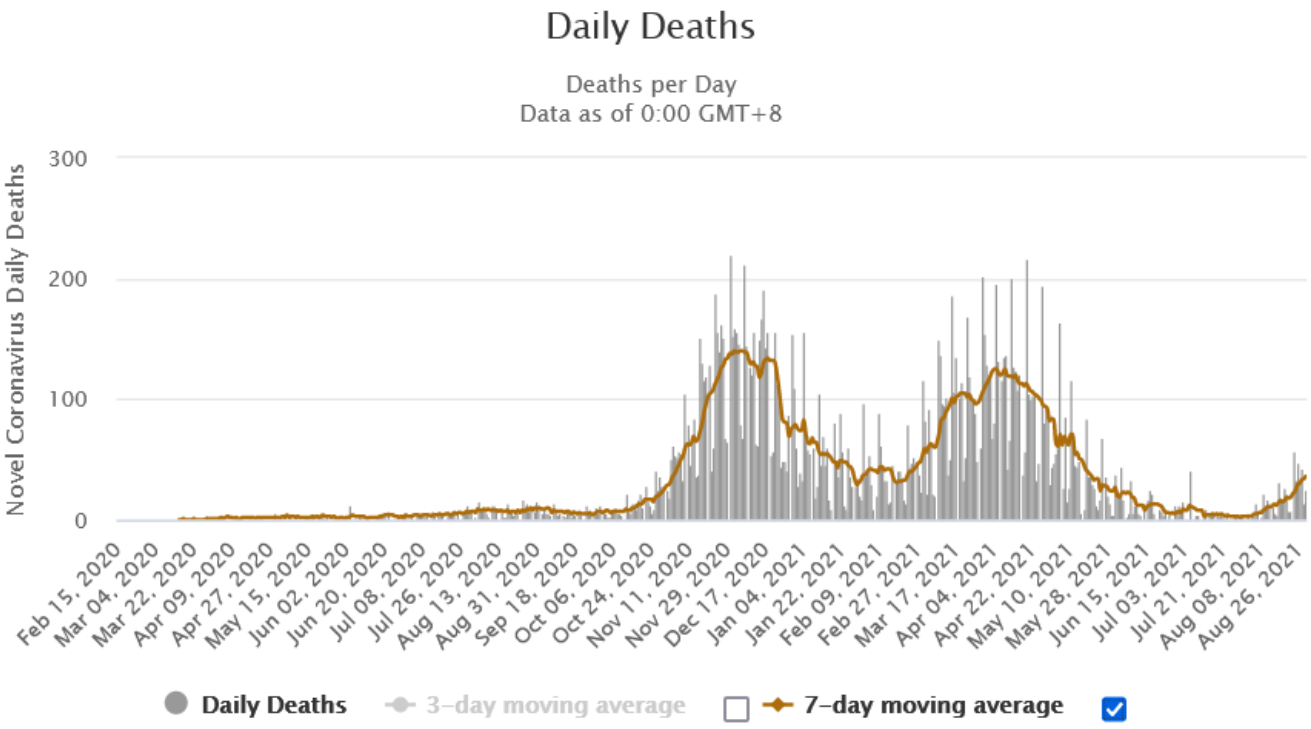
Bulgaria

Just 16% of the population Was fully vaccinated as of August 29th.

Daily New Cases in Bulgaria



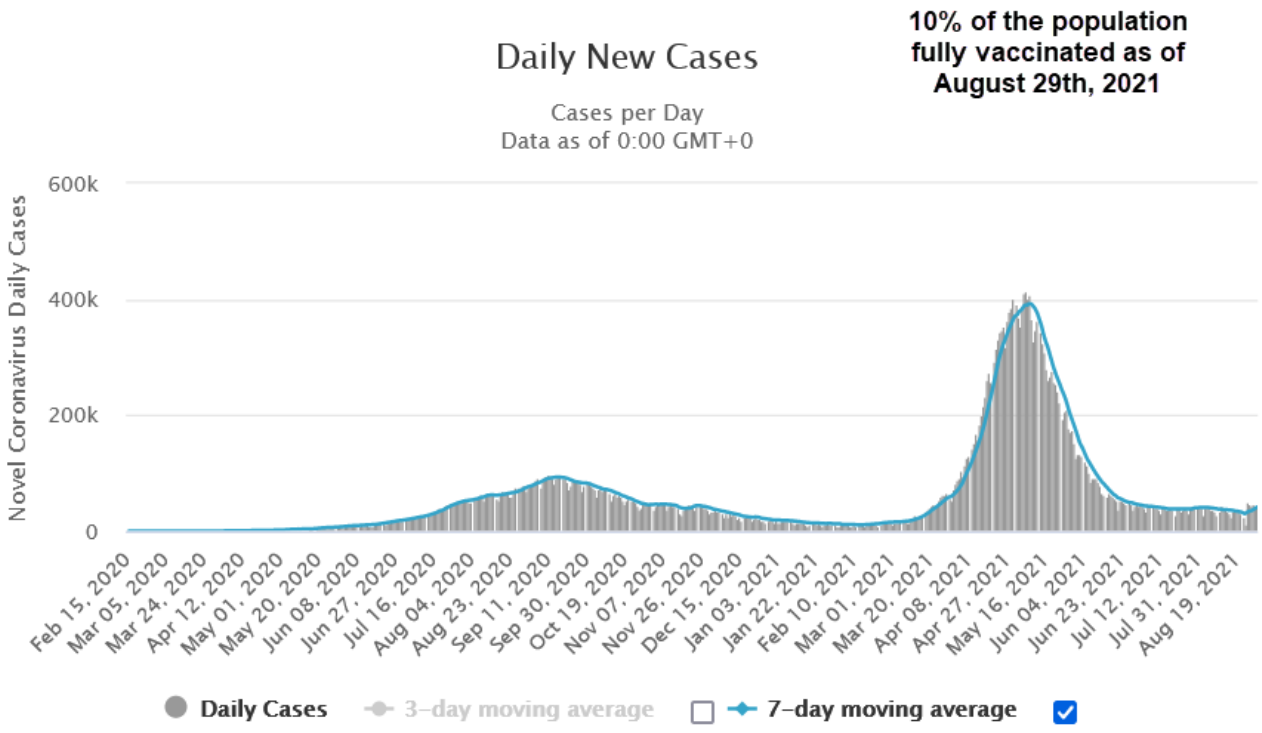
Daily New Deaths in Bulgaria



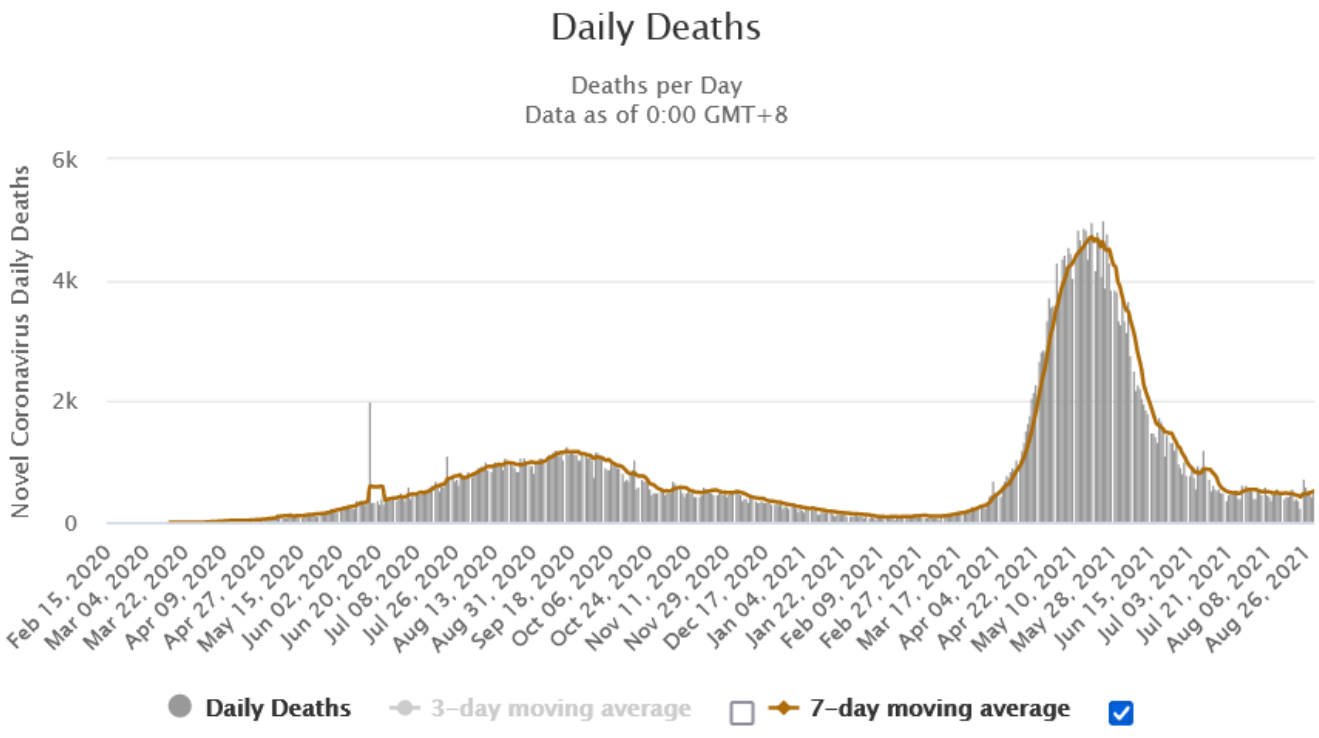
India

Just 10% of the 1.35 billion people in India have been fully vaccinated. So, how are they doing?

Daily New Cases in India



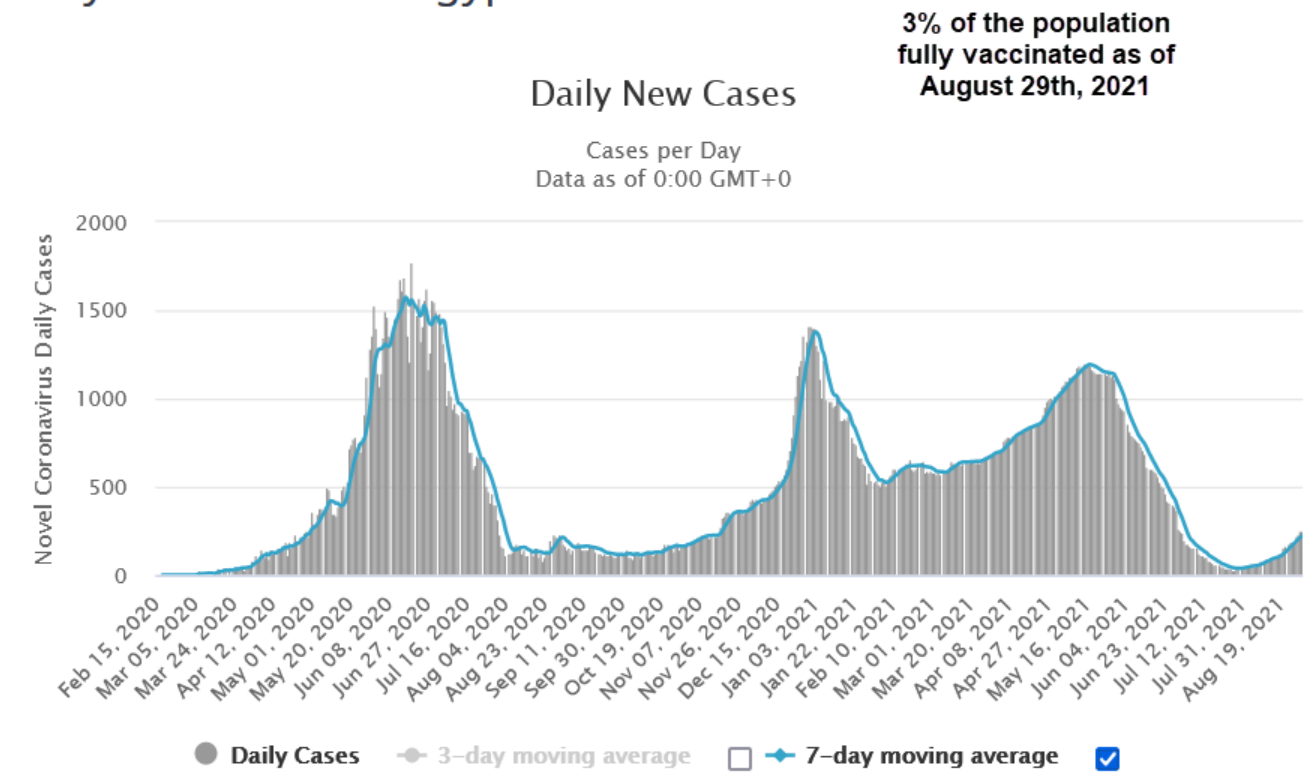
Daily New Deaths in India



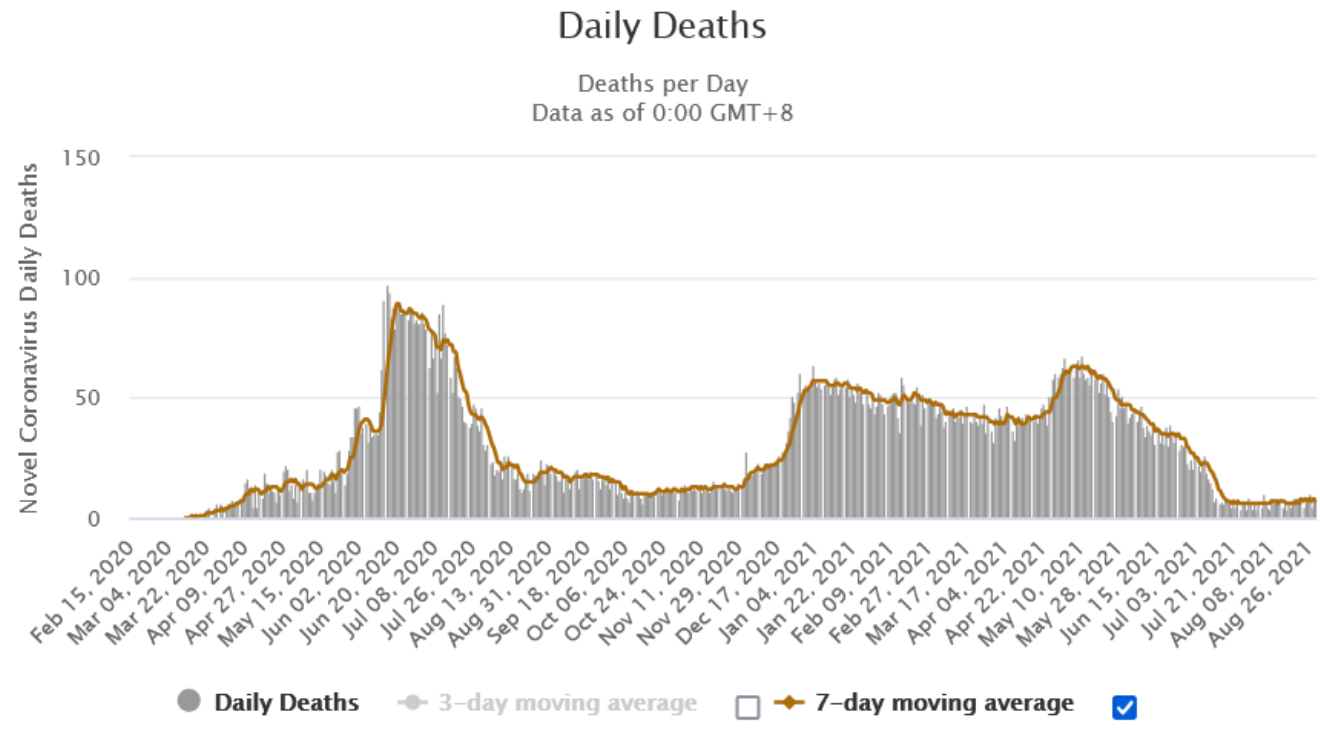
Egypt

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

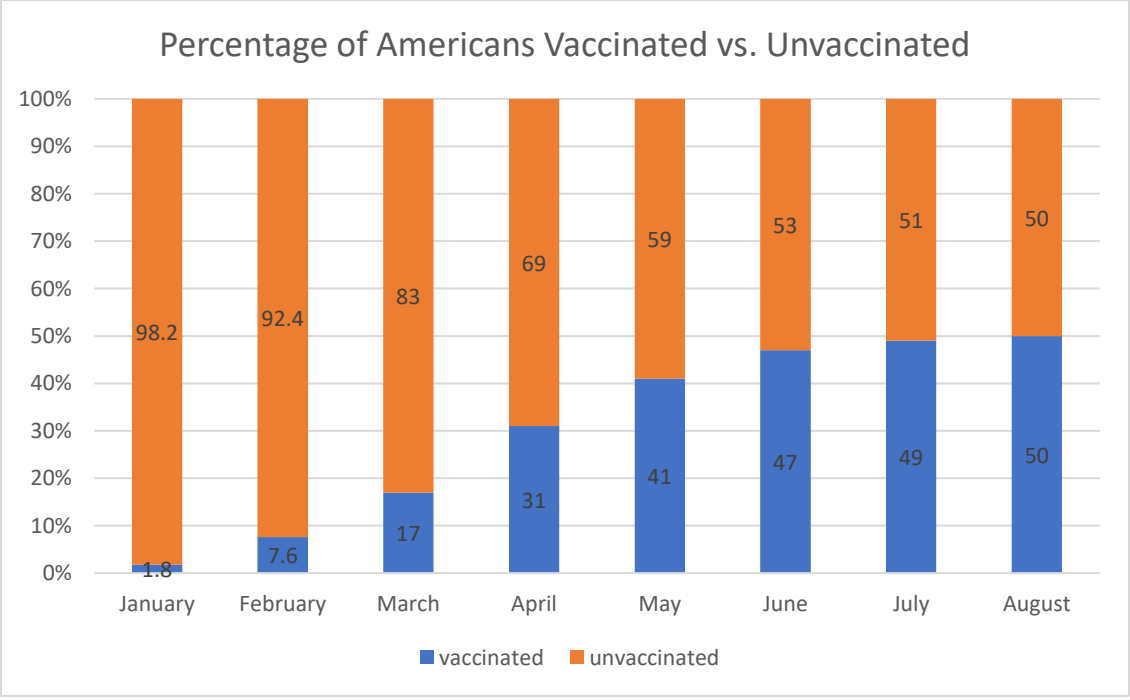
We have all heard reports over the last few months, that the majority of cases are people who are unvaccinated. What is the truth? Last month I covered the statistics coming from Israel and the U.K. showing that the numbers of cases, hospitalizations and deaths have been steadily increasing in the fully 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."

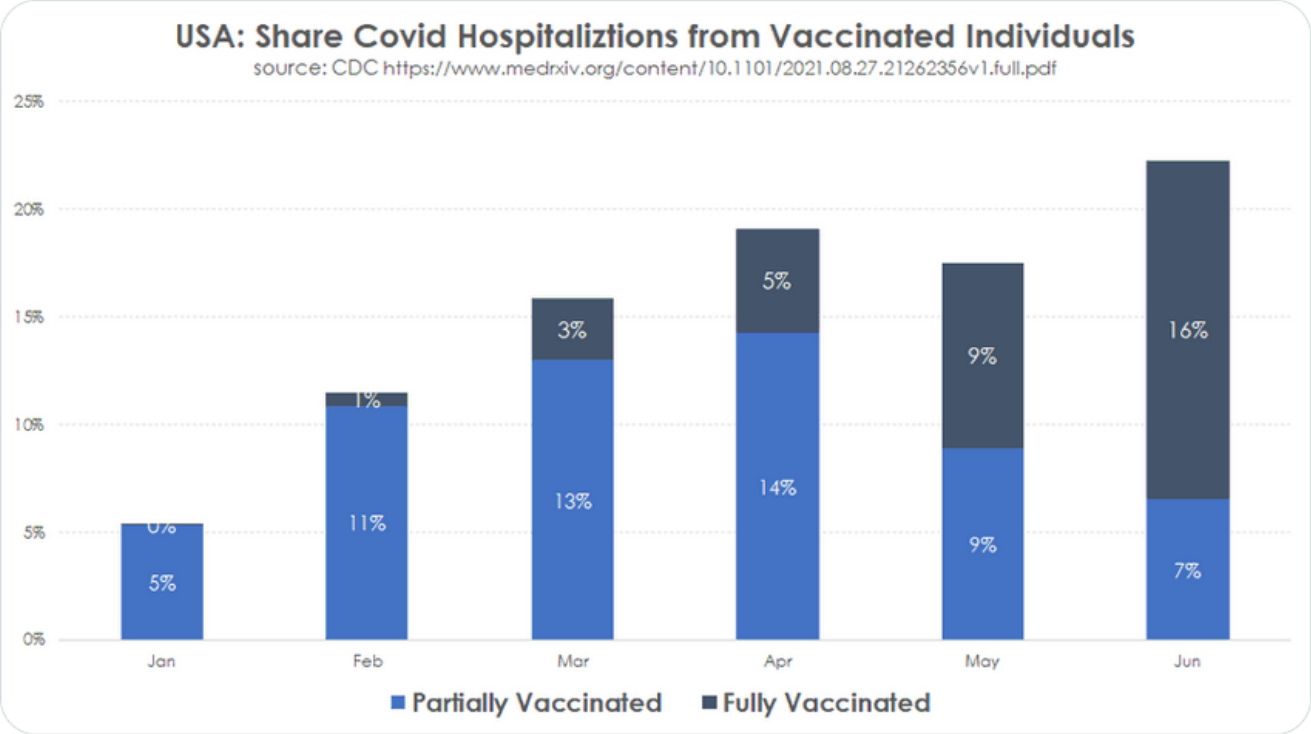
https://www.cdc.gov/vaccines/covid-19/health-departments/breakthrough-cases.html

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**.

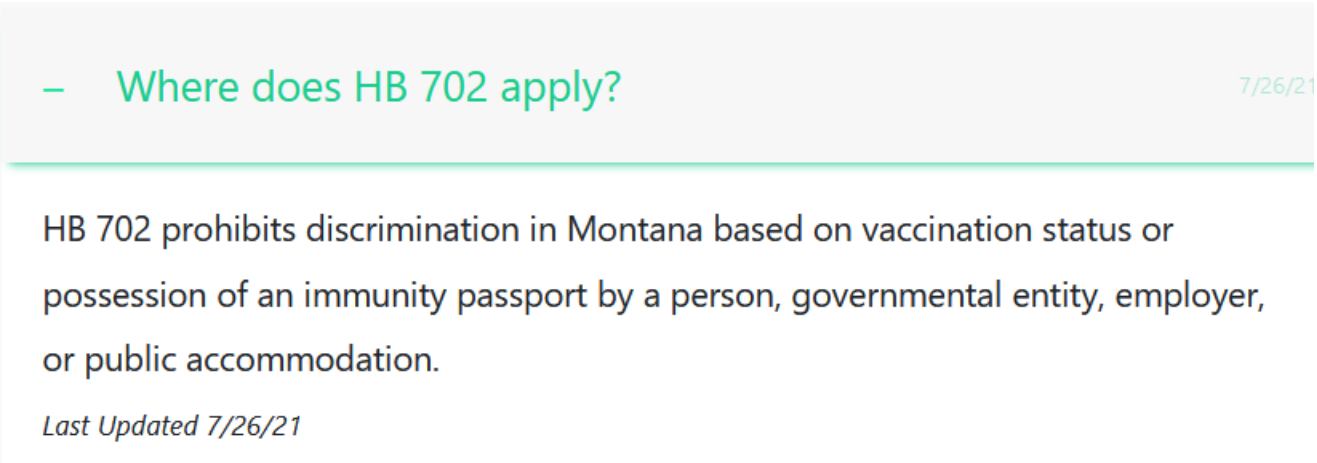
Medical Freedom should be non-negotiable

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

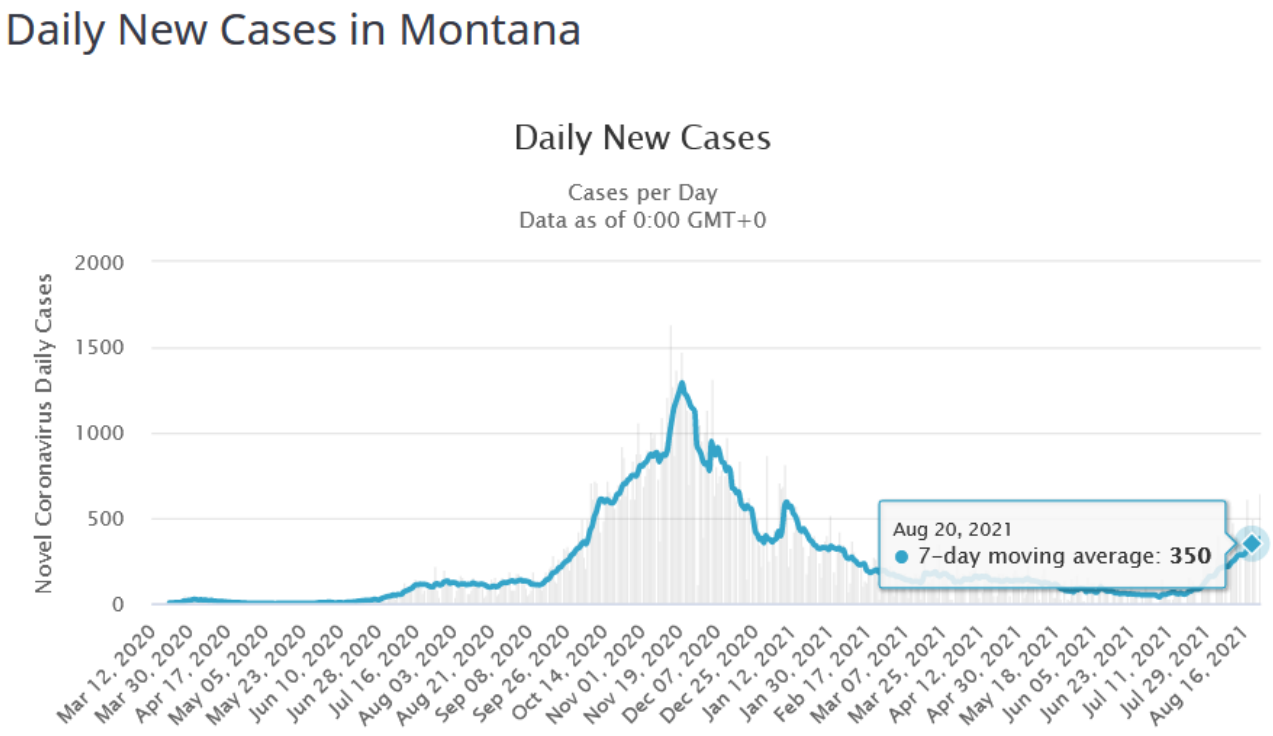
While many large companies across the U.S. have announced that COVID-19 vaccines will be required for their employees to return to work in-person, there is one state where such requirements are banned: Montana. Under a new law passed by the state's Republican-controlled Legislature earlier this year, 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

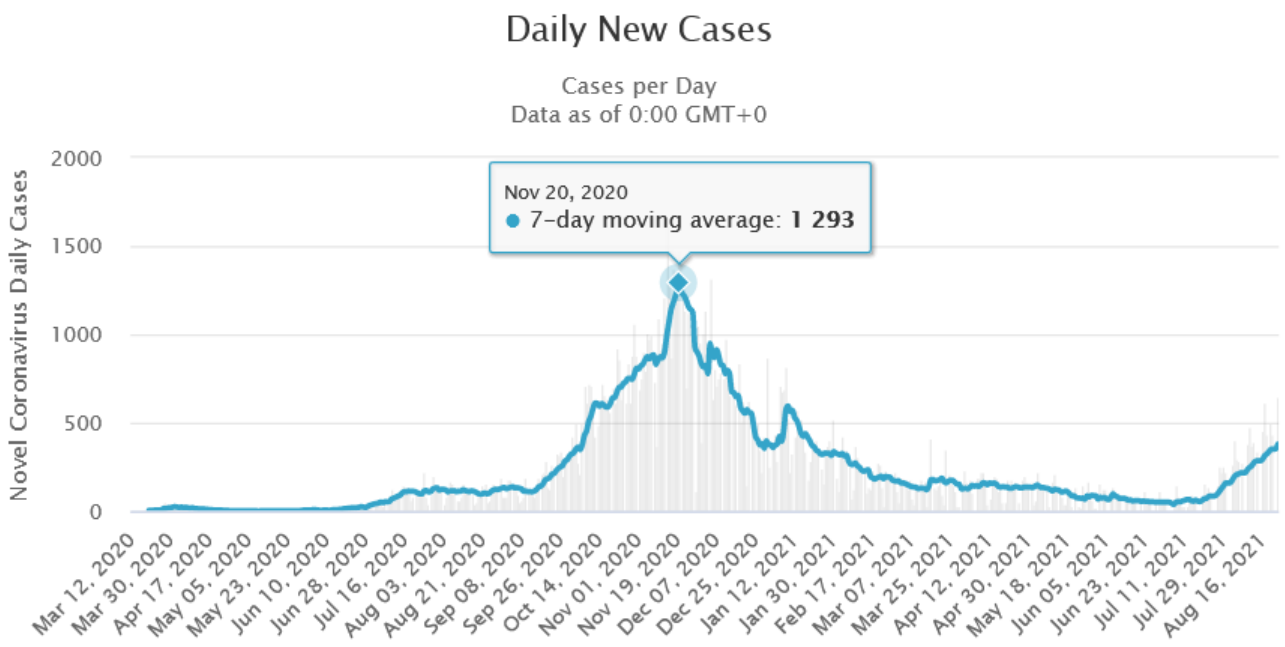
WAIT! Hold the press. Let's look at just how strained the state's health care system really was at the time that this comment was made.

Because I deal in raw data and facts, nor hyperbole and fearmongering let's take a look.



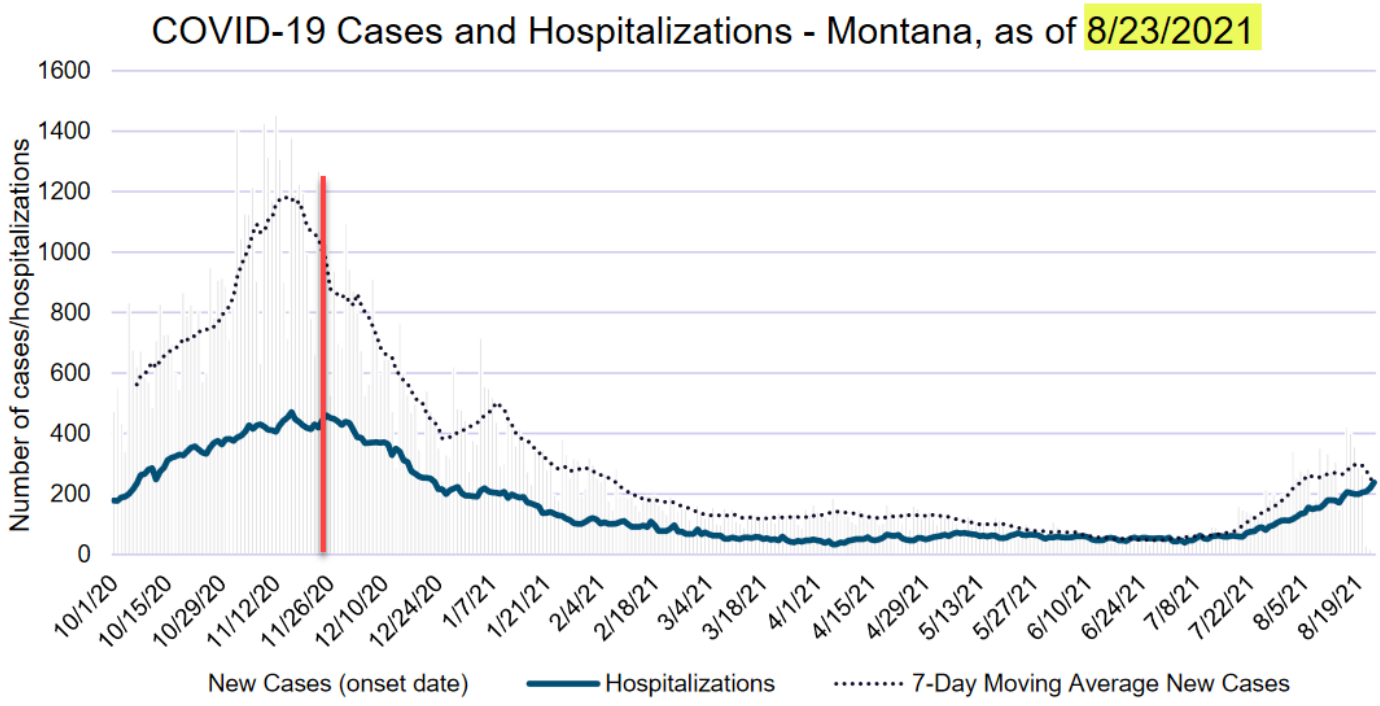
https://www.worldometers.info/coronavirus/usa/montana/

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

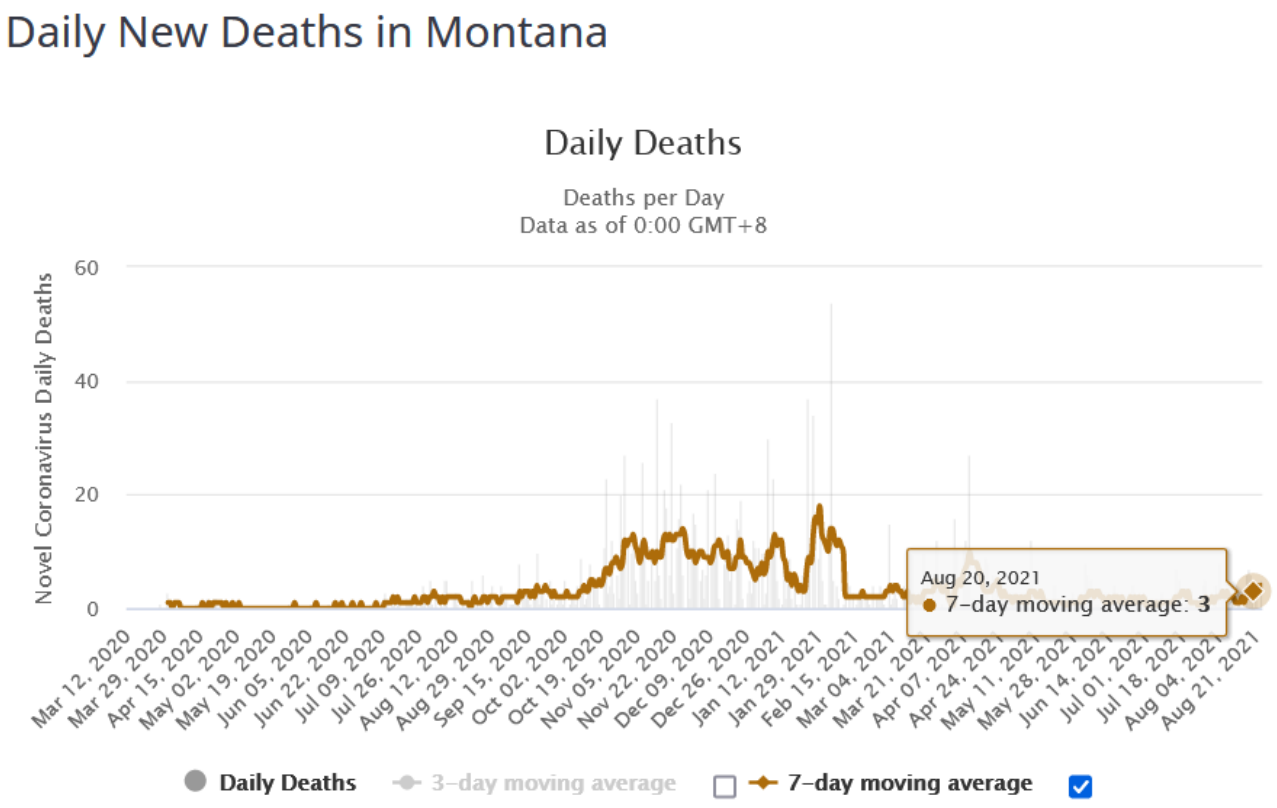
The red line represents November 20th, 2020, when the number of PCR positives reached its peak.

Notice from the table below, that only 5% of cases ever needed to go to the hospital.

Montana as of August 23rd, 2021

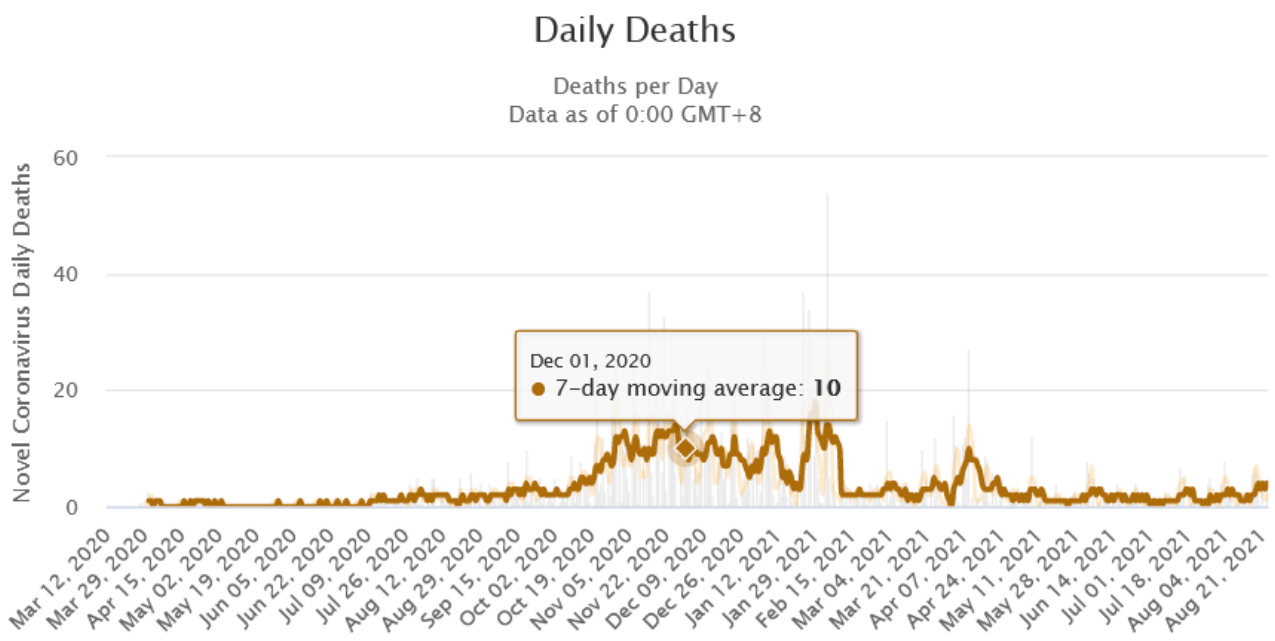
Hospitalization Status	Number of Cases (percent of total)
Ever hospitalized	6201 (5%)
Never hospitalized	117473 (95%)
Total	123674

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.

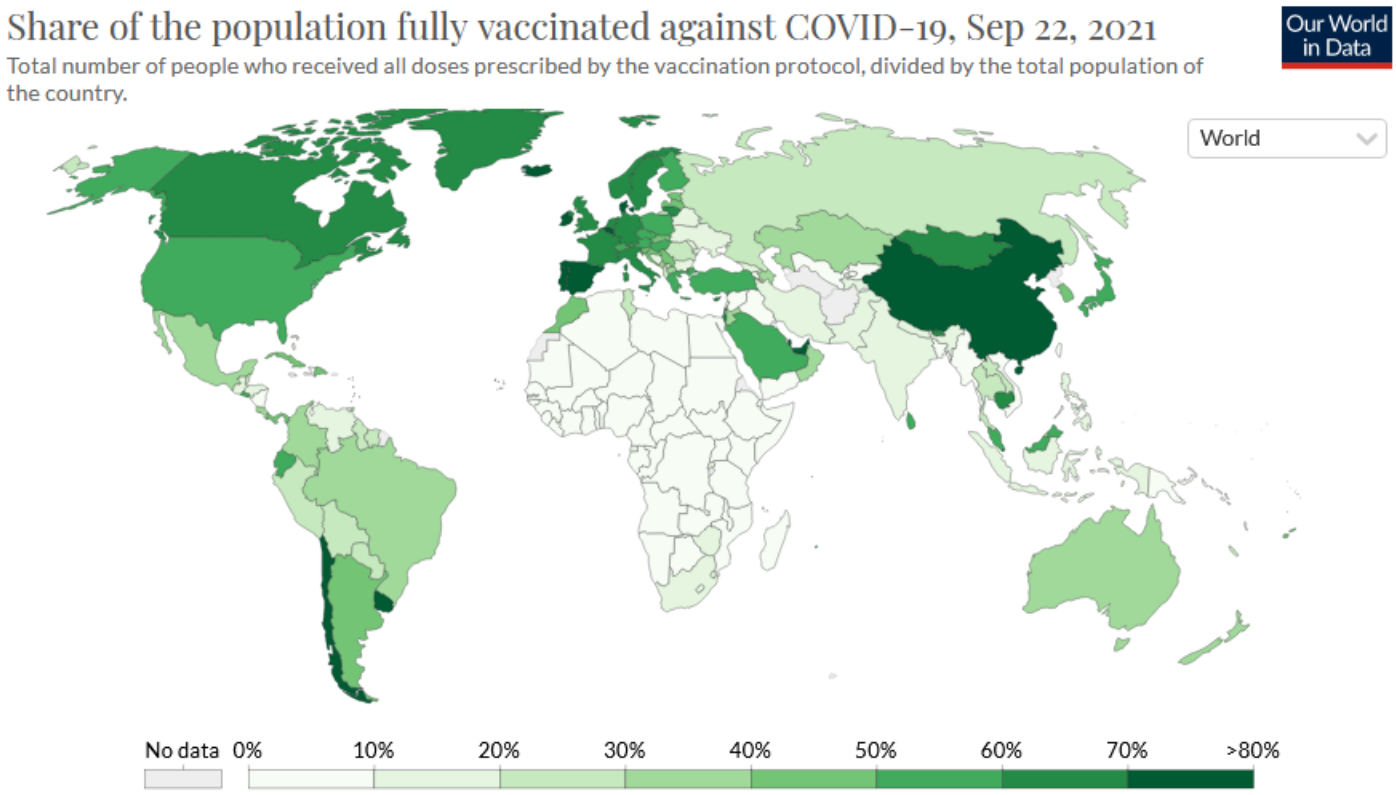
As of May 28, 2021, there have been 259,308 confirmed cases of SARS-CoV-2 infections in Canadians 19 years and under. Of these, 0.048% were hospitalized, but only 0.004% died, according to the CCCA statement. "Seasonal influenza is associated with more severe illness than COVID-19."

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
```

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.

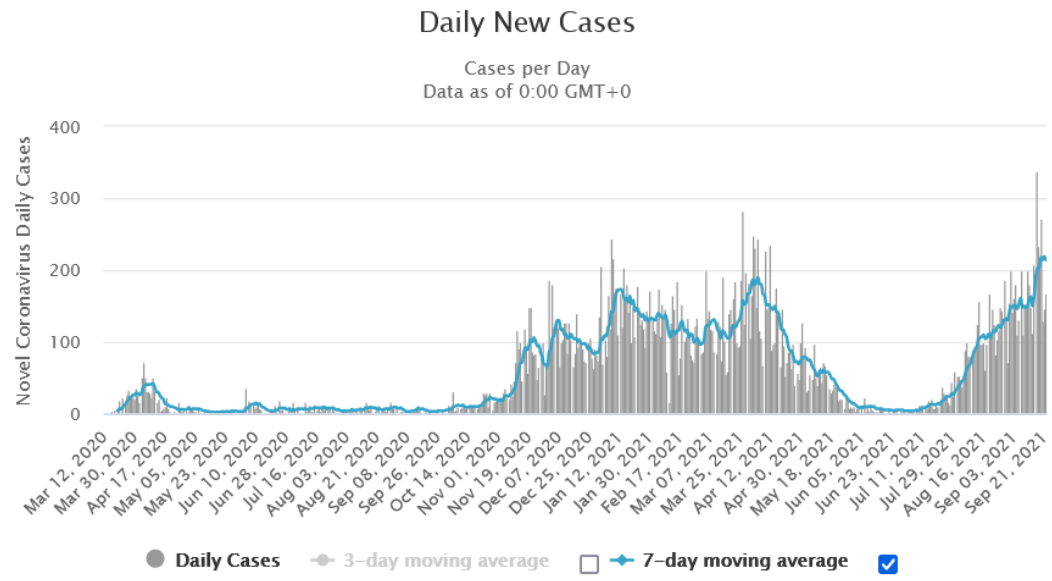
Unfortunately, it took the medical profession decades to learn this lesson with the indiscriminate use of antibiotics. And it's the reason we have not been able to keep up with bacterial mutations and the creation of these bacterial "super germ" variants. Now, well over 100,000 people a year die in the 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.

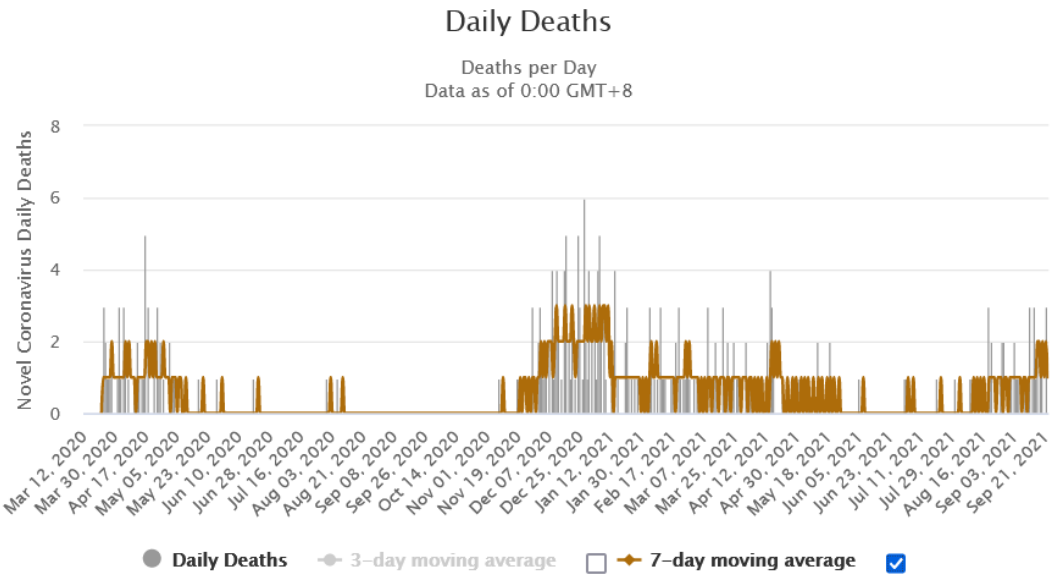
Vermont, the highest vaccinated state in the U.S. has skyrocketing cases, hospitalizations and deaths

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.

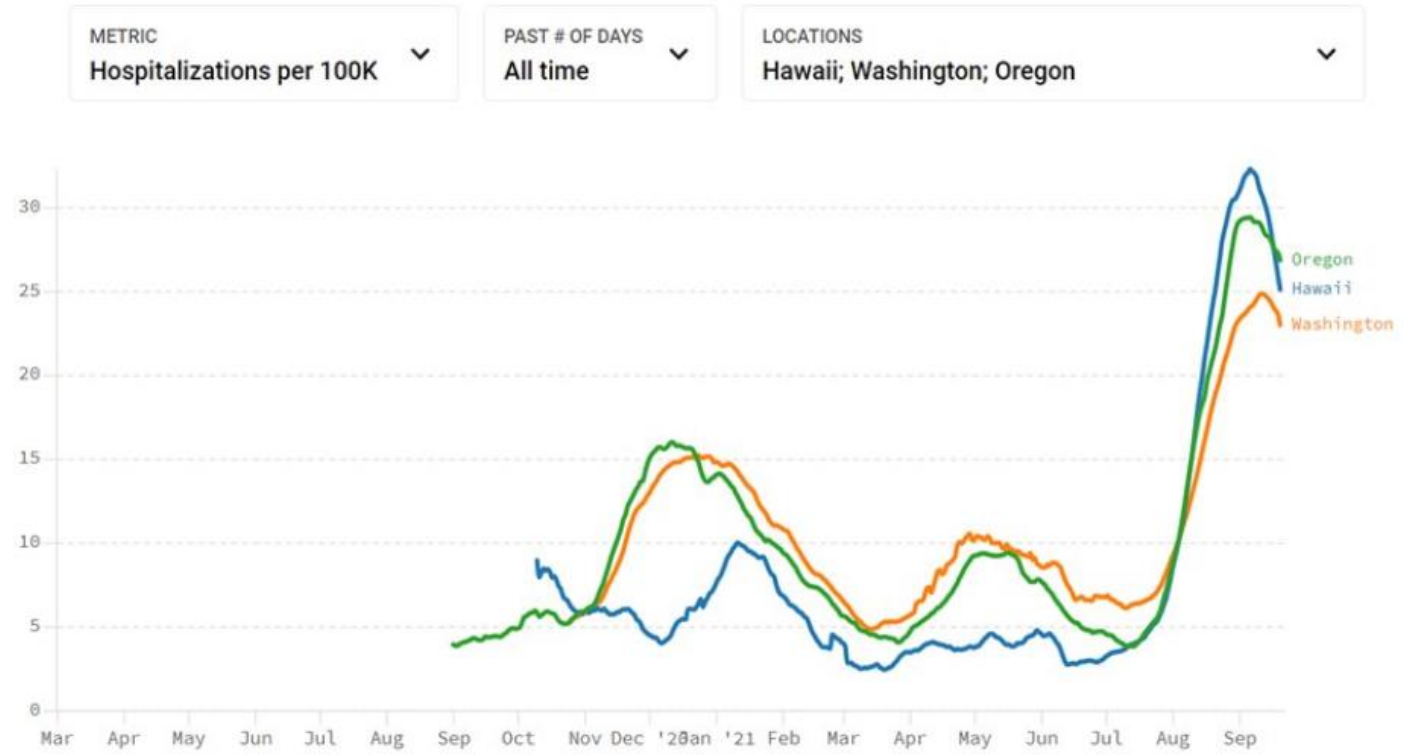
Daily New Cases in Vermont



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

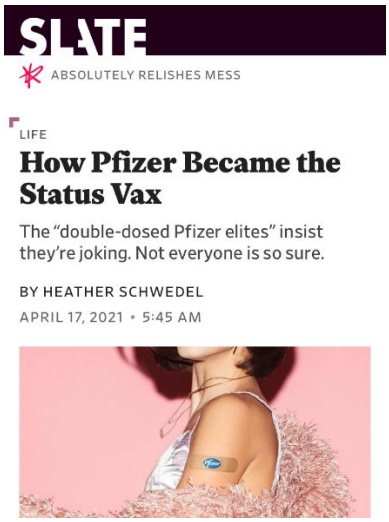
Let's go to the videotape!

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.

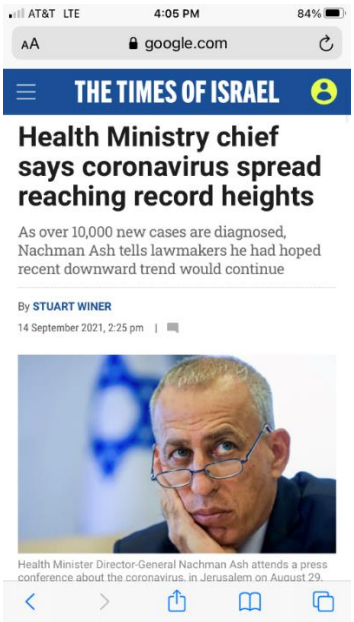
The next thing is you can eliminate, and you generally do that by having certain countries, usually with good vaccination programs, essentially eliminate the presence of a particular pathogen in society. We've done that with polio in the United States. We've done that with measles in the United States 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!

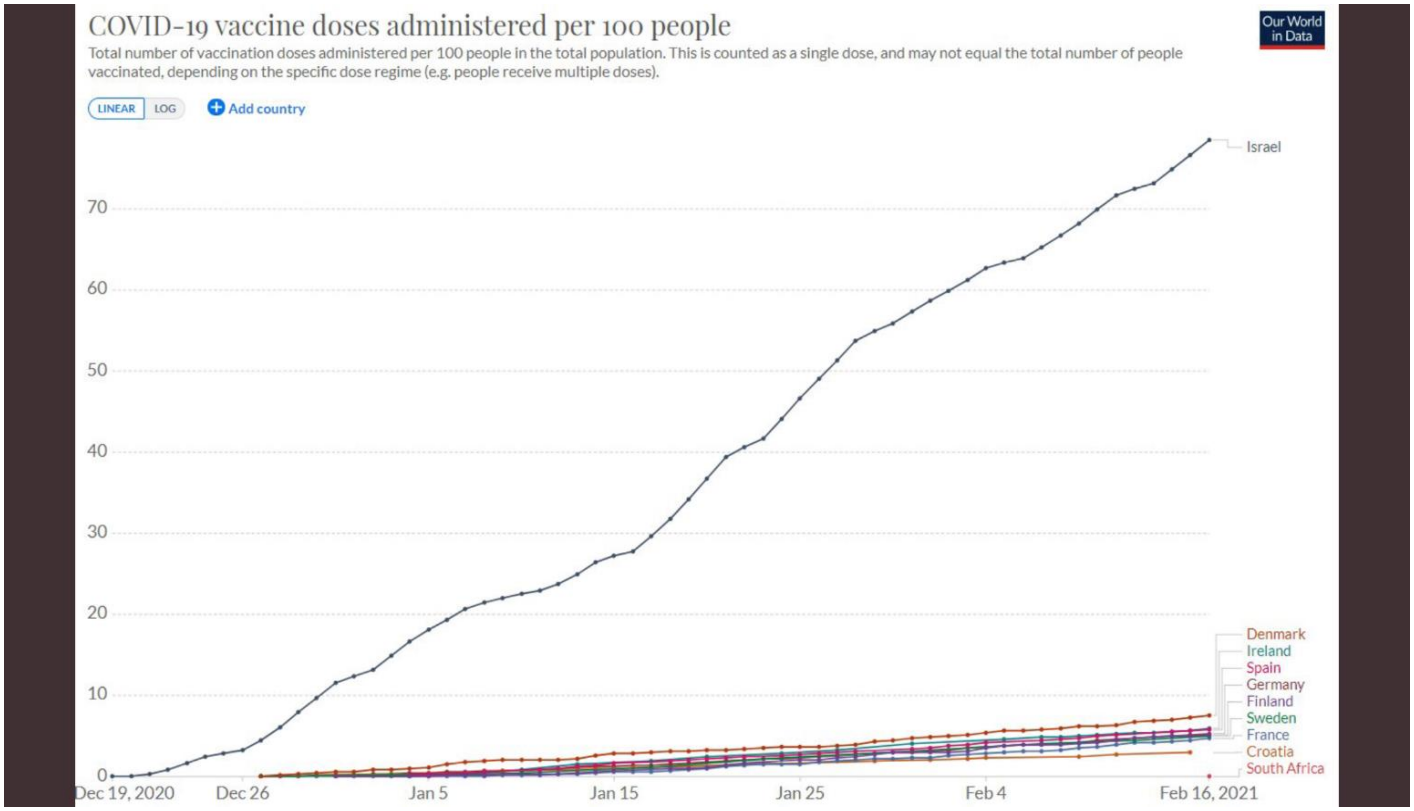
Anyway the Haftarah from Isaiah is what really matters.

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.

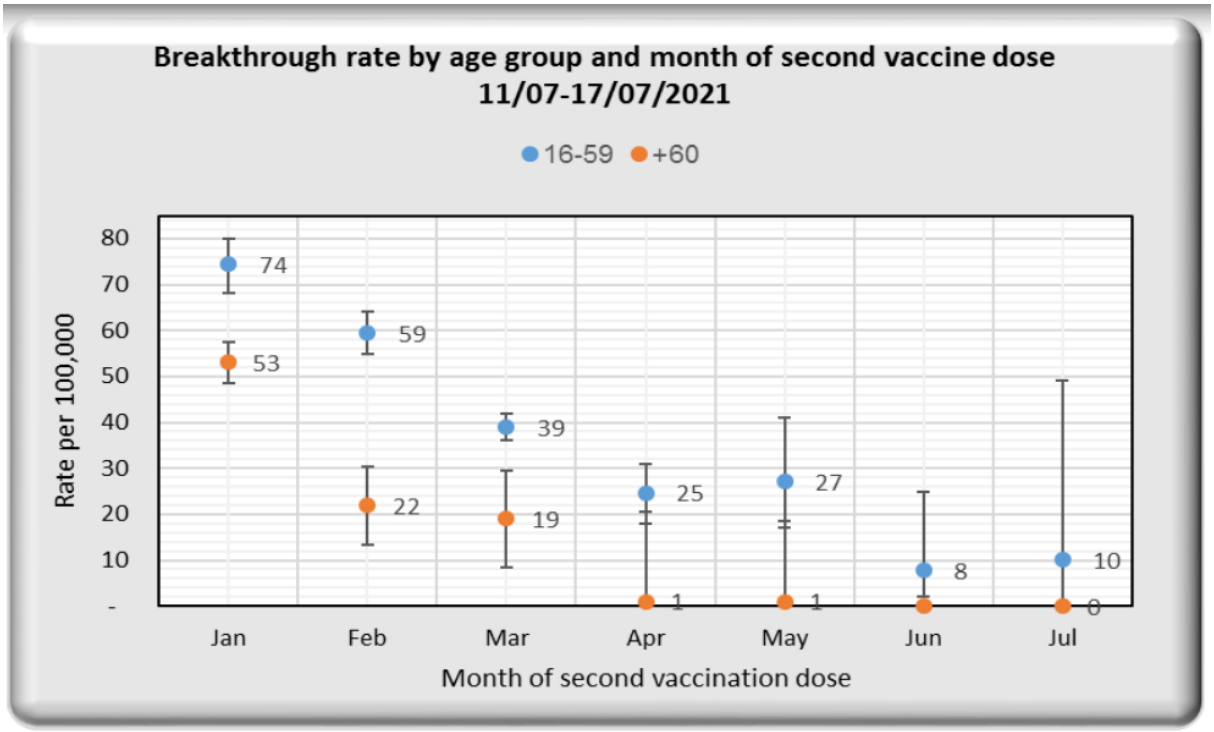
Hopefully that approach will be the one that I and thousands of other physicians and scientists have been advocating for nearly a year and a half now. And that is **EARLY** treatment with the widely available, non-patented, inexpensive, and safe medications like Hydroxychloroquine with Zinc, Ivermectin 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)

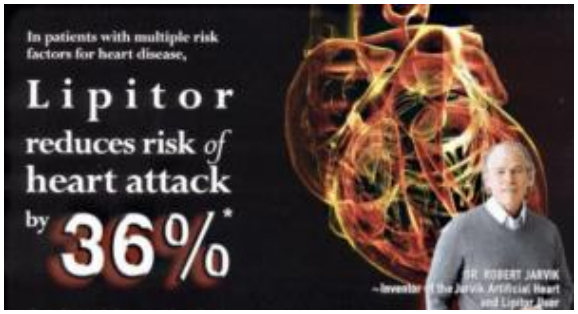
https://www.gov.il/BlobFolder/reports/vaccine-efficacy-safety-follow-up-committee/he/files_publications_corona_two-dose-vaccination-data.pdf

***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.

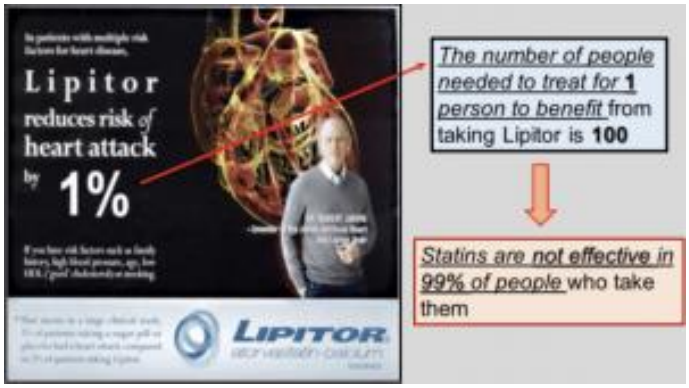
A much more important calculation would be the number of people needing to get the vaccine or treatment, also called the NNT or Number Needed to Treat in order to protect one person. Let's take a look at that.

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.

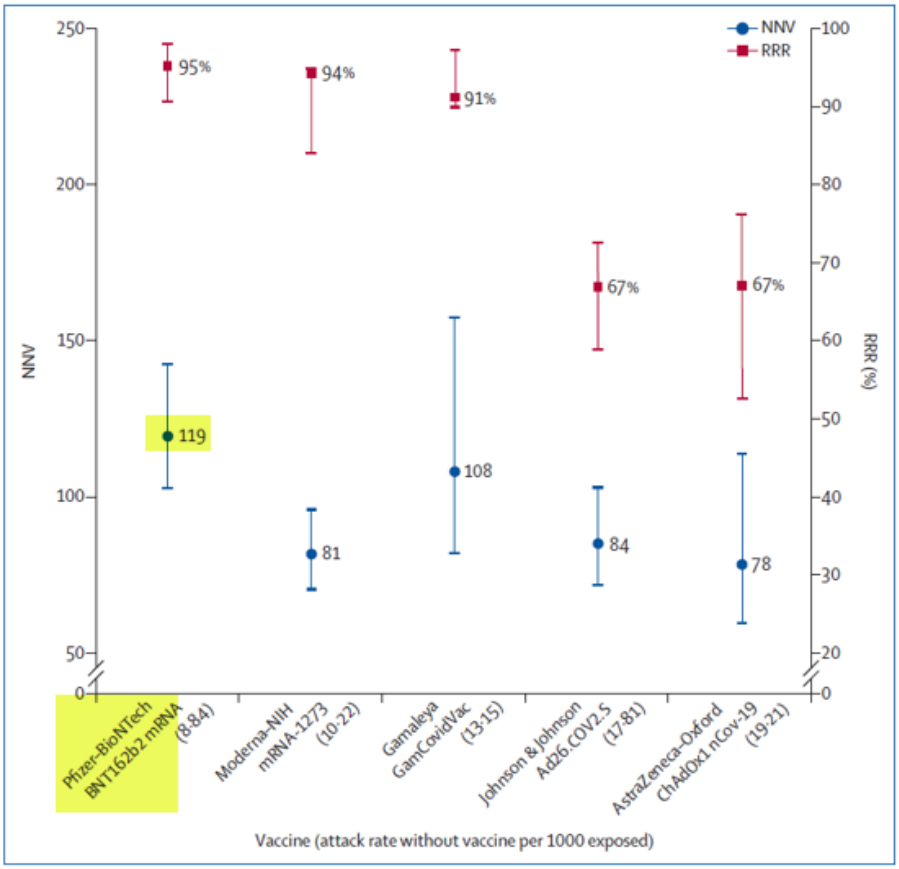


Figure: **RRR and NNV with 95% CI ranked by attack rate in the unvaccinated (placebo) group for five COVID-19 vaccines**
The lower the NNV and the higher the RRR, the better the vaccine efficacy. Details are in the appendix (p 3). RRR=relative risk reduction. NNV=numbers needed to vaccinate. NIH=US National 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

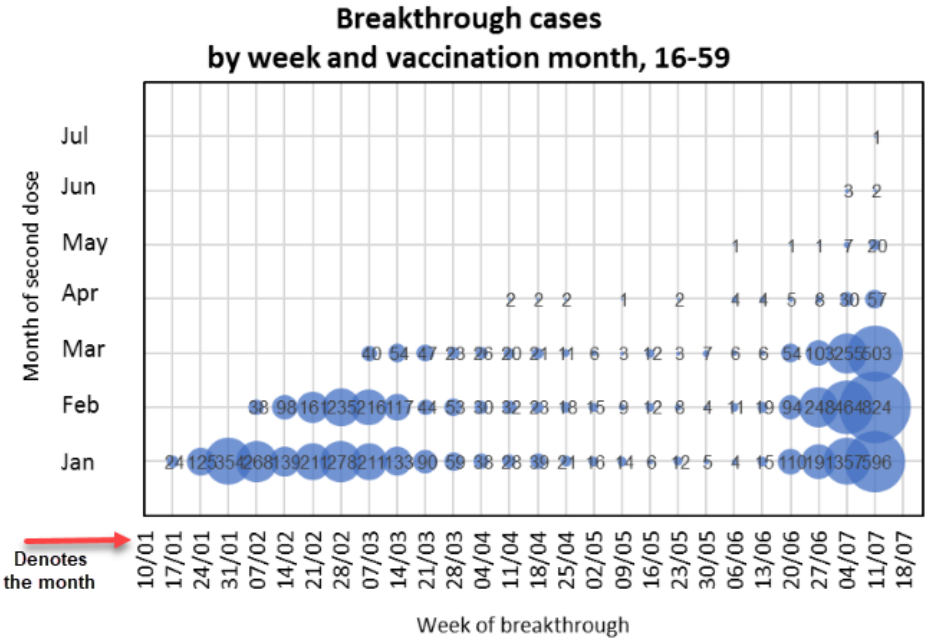
End of excerpts

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

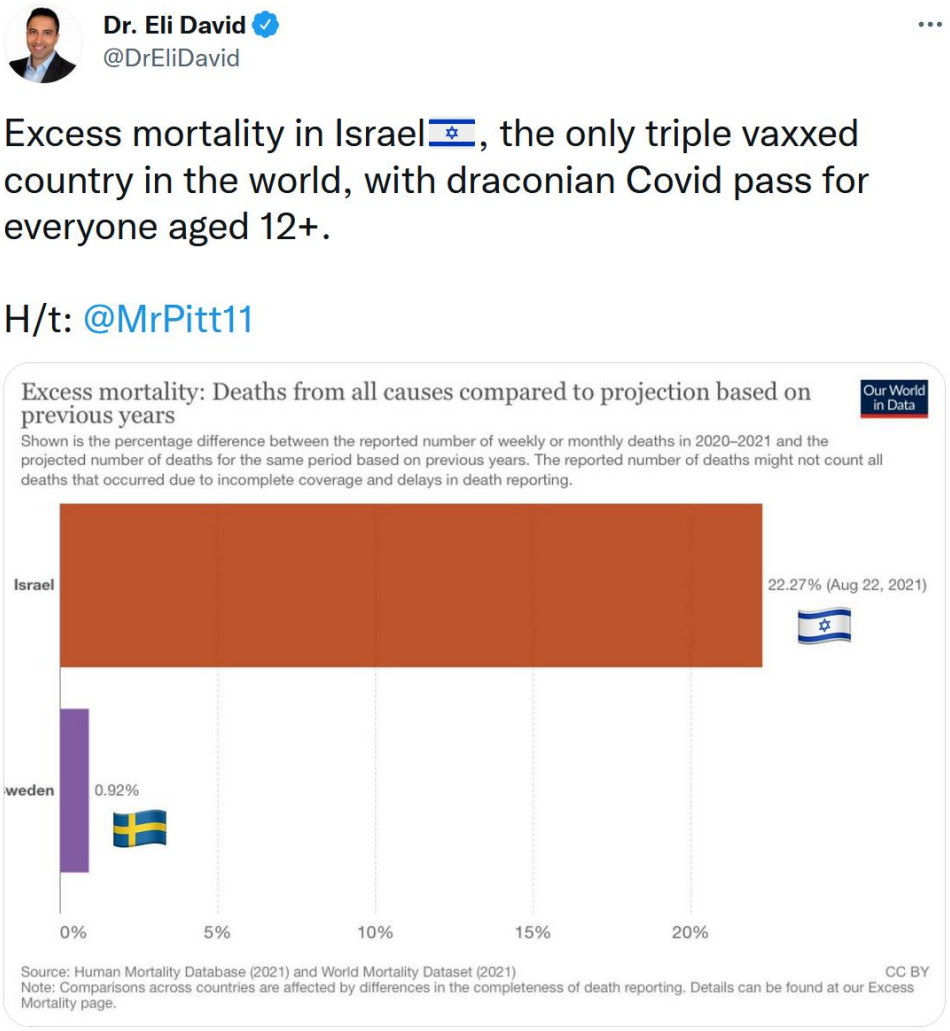


The first shot typically doesn't produce ample levels of neutralizing antibodies, but instead produces more non neutralizing antibodies. It's the neutralizing antibodies that are the most important to prevent infection. The second shot appears to produce more of the neutralizing antibodies to the spike 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.

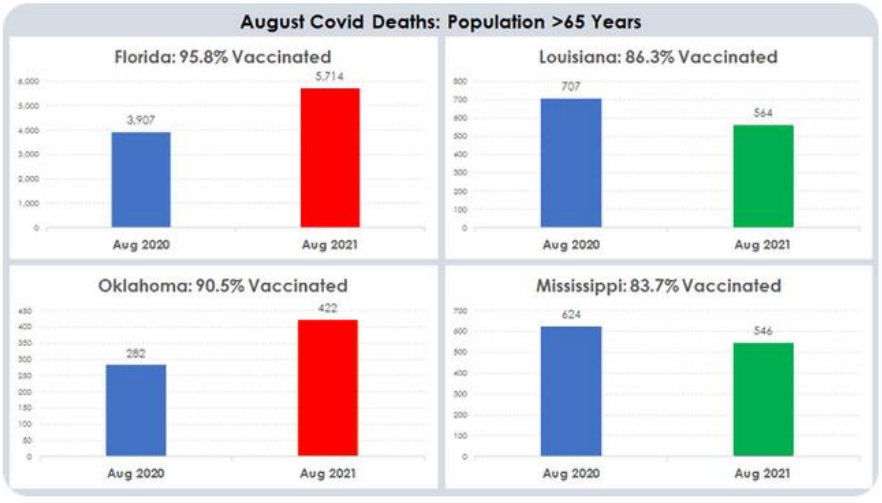
Scroll to next page…

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.



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.

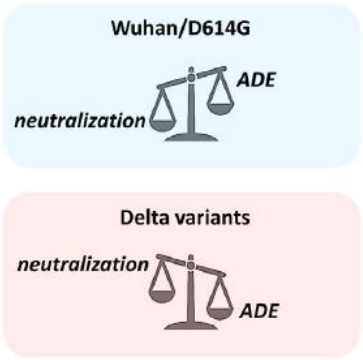


Fig. 2. Neutralization vs ADE balance according to SARS-CoV-2 strains.

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).

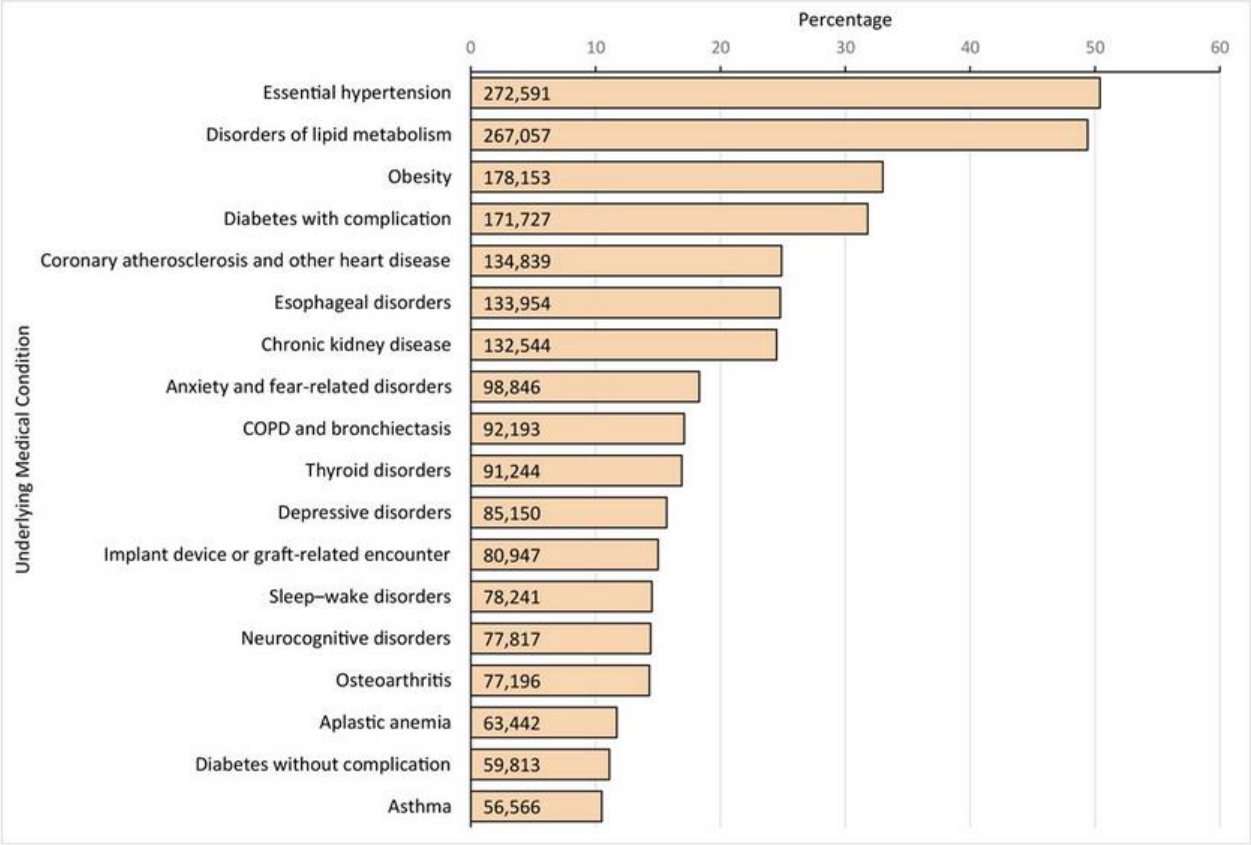
Conclusion

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…

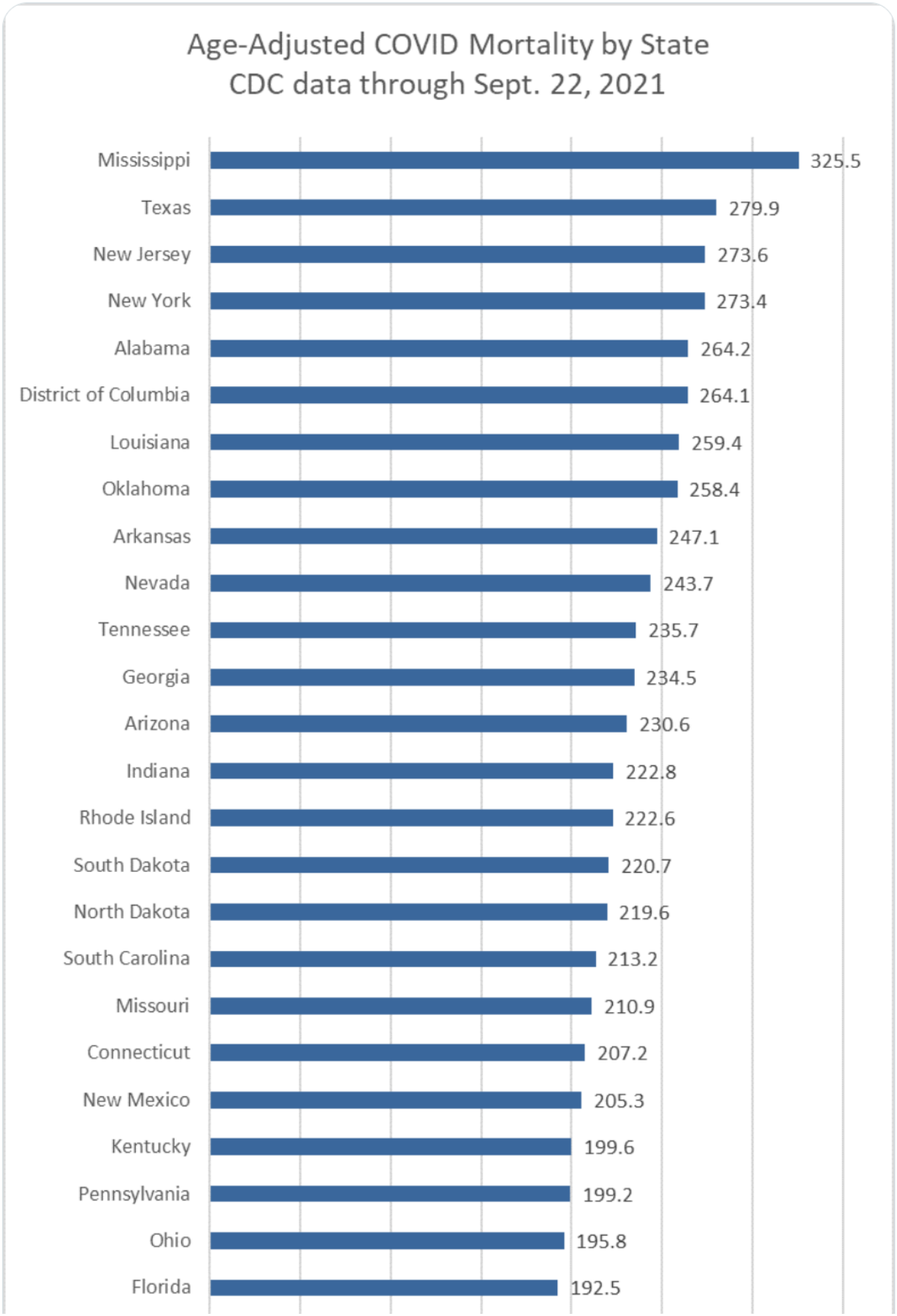
Compared with patients with no documented underlying medical conditions, patients' risk of death was

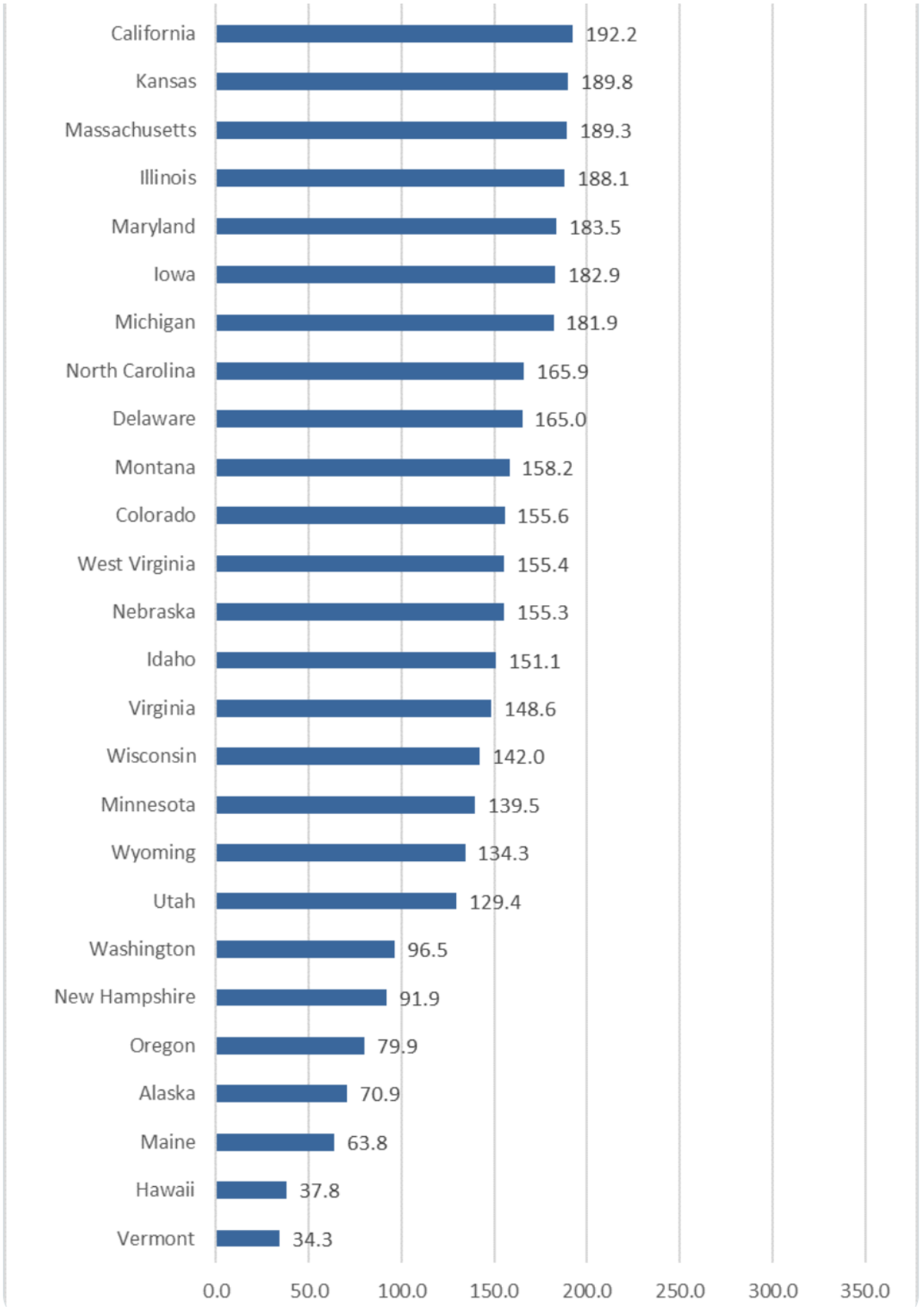
- 1.53 times (95% CI, 1.41–1.67) as high if they had 1 condition,
- 2.55 times (95% CI, 2.32–2.80) as high if they had 2 to 5 conditions,
- 3.29 times (95% CI, 2.98–3.63) as high if they had 6 to 10 conditions,
- 3.82 times (95% CI, 3.45–4.23) as high if they had more than 10 conditions.

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?

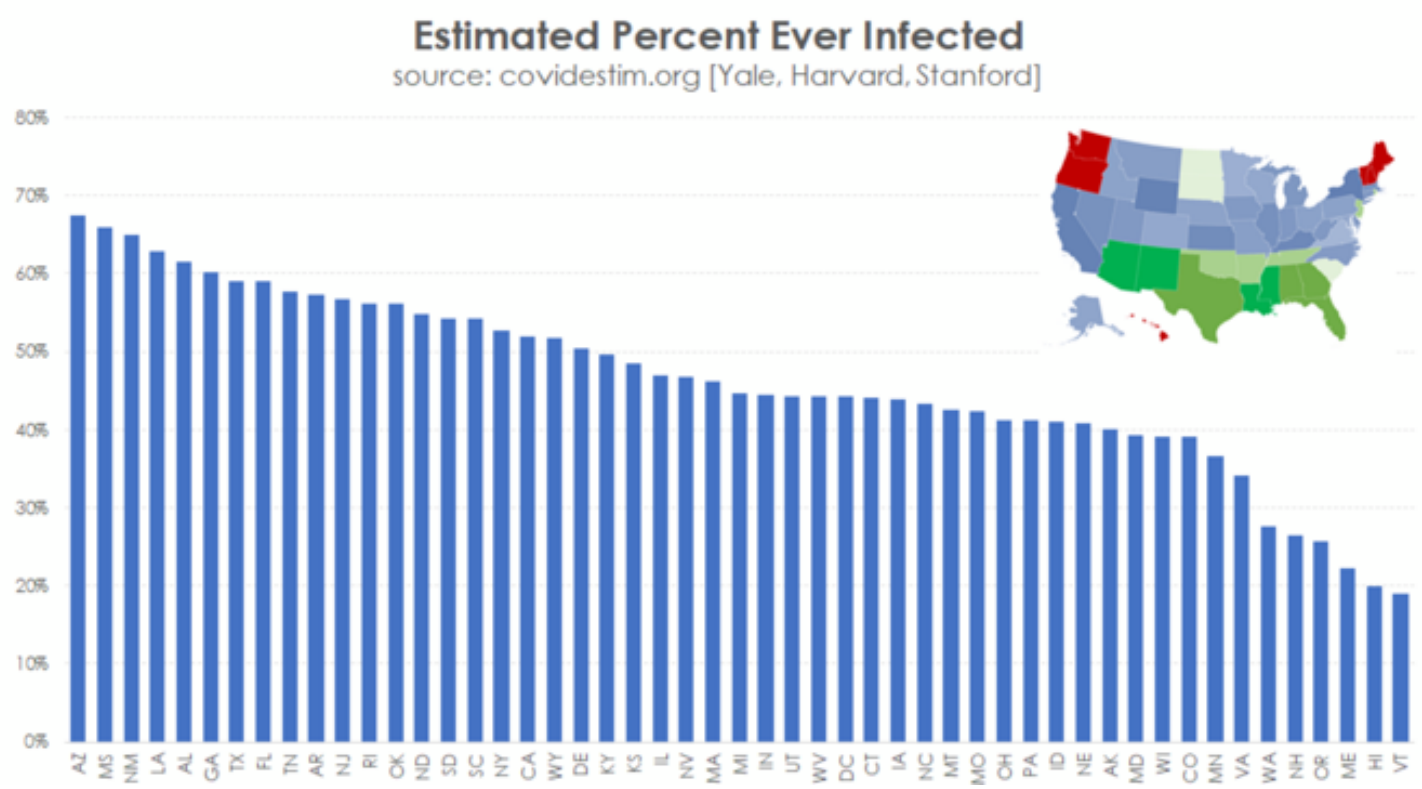



California 192.2
Kansas 189.8
Massachusetts 189.3
Illinois 188.1
Maryland 183.5
Iowa 182.9
Michigan 181.9
North Carolina 165.9
Delaware 165.0
Montana 158.2
Colorado 155.6
West Virginia 155.4
Nebraska 155.3
Idaho 151.1
Virginia 148.6
Wisconsin 142.0
Minnesota 139.5
Wyoming 134.3
Utah 129.4
Washington 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

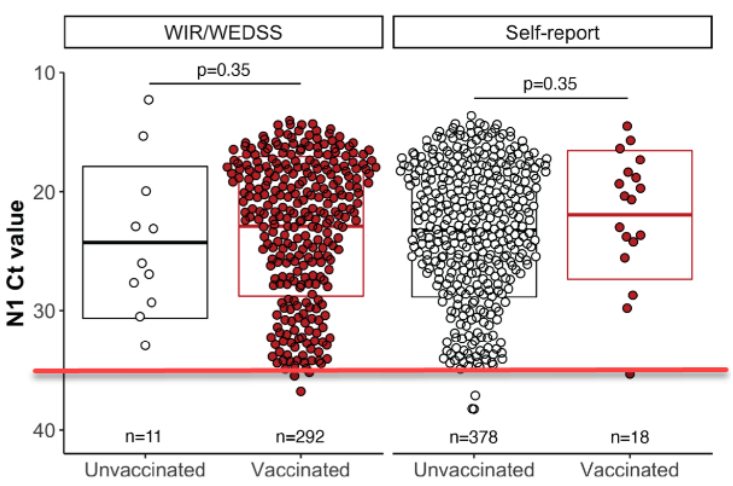
The SARS-CoV-2 Delta variant might cause high viral loads, is highly transmissible, and contains mutations that confer partial immune escape. Outbreak investigations suggest that vaccinated persons can spread Delta. We compared RT-PCR cycle threshold (Ct) data from 699 swab specimens collected in Wisconsin 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:

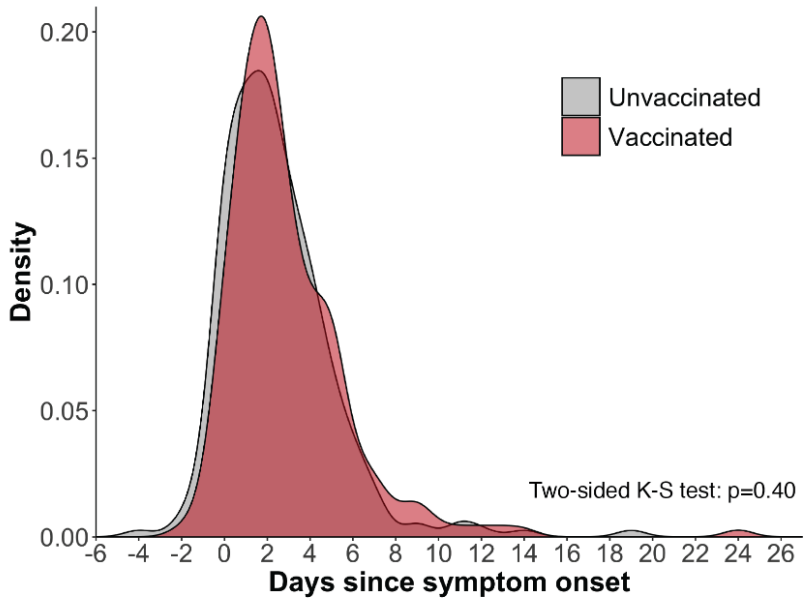
Low Ct values were detected in vaccinated people regardless of symptoms at the time of testing.

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.

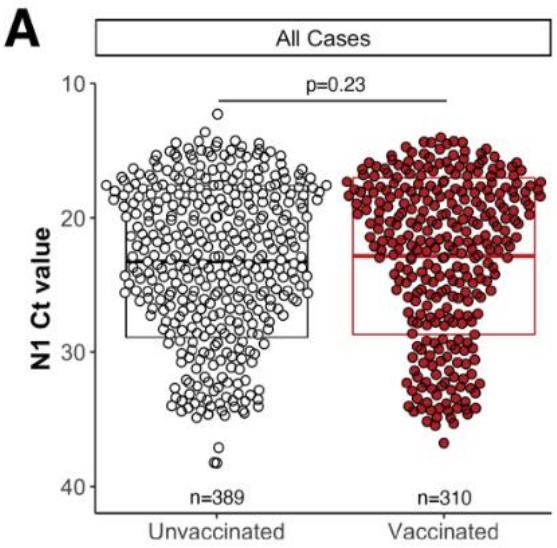
Combined with other studies 2–5, these data indicate that vaccinated and unvaccinated individuals infected with the Delta variant might transmit infection. Importantly, we show that infectious SARS-CoV-2 is frequently found even in vaccinated persons when specimen Ct values are low. The inclusion of 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.

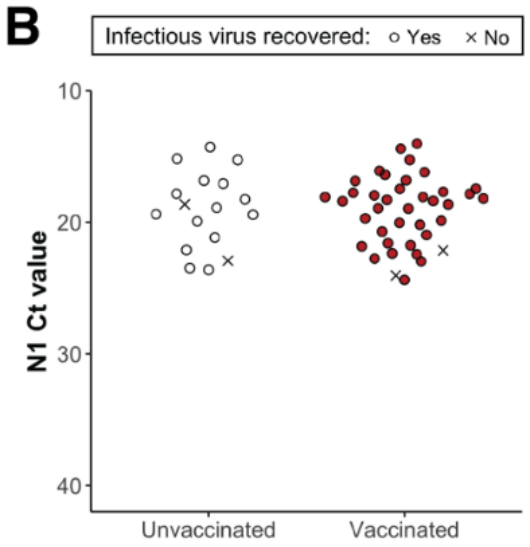
Figure 1, A



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.

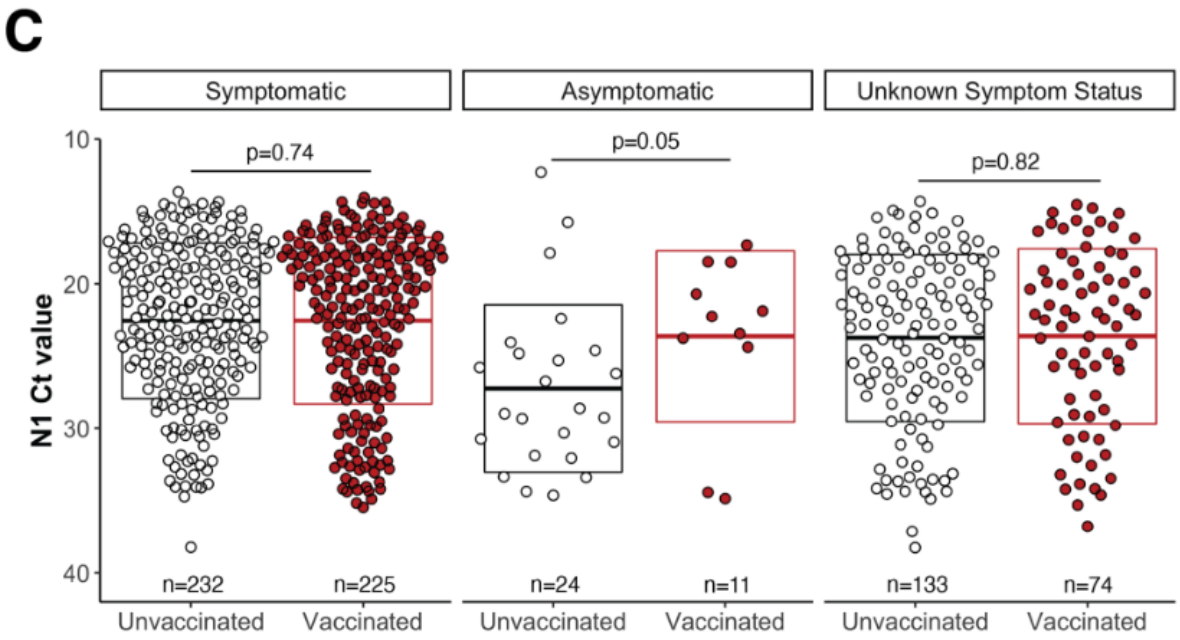
Testing a subset of low-Ct samples revealed infectious SARS-CoV-2 in 15 of 17 specimens (88%) from unvaccinated individuals and 37 of 39 (95%) from vaccinated people.

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

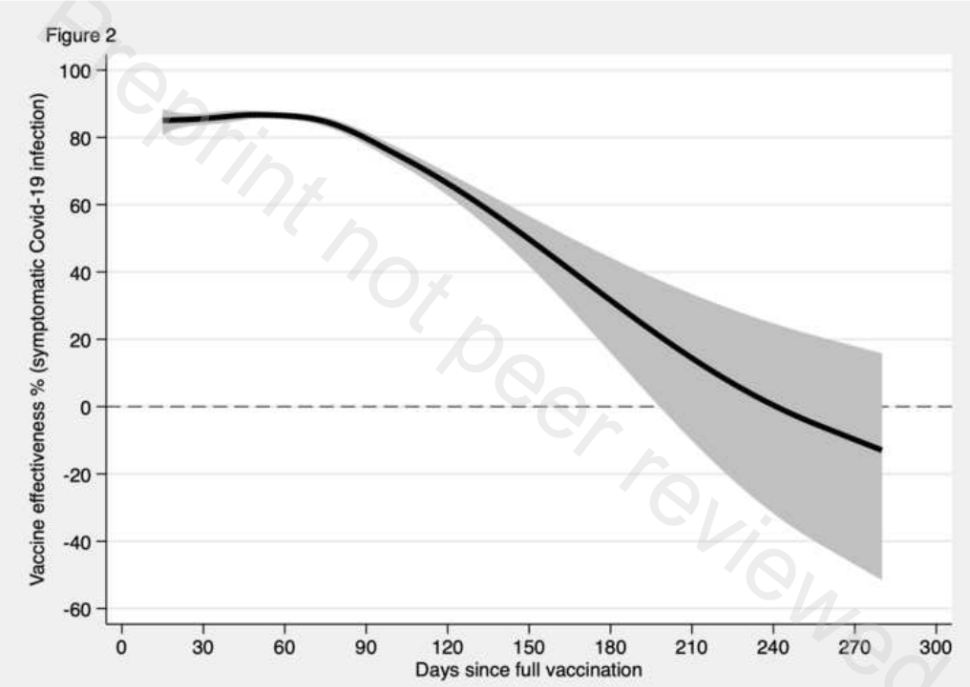
The study is a preprint posted October 25th 2021 titled, **Effectiveness of COVID-19 vaccination against risk of symptomatic infection, hospitalization, and death up to nine months: a Swedish total population cohort study.** The findings mirror other studies and reports from all over the world showing the dramatic decline in effectiveness of the vaccines within a few months.

Findings of vaccine effectiveness against infection:

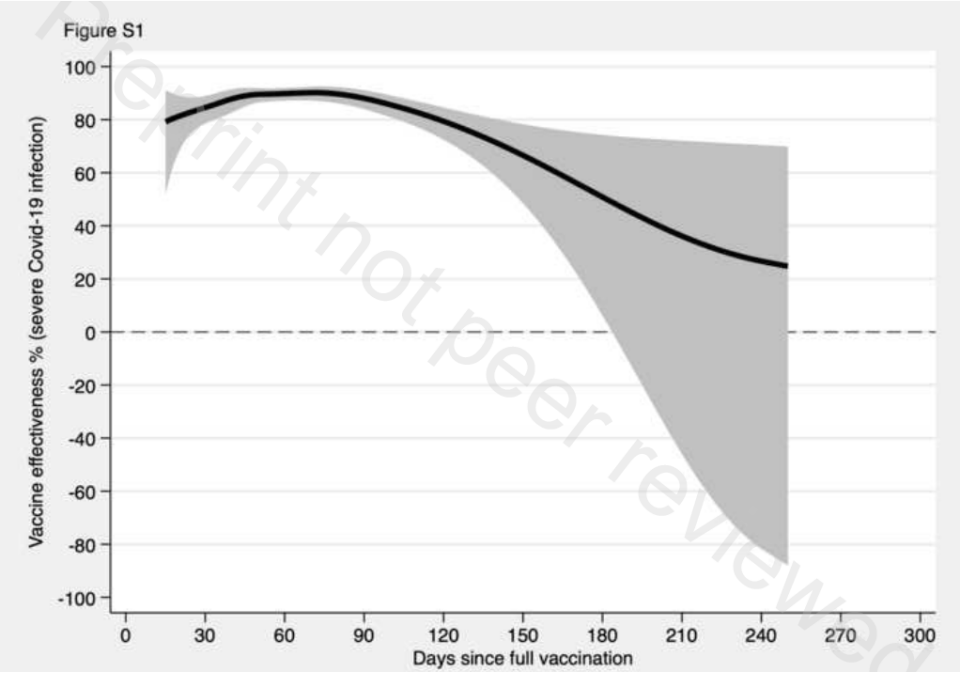
- Pfizer waned progressively from 92% at day 15-30 to 47%, and from day 211 and onwards no effectiveness could be detected.
- Moderna waned to 59% from day 181 and onwards.
- AstraZeneca's effectiveness was generally lower and waned faster, with no effectiveness detected from day 121 and onwards.

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.

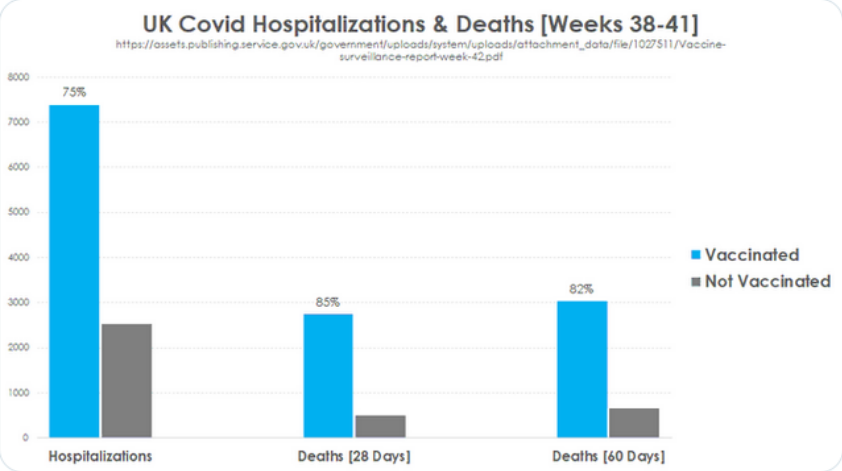
Scroll to the next page…

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...

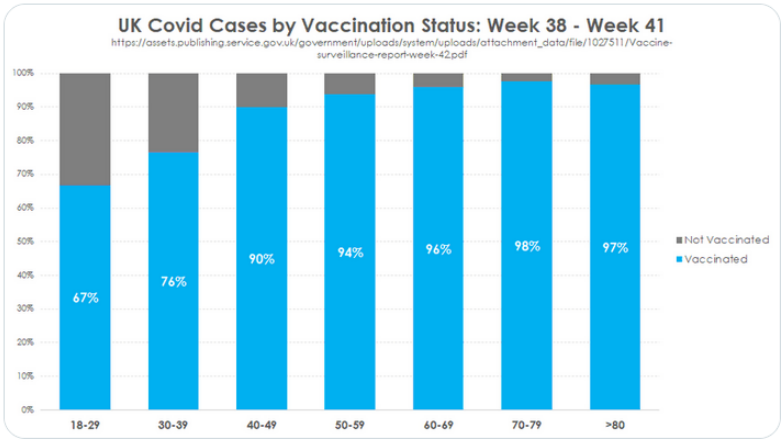


12:13 PM · Oct 28, 2021 · Twitter Web App

PLC
@Humble_Analysis

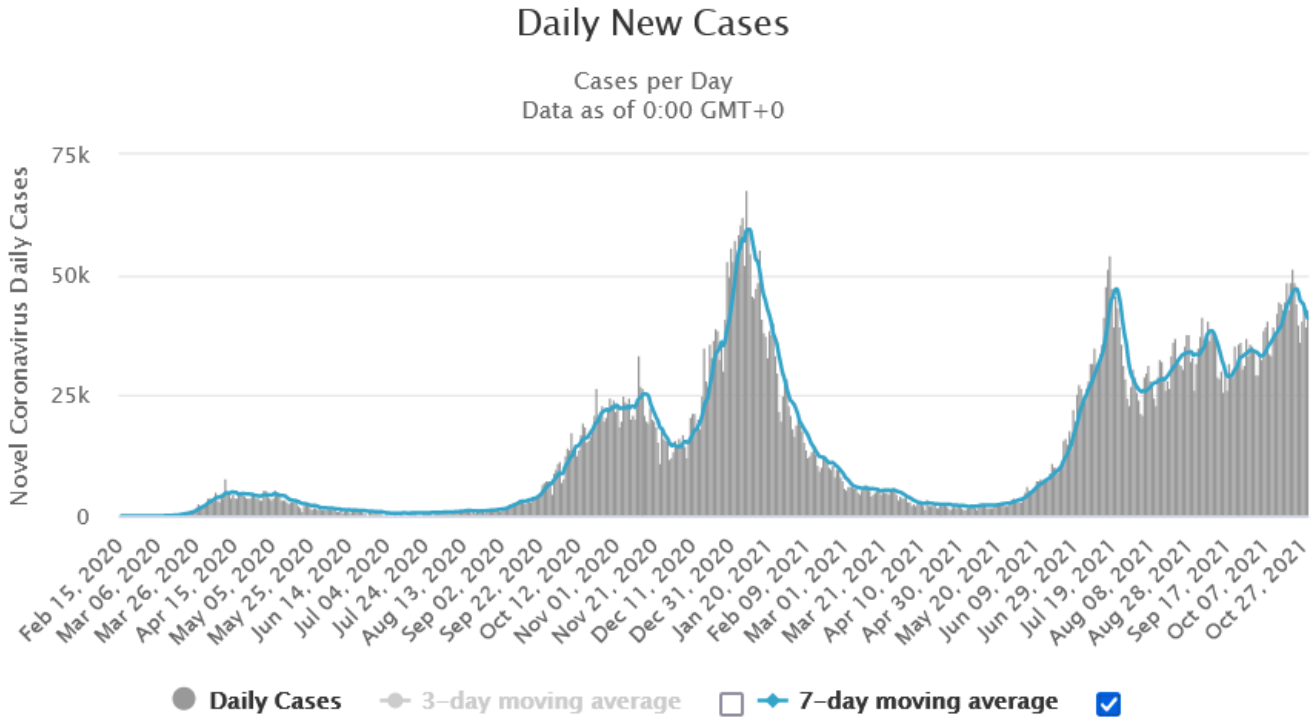
For all ages >18, the vast majority of covid infections reported by the NHS in UK are vaccinated. For those over 40, more than 90% of cases are vaccinated.

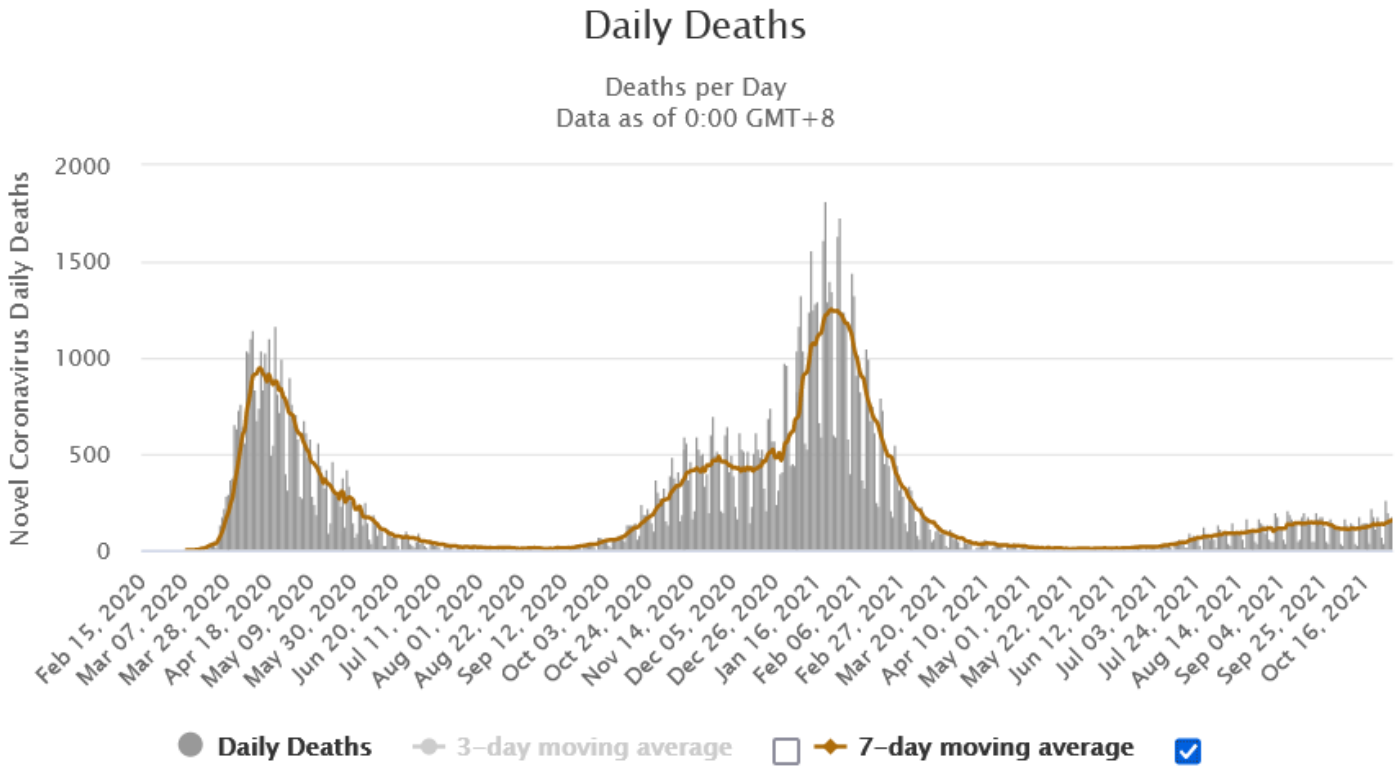
assets.publishing.service.gov.uk/government/upl...



4:09 AM · Oct 27, 2021 · Twitter Web App

Daily New Cases in the United Kingdom



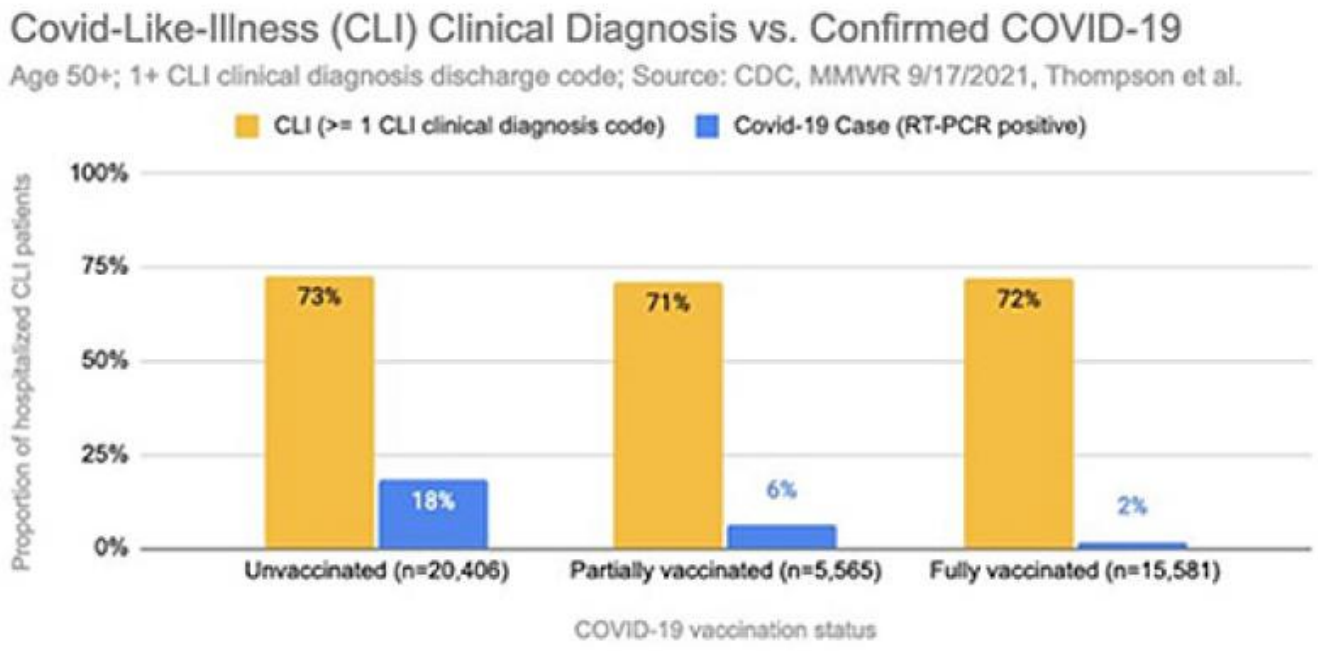


More statistics on the failure of the vaccines

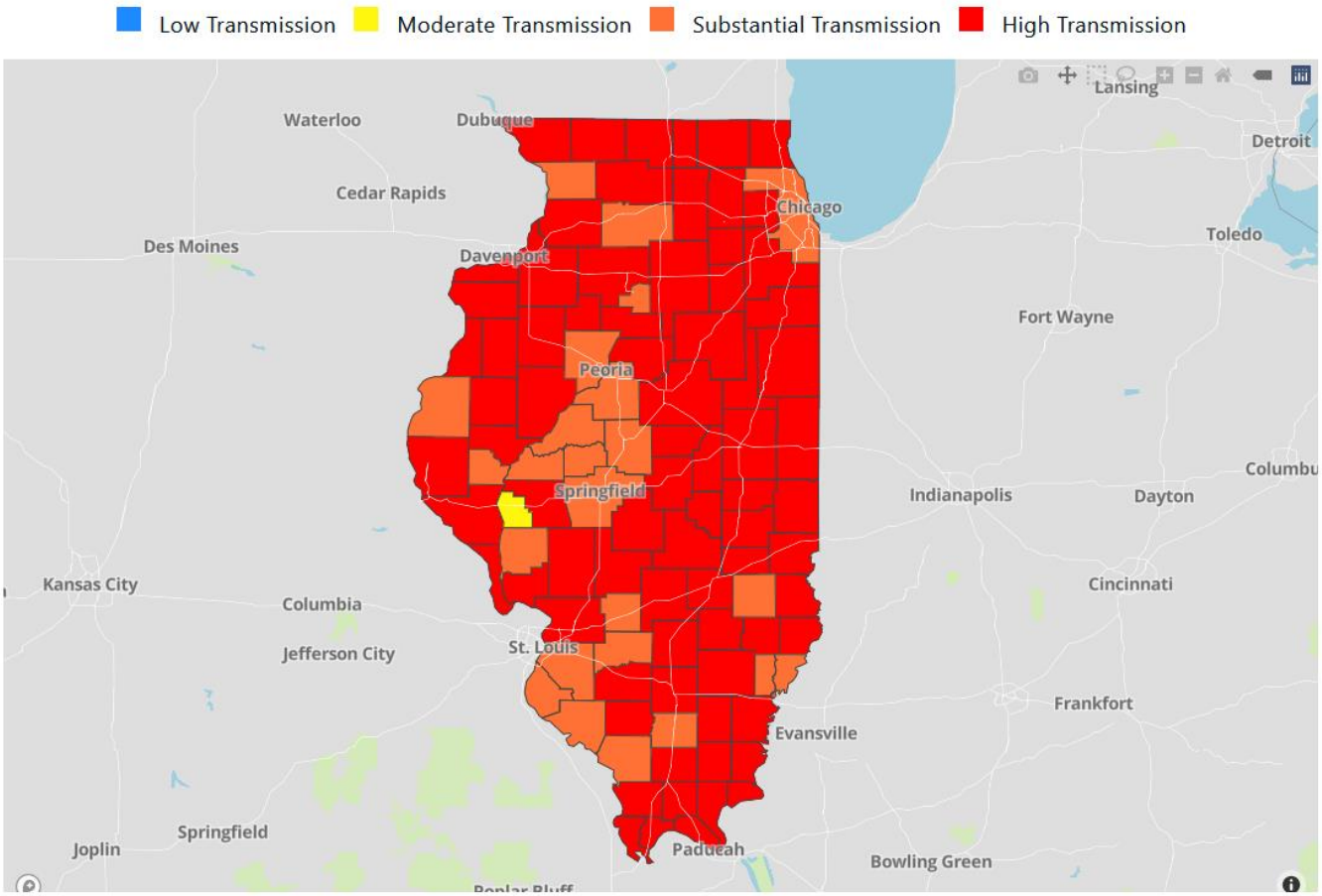
An article published by ***Dr. Mercola*** titled, **Are the COVID Shots Working?**, highlights some lowlights of the statistics comparing case numbers and degree of illness of vaccinated vs. unvaccinated individuals.

STORY AT-A-GLANCE

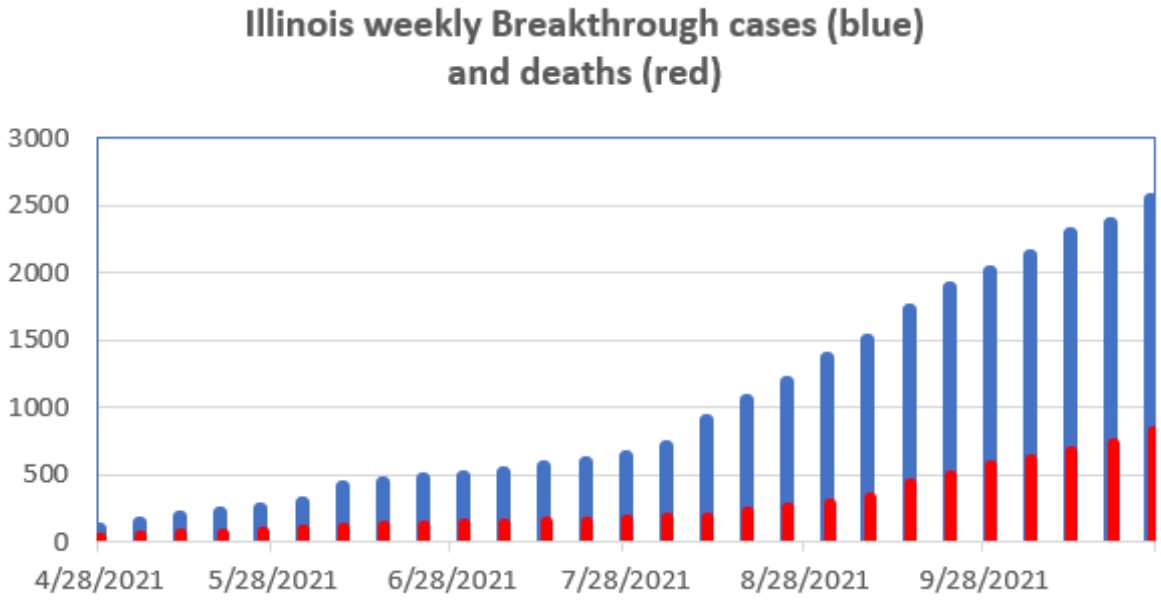
- A recent report details a SARS-CoV-2 Delta outbreak in an Israeli hospital where 238 out of 248 (96%) of the exposed patients and staff had been fully vaccinated with Pfizer's mRNA vaccine
- Of the 238 fully vaccinated individuals, 39 (16%) were infected, as were three of the 10unvaccinated individuals 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

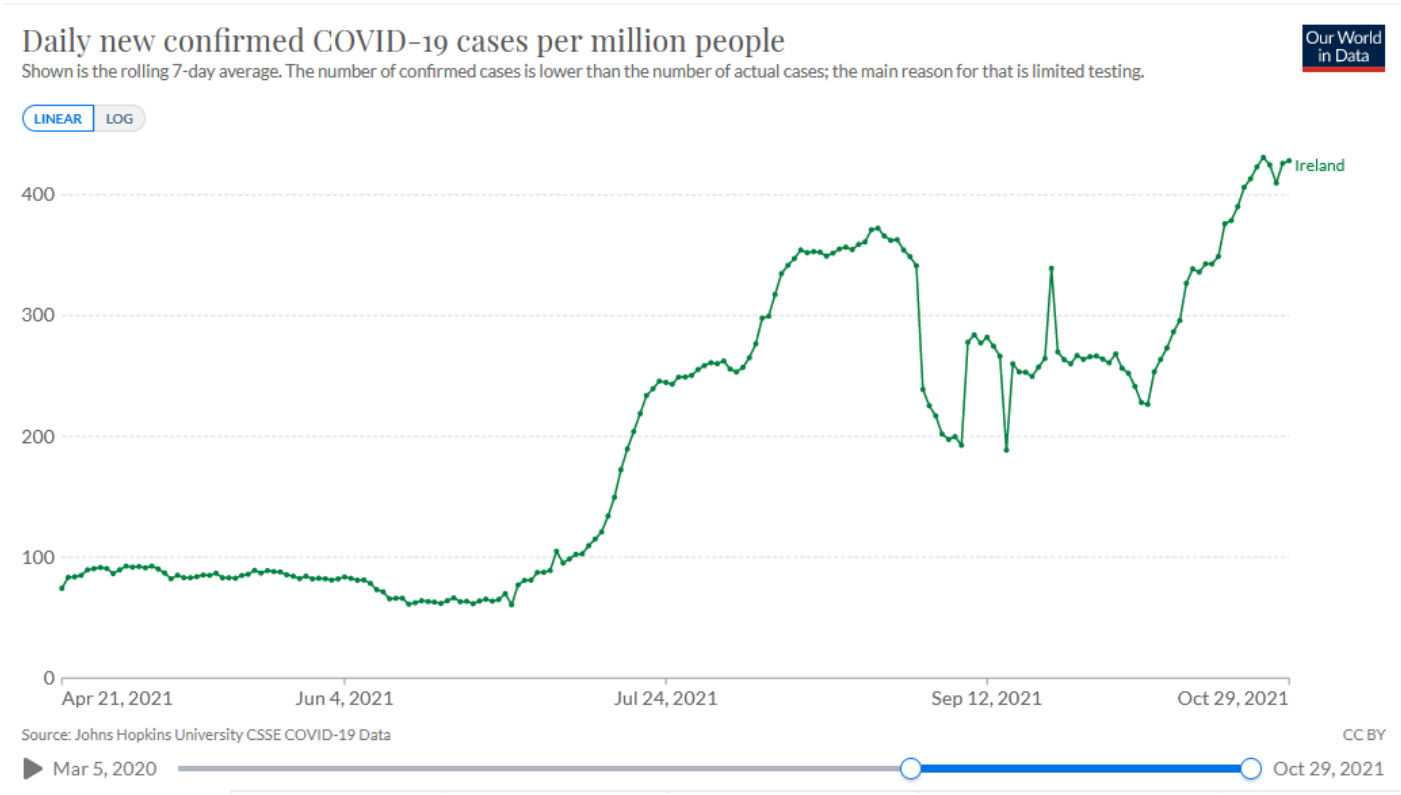
Waterford, once the crown jewel of Ireland's Vaccination program, now has the highest rate of infection in the country. For the first time since March, the number of patients in hospital with Covid in Ireland is over 400. This in a country where 92% of adults have been Vaccinated against the CCP Virus.

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.

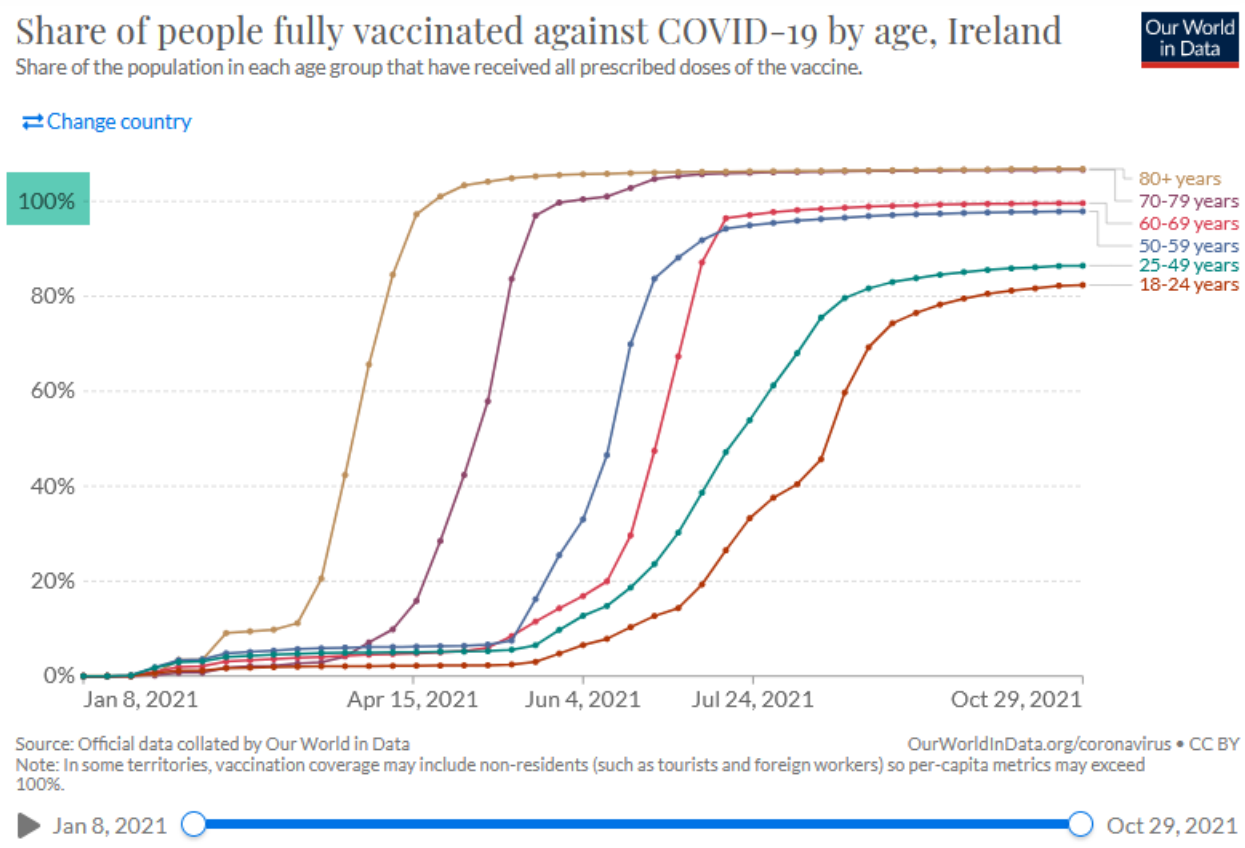
The number of vaccinated patients in ICU now is almost as high as the entire number of Covid patients in ICU a year ago. HSE chief clinical officer Dr Colm Henry admitted the figures were "higher than we would like" but added they would be even higher but for the impact of vaccination.

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

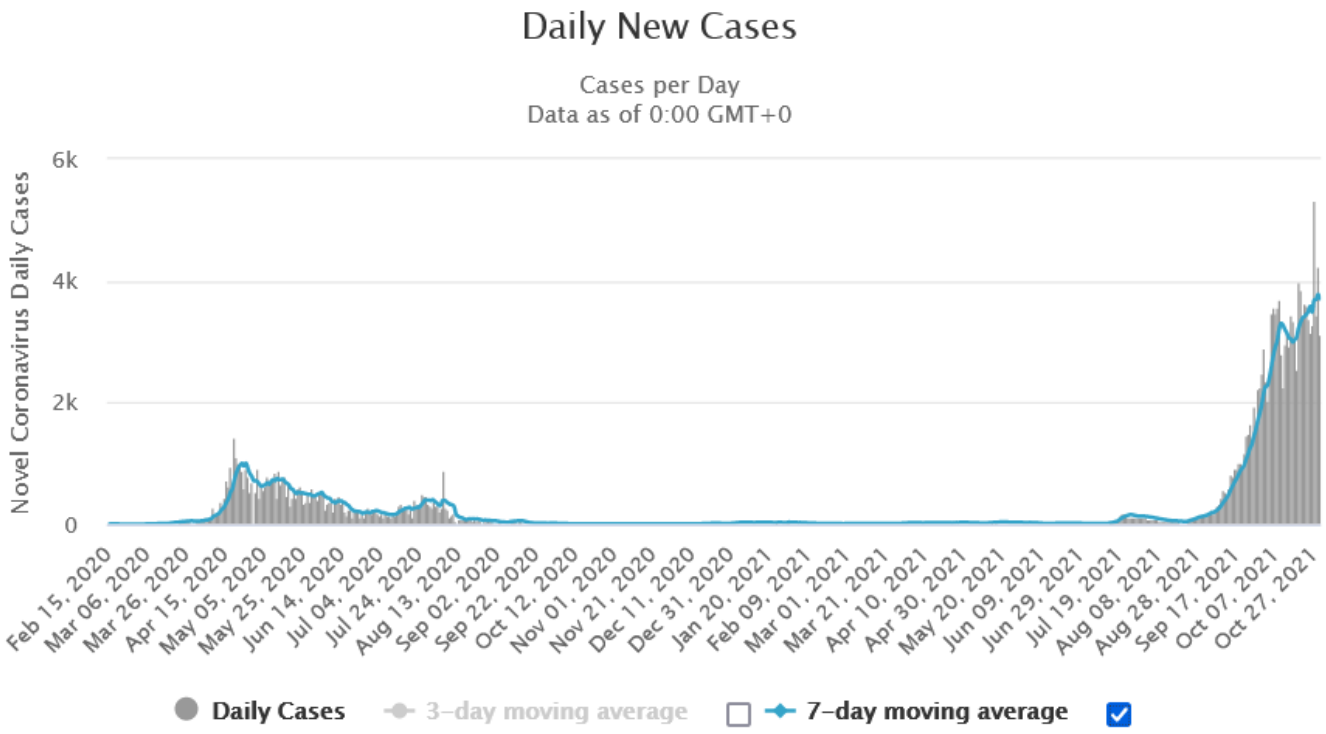


Yet nearly 100% of the population over the age of 50 are vaccinated

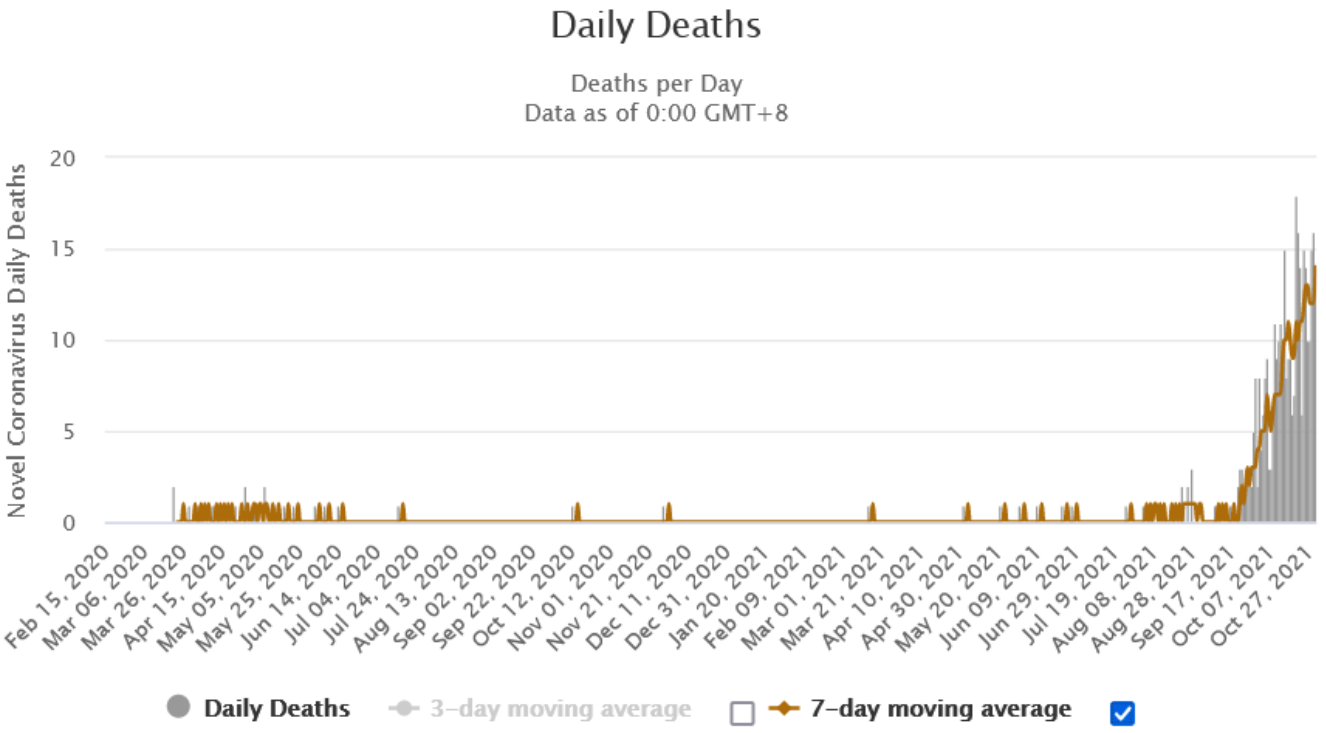


Singapore, a country then has fully vaccinated 80% of their population is experiencing soaring case rates

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

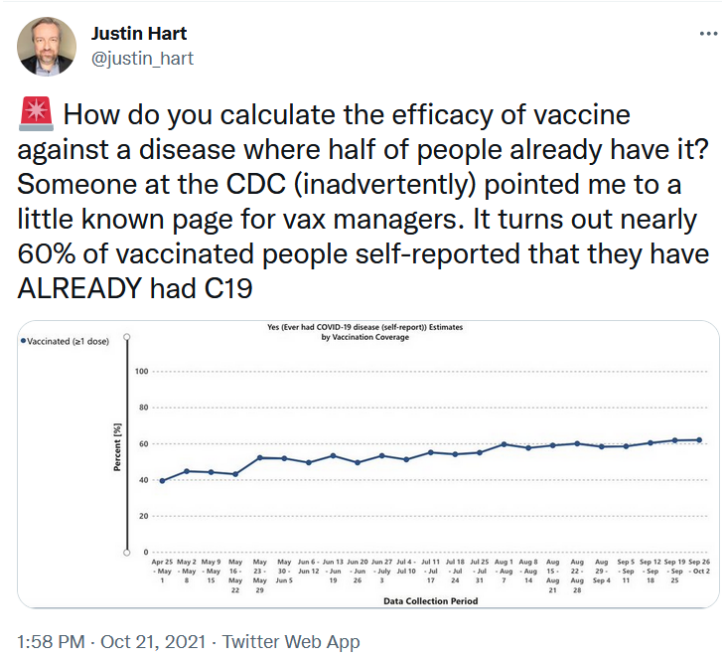
Severe acute respiratory syndrome corona virus 2 (SARS-CoV-2) causes severe acute respiratory syndrome. mRNA vaccines directed at the SARS-CoV-2 spike protein resulted in development of Abs and protective immunity. To determine the mechanism, we analyzed the kinetics of induction of circulating exosomes 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

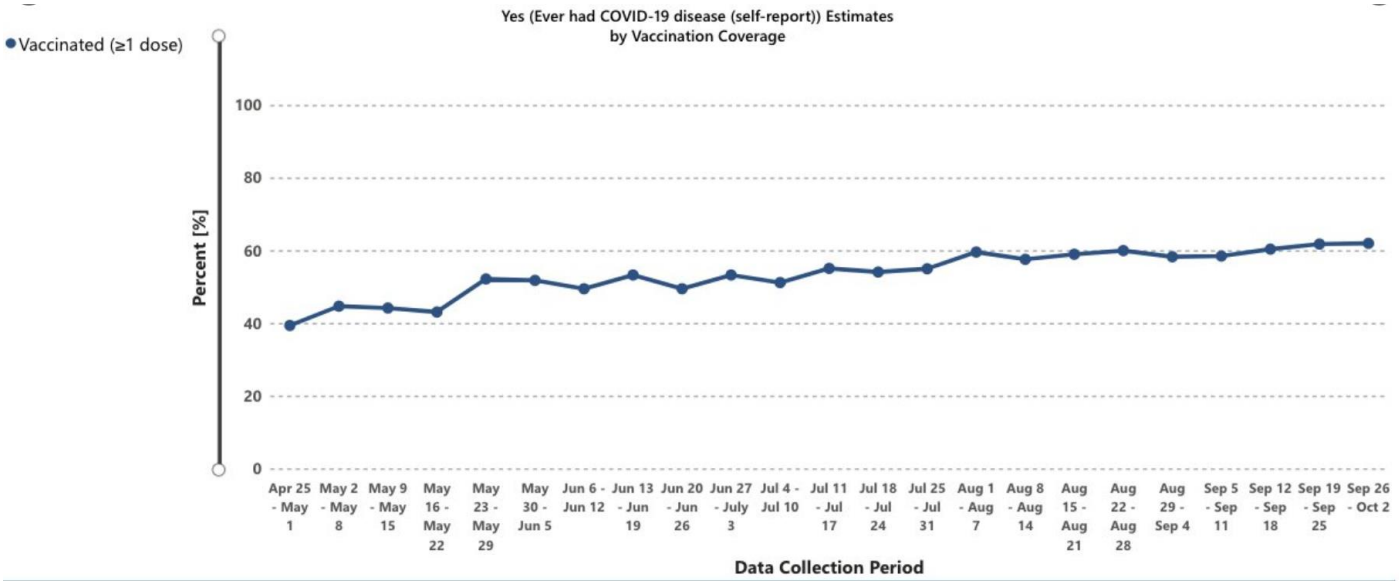
Scroll to the next page…

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…



ENLARGED



December 1st, 2021

Study concludes that mRNA vaccines cause inflammation of the endothelium and vascular changes that may explain the various types of cardiovascular complications after vaccination

An article published November 8th, 2021, in the ***American Heart Association Journal*** titled, **Abstract 10712: Mrna COVID Vaccines Dramatically Increase Endothelial Inflammatory Markers and ACS Risk as Measured by the PULS Cardiac Test: a Warning**, reveals just how common heart related problems can be after the mRNA COVID-19 vaccines**.** By Steven R Gundry. Dr. Gundry has reportedly published three hundred articles and registered several patents for medical devices. He was a Clinical Professor of Cardiothoracic Surgery at ***Loma Linda University School of Medicine***. He later started ***The International Heart & Lung Institute*** in Palm Springs, California.

Abstract- (emphasis mine)

Our group has been using the **PLUS Cardiac Test** (GD Biosciences, Inc, Irvine, CA) a clinically validated measurement of multiple protein biomarkers which **generates a score predicting the 5 yr risk (percentage chance) of a new Acute Coronary Syndrome (ACS).** The score is based on changes from the norm of multiple protein biomarkers including IL-16, a proinflammatory cytokine, soluble Fas, an inducer of apoptosis, and Hepatocyte Growth Factor (HGF) which serves as a marker for chemotaxis of T-cells into epithelium and cardiac tissue, among other markers. Elevation above the norm increases the PULS score, while decreases below the norm lowers the PULS score. The score has been measured every 3-6 months in our patient population for 8 years. Recently, with the advent of the mRNA COVID 19 vaccines (vac) by Moderna and Pfizer, dramatic changes in the PULS score became apparent in most patients. This report summarizes those results. **A total of 566 pts, aged 28 to 97, M:F ratio 1:1 seen in a preventive cardiology practice had a new PULS test drawn from 2 to 10 weeks following the 2nd COVID shot and was compared to the previous PULS score drawn 3 to 5 months previously pre- shot. Baseline IL-16 increased from 35=/-20 above the norm to 82 =/-75 above the norm post-vac; sFas increased from 22+/- 15 above the norm to 46=/-24 above the norm post-vac; HGF increased from 42+/-12 above the norm to 86+/-31 above the norm post-vac. These changes resulted in an increase of the PULS score from 11% 5 yr ACS risk to 25% 5 yr. ACS risk. At the time of this report, these changes persist for at least 2.5 months post second dose of vac. We conclude that the mRNA vacs dramatically increase inflammation on the endothelium and T cell infiltration of cardiac muscle and may account for the observations of increased thrombosis, cardiomyopathy, and other vascular events following vaccination.**

https://www.ahajournals.org/doi/abs/10.1161/circ.144.suppl_1.10712

Wow, this is astounding! This assessment predicts the 5-year risk of a new Acute Coronary Syndrome (ACS). To increase the risk from an average baseline of 11% to as much as 25% is a very significant risk. Let's read the last sentence of the abstract again.

"We conclude that the mRNA vacs dramatically increase inflammation on the endothelium and T cell infiltration of cardiac muscle and may account for the observations of increased thrombosis, cardiomyopathy, and other vascular events following vaccination."

The tsunami of thromboses, thrombocytopenia, myocarditis, pericarditis and heart related issues that we are already seeing may just be the tip of the iceberg of what's to come.

Study finds no need for children to be vaccinated against COVID-19 and shocking finds that at least 5 times as many people over 65 die from the vaccines than from COVID

A September 2021 article published in the journal ***Toxicology Reports*** titled, **Why are we vaccinating children against COVID-19?** is not only highly critical of the suggestion that children should be vaccinated against COVID-19, but it also suggests that at least 5 times more people over the age of 65 have died from the shots than from the disease itself (see my story in this issue on the country of Gibraltar as one example). The paper is also highly critical of the Pfizer clinical trials, pointing out various flaws, design deficiencies and erroneous findings. The paper has 127 references.

The abstract

This article examines issues related to COVID-19 inoculations for children. The bulk of the official COVID-19-attributed deaths per capita occur in the elderly with high comorbidities, and the COVID-19 attributed deaths per capita are negligible in children. The bulk of the normalized post-inoculation deaths also occur in the elderly with high comorbidities, while the normalized post-inoculation deaths are small, but not negligible, in children. Clinical trials for these inoculations were very short-term (a few months), had samples not representative of the total population, and for adolescents/children, had poor predictive power because of their small size. Further, the clinical trials did not address changes in biomarkers that could serve as early warning indicators of elevated predisposition to serious diseases. Most importantly, the clinical trials did not address long-term effects that, if serious, would be borne by children/adolescents for potentially decades. A novel *best-case scenario* cost-benefit analysis showed *very conservatively* that there are five times the number of deaths attributable to each inoculation vs those attributable to COVID-19 in the most vulnerable 65+ demographic. The risk of death from COVID-19 decreases drastically as age decreases, and the longer-term effects of the inoculations on lower age groups will increase their risk-benefit ratio, perhaps substantially.

The article is full of interesting and thoughtful analysis. I'm not sure that I would support every conclusion they make, but here are just a few of those…

A vaccine is legally defined as any substance designed to be administered to a human being for the prevention of one or more dis- eases [5]. For example, a January 2000 patent application that defined vaccines as "compositions or mixtures that when introduced into the circulatory system of an animal will evoke a protective response to a pathogen." was rejected by the U.S. Patent Office because "The immune response produced by a vaccine must be more than merely some immune response but must be protective. As noted in the previous Office Action, the art recognizes the term "vaccine" to be a compound which prevents infection" [6]. In the remainder of this article, we use the term inoculated' rather than vaccinated, because the injected material in the present COVID-19 inoculations prevents neither viral infection nor transmission. Since its main function in practice appears to be symptom suppression, it is operationally a "treatment".

By the end of May 2021, the official CDC death count attributed to COVID-19 was approaching 600,000, as stated previously. This number has been disputed for many reasons. First, before COVID-19 testing began, or in the absence of testing, after it was available, the diagnosis of COVID-19 (in the USA) could be made by the

presumption of the healthcare practitioner that COVID-19 existed [4,18]. Second, after testing began, the main diagnostic used was the RT-PCR test. This test was done at very high amplification cycles, ranging up to 45 [19–21]. In this range, very high numbers of false positives are possible [22]. Third, most deaths attributed to COVID-19 were elderly with high comorbidities [1,22]. As we showed in a previous study [22], attribution of death to one of many possible comorbidities or especially toxic exposures in combinations [23] is highly arbitrary and can be viewed as a political decision more than a medical decision. For over 5 % of these deaths, COVID-19 was the only cause mentioned on the death certificate. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death [24]. These deaths with comorbidities could equally have been ascribed to any of the comorbidities [22]. Thus, the actual number of COVID-19-based deaths in the USA may have been on the order of 35,000 or less, characteristic of a mild flu season.

Even the 35,000 deaths may be an overestimate. Comorbidities were based on the clinical definition of specific diseases, using threshold biomarker levels and relevant symptoms for the disease(s) of interest [25,26]. But many people have what are known as pre-clinical conditions. The biomarkers have not reached the threshold level for official disease diagnosis, but their abnormality reflects some degree of under- lying dysfunction. The immune system response (including pre-clinical conditions) to the COVID-19 viral trigger should not be expected to be the same as the response of a healthy immune system [27]. If pre-clinical conditions had been taken into account and coupled with the false positives as well, the CDC estimate of 94 % misdiagnosis would be substantially higher.

On the other hand, the inoculation landscape has become even more complex due to new circulating viral variants. Authorities recommend genomic surveillance and adaptation in order to be effective against new variants (different from the initial strain that was detected at the end of 2019). The efficacy data of Comirnaty against circulating viral variants are highlighted in a very recent study in Israel which showed that the protection offered by the Pfizer inoculant against variant B.1.351 (first identified in South Africa) is lower [112]. The results have not yet been submitted to the expertise of specialists. The study compared nearly 400 adults who were diagnosed with COVID-19 at least 14 days after receiving one or two doses of the inoculant to the same number of uninoculated people. It was found that B.1.351 represents approximately 1 % of the COVID-19 cases studied. **But among patients who received two doses of inoculant, the prevalence rate of the variant was eight times higher than in those not inoculated - 5.4 % compared to 0.7 %.** This suggests that Comirnaty is less effective against variant B.1.351, compared to the original variant and variant B.1.1.7. The limitation of the study comes from the small number of adult people studied, but it is an alarm signal for a closer study of these cases. In addition, it seems that at present, the prevalence of this variant is low. On the other hand, in early April, Pfizer announced that according to the results of the Phase III study in the adult population, Comirnaty also demonstrated 100 % efficacy in the prevention of Covid-19 disease caused by SARS-CoV-2 variant B.1.351 (9 cases of Covid-19 were recorded, all in the placebo group, and after sequencing it was found that 6 had been determined by B.1.351) [117].

A2-b Ongoing Clinical Trials in the Pediatric Population

In a recent Phase III study performed in the pediatric population, Comirnaty (Pfizer) was tested on a group of 2,260 children, aged 12–15, years who had no previous clinical signs of SARS-CoV-2 infection. They were divided into two groups, one placebo (978 children) and the other with Comirnaty (1005 children). In the Comirnaty group, of the 1005 children in whom the serum was administered, none developed COVID-19 disease, compared with the placebo group in which 16 children in 978 had clinical signs of the disease. The Pfizer study showed that the children's immune response was comparable to the immune response in the 16–

25 age group (measured by the level of antibodies against SARS-CoV-2). It could be concluded that in this study, Comirnaty was 100 % effective in preventing SARS-CoV-2 infection, although the actual rate could be between 75 % and 100 %. [63]. The results will be evaluated by the FDA and EMA. **(which they have since done)**

The predictive value (for mass inoculation results) of the Comirnaty trial for the children aged 12–15 years is questionable. There were 1005 children who were inoculated with Comirnaty. Using the rule of three in statistics, where to obtain a predictive result of 1/x with high confidence (e.g., 1 in a thousand), 3x participants are required for the test sample. For the Comirnaty test sample of 1005, an adverse event of about 1/340 could be detected with high confidence.

What does this mean in the real world? In the USA, there are approximately 4,000,000 children in each age year for adolescents. Thus, there are˜16,000,000 children in the 12–15 age band. A serious adverse event, including death, that occurred at a 1/800 rate would not be detectable with high confidence in a sample of 1005 people. Thus, the results of the trials for 1005 children would allow for 20,000 children to suffer a non-trial-detected serious adverse event, including death, when extrapolated to potential inoculation of all children in the 12–15 age group! Given that the risk of contracting COVID-19 with serious outcomes is negligible in this population, ***proceeding with mass inoculation of children 12–15 years old based on the trials that were conducted cannot be justified on any cost-benefit ratio findings***. (The authors had bolded this sentence.)

4. Discussion

Two issues arise from these results. First, where is the data justifying inoculation for children, much less most people under forty? It's not found on Fig. 1, where the most vulnerable are almost exclusively the elderly with many comorbidities [83]. Yet, in the USA, Pfizer has been approved to inoculate children 12–17, and the goal is to accomplish this by the start of the school year in the Fall. As stated previously, there are plans to inoculate children as young as six months starting before the end of 2021.

What is the rush for a group at essentially zero risks? Given that the inoculations were tested only for a few months, only very short-term adverse effects could be obtained. It is questionable how well even these short-term effects obtained from the clinical trials reflect the short-term effects from the initial mass inoculation results reported in VAERS.

Figs. 1 and 2 reflect only these very short-term results. A number of researchers have suggested the possibility of severe longer-term autoimmune, Antibody-Dependent Enhancement, neurological, and other potentially serious effects, with lag periods ranging from months to years. If such effects do turn out to be real, the children are the ones who will have to bear the brunt of the suffering. There appear to be no benefits for the children and young adults from the inoculations and only Costs!

The second issue is why the deaths shown on Fig. 2 were not predicted by the clinical trials. We examined the Pfizer trial results (based on a few months of testing) and did not see how (potentially) hundreds of thousands of deaths could have been predicted from the trials' mortality results. Why this gap?

As we showed in the clinical trials section, 17.4 % of the Pfizer sample members were over 65, and 4.4 % were over 75. When the later phases of the trials started in late July 2020, the managers knew the COVID-19 age demographics affected from the July 2020 analog of Fig. 1. Rather than sampling from the age region most affected, they sampled mainly from the age region least affected! And even in the very limited sampling from

the oldest groups, it is unclear whether they selected from those with the most serious comorbidities. Our impression is that the sickest were excluded from the trials, but were first in line for the inoculants.

It is becoming clear that the central ingredient of the injection, the recipe for the spike protein, will produce a product that can have three effects. Two of the three occur with the production of antibodies to the spike protein. These antibodies could allegedly offer protection against the virus (although with all the "breakthrough" cases reported, that is questionable), or could suppress serious symptoms to some extent. They could also cross-react with human tissue antigen, leading to potential autoimmune effects. The third occurs when the injected material enters the bloodstream and circulates widely, which is enabled by the highly vascular injection site and the use of the PEG-2000 coating.

This allows spike protein to be manufactured/expressed in endothelial cells at any location in the body, both activating platelets to cause clotting and causing vascular damage. It is difficult to believe this effect is unknown to the manufacturer, and in any case, has been demonstrated in myriad locations in the body using VAERS data. There appears to be modest benefit from the inoculations to the elderly population most at risk, no benefit to the younger population not at risk, and much potential for harm from the inoculations to both populations. It is unclear why this mass inoculation for all groups is being done, being allowed, and being promoted.

5. Overall conclusions

The people with myriad comorbidities in the age range where most deaths with COVID-19 occurred were in very poor health. Their deaths did not seem to increase all-cause mortality as shown in several studies. If they hadn't died with COVID-19, they probably would have died from the flu or many of the other comorbidities they had. We can't say for sure that many/most died from COVID-19 because of: 1) how the PCR tests were manipulated to give copious false positives and 2) how deaths were arbitrarily attributed to COVID-19 in the presence of myriad comorbidities.

The graphs presented in this paper indicate that the frail injection recipients receive minimal benefit from the inoculation. Their basic problem is a dysfunctional immune system, resulting in part or in whole from a lifetime of toxic exposures and toxic behaviors. They are susceptible to either the wild virus triggering the dysfunctional immune system into over-reacting or under-reacting, leading to poor outcomes or the injection doing the same.

This can be illustrated by the following analogy. A person stands in a bare metal enclosure. What happens when the person lights a match and drops it on the floor depends on what is on the floor. If the floor remains bare metal, the match burns for a few seconds until extinguished. If there is a sheet of paper on the floor under the match, the match and the paper will burn for a short time until both are extinguished. If, however, the floor is covered with ammonium nitrate and similar combustible/ explosive materials, a major explosion will result! For COVID-19, the wild virus is the match. The combustible materials are the toxic exposures and toxic behaviors. If there are no biomarker 'footprints' from toxic exposures and toxic behaviors, nothing happens. If there are significant biomarker 'footprints' from toxic exposures and toxic behaviors, bad outcomes result.

Adequate safety testing of the COVID-19 inoculations would have provided a distribution of the outcomes to be expected from 'lighting the match'. Since adequate testing was not performed, we have no idea how many combustible materials are on the floor, and what the expected outcomes will be from 'lighting the match'.

The injection goes two steps further than the wild virus because 1) it contains the instructions for making the spike protein, which several experiments are showing can cause vascular and other forms of damage, and 2) it bypasses many front-line defenses of the innate immune system to enter the bloodstream directly in part. Unlike the virus example, the injection ensures there will always be some combustible materials on the floor, even if there are no other toxic exposures or behaviors. In other words, the spike protein and the surrounding LNP are toxins with the potential to cause myriad short-, mid-, and long-term adverse health effects even in the absence of other contributing factors! Where and when these effects occur will depend on the biodistribution of the injected material. Pfizer's own biodistribution studies have shown the injected material can be found in myriad critical organs throughout the body, leading to the possibility of multi-organ failure. And these studies were from a single injection. Multiple injections and booster shots may have cumulative effects on organ distributions of inoculant!

The COVID-19 reported deaths are people who died **with** COVID-19, not necessarily **from** COVID-19. Likewise, the VAERS deaths are people who have died **following** inoculation, not necessarily **from** inoculation.

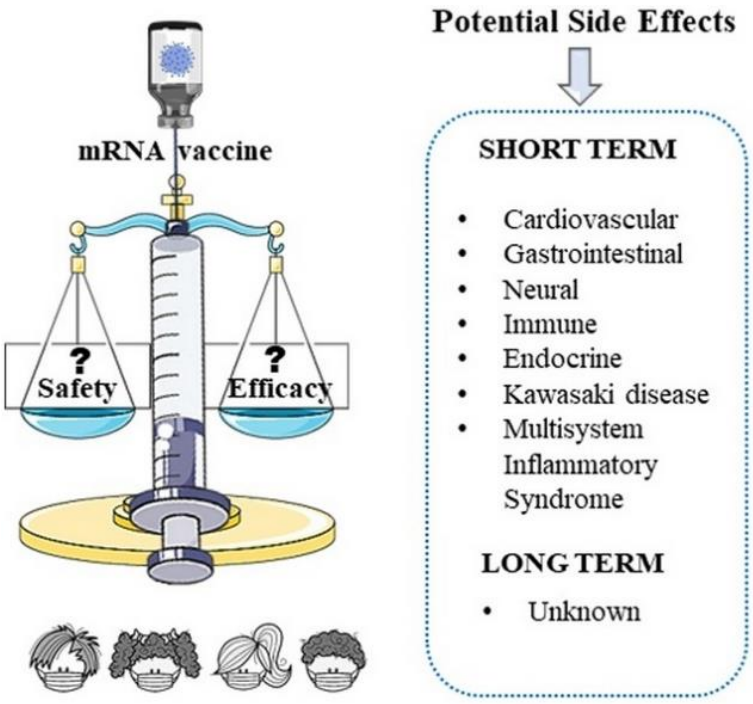
As stated before, CDC showed that 94 % of the reported deaths had multiple comorbidities, thereby reducing the CDC's numbers attributed strictly to COVID-19 to about 35,000 for all age groups. Given the number of high false positives from the high amplification cycle PCR tests, and the willingness of healthcare professionals to attribute death to COVID-19 in the absence of tests or sometimes even with negative PCR tests, this 35,000 number is probably highly inflated as well.

On the latter issue, both Virginia Stoner [85] and Jessica Rose [86] have shown independently that the deaths **following** inoculation are not coincidental and are **strongly related to** inoculation through strong clustering around the time of injection. Our independent analyses of the VAERS database reported in Appendix 1 confirmed these clustering findings.

Additionally, VAERS historically has under-reported adverse events by about two orders-of-magnitude, so COVID-19 inoculation deaths ***in the short-term*** could be in the hundreds of thousands for the USA for the period mid-December 2020 to the end of May 2021, potentially swamping the *real* COVID-19 deaths. Finally, the VAERS deaths reported so far are for the very short term. We have no idea what the death numbers will be in the intermediate and long-term; the clinical trials did not test for those.

The clinical trials used a non-representative younger and healthier sample to get EUA for the injection. Following EUA, the mass inoculations were administered to the very sick (and first responders) initially, and many died quite rapidly. However, because the elderly who died following COVID-19 inoculation were very frail with multiple comorbidities, their deaths could easily be attributed to causes other than the injection (as should have been the case for COVID-19 deaths as well).

Now the objective is the inoculation of the total USA population. Since many of these potential serious adverse effects have built-in lag times of at least six months or more, we won't know what they are until most of the population has been inoculated, and corrective action may be too late.

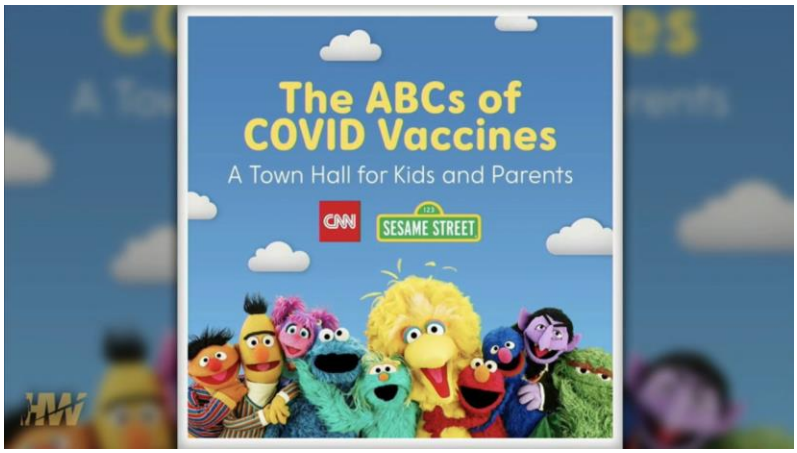


Note: ***Appendix A*** goes into great detail about the ***EXPECTED DEATHS IN 65+ DEMOGRAPHIC VS COVID-19 INOCULATION DEATHS.***
https://reader.elsevier.com/reader/sd/pii/S221475002100161X

End of excerpts

This picture pretty much sums it up nicely

Yet, this is kind of disgusting crap they are resorting to… (notice the Communist News Network CNN logo)



Study shows another mechanism for the way that the spike protein alone causes cardiovascular damage

A ***bioRxiv*** pre-print study titled, **The SARS-CoV-2 Spike protein disrupts human cardiac pericytes function through CD147-receptor-mediated signalling: a potential non-infective mechanism of COVID-19 microvascular disease** explores a fascinating mechanism for cardiovascular damage from the spike protein.

ABSTRACT

Severe coronavirus disease 2019 (COVID-19) manifests as a life-threatening microvascular syndrome. The severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) uses the Spike (S) protein to engage with its receptors and infect host cells. To date, it is still not known whether heart vascular pericytes (PCs) are infected by SARS-CoV-2, and if the S protein alone provokes PC dysfunction. Here, we aimed to investigate the effects of the S protein on primary human cardiac PC signalling and unction. Results show, for the first time, that cardiac PCs are not permissive to SARS-CoV-2 infection in vitro, whilst a recombinant S protein alone elicits functional alterations in PCs. This was documented as: increased migration, reduced ability to support endothelial cell (EC) network formation on Matrigel, secretion of pro-inflammatory molecules typically involved in the cytokine storm, and production of pro-apoptotic factors responsible for EC death. Next, adopting a blocking strategy against the S protein receptors angiotensin-converting enzyme 2 (ACE2) and CD147, we discovered that the S protein stimulates the phosphorylation/activation of the extracellular signal-regulated kinase 1/2 (ERK1/2) through the CD147 receptor, but not ACE2, in PCs. The neutralisation of CD147, either using a blocking antibody or mRNA silencing, reduced ERK1/2 activation and rescued PC function in the presence of the S protein. In conclusion, our findings suggest that circulating S protein prompts vascular PC dysfunction, potentially contributing to establishing microvascular injury in organs distant from the site of infection. This mechanism may have clinical and therapeutic implications.

From the study

Pericytes (PCs) are pleiotropic cells that wrap ECs. In the heart, they are abundantly associated with the coronary microvasculature. They support the integrity of coronary artery ECs (CAECs), participate in vascular remodelling and cardiac repair, and modulate inflammatory responses. Dysfunctional cardiac PCs were found in patients with severe myocardial disease. Dysfunctional PCs participate in adverse vascular phenomena; for

instance, after a heart attack, persistently contracted PCs block the coronary microvascular circulation, thereby causing blood to clot.

Clinical perspective

- Severe COVID-19 manifests as a microvascular syndrome, but whether SARS-CoV-2 infects and damages heart vascular pericytes (PCs) remains unknown.

- We provide evidence that cardiac PCs are not infected by SARS-CoV-2. Importantly, we show that the recombinant S protein alone elicits cellular signalling through the CD147 receptor in cardiac PCs, thereby inducing cell dysfunction and microvascular disruption in vitro.

- This study suggests that soluble S protein can potentially propagate damage to organs distant from sites of infection, promoting microvascular injury. Blocking the CD147 receptor in patients may help protect the vasculature not only from infection, but also from the collateral damage caused by the S protein.

The S protein also activated or enhanced the production of pro-inflammatory cytokines by cardiac PCs. MCP1, IL-6, IL-1β and TNFα are typical components of the cytokine storm associated with respiratory failure and high mortality in COVID-19 patients. (38, 49) This pro-inflammatory secretome could produce harmful paracrine effects on the surrounding vascular cells, as our experiment on CAEC apoptosis suggests. This mechanism can propagate functional alterations even to those cell populations which may not be directly infected by the virus, ultimately contributing to vascular disruption.

Scroll to next page for large image…

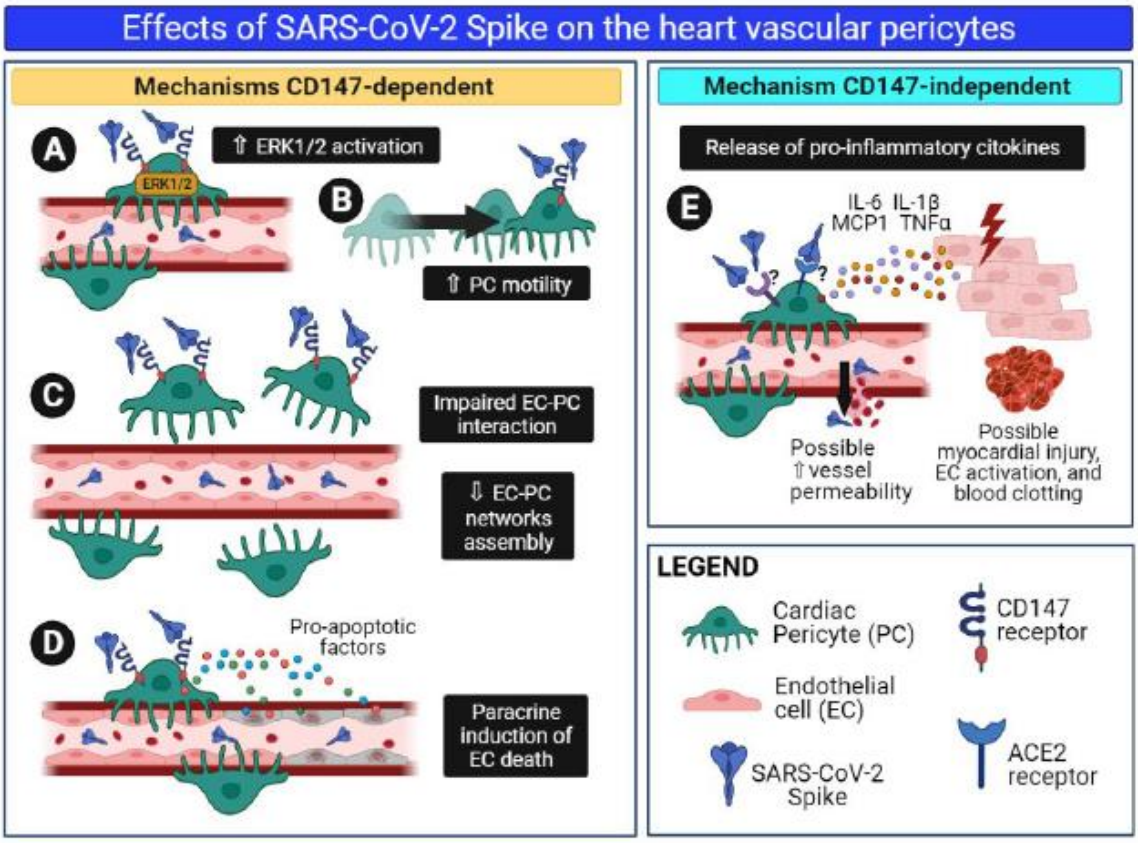


Figure 9. The SARS-CoV-2 S protein alters cardiac pericyte function. Schematic summary of the research. We hypothesize that in patients with acute COVID-19, S protein molecules are cleaved from the virus particle and released from the respiratory system into the bloodstream. Through the circulation, isolated S protein fragments reach all organs of the body, including the heart. Here, the interaction of the S protein with the CD147 receptor on cardiac PCs triggers the ERK1/2 signalling **(A)** and provokes PC dysfunction, including increased cell motility **(B)** and decreased angiogenic activity in cooperation with coronary ECs **(C)**. In addition, the S protein-CD147 interaction prompts cardiac PCs to release pro-apoptotic factors, which cause EC death **(D)**. Finally, through a mechanism CD147-independent, the S protein induces PCs to release pro-inflammatory cytokines, which include MCP-1, IL-6, IL-1β, and TNF-α **(E)**. These cytokines can damage neighbouring cardiomyocytes and activate ECs, potentially promoting blood to clot and increasing vascular permeability.

In conclusion, although more investigation being needed to definitively prove the harmful effects of the S protein on the heart PCs and associated microvasculature in vivo, this work suggests that fragments of the S protein may elicit vascular cell dysfunction through CD147, independently from the infection. This mechanism has the potential to spread cellular and organ injury beyond the infection sites and may have important clinical implications. For instance, in patients with disrupted endothelial barrier and increased vascular permeability due to underlying diseases, such as hypertension, diabetes, nd severe obesity, S protein molecules could easily spread to the PC compartment and cause, or exacerbate, microvascular injury. Blocking the CD147 receptor may help protect the vasculature of the most vulnerable patients from infection and the collateral damage caused by the S protein.

End of excerpts

https://www.biorxiv.org/content/10.1101/2020.12.21.423721v2

This could further explain why so many adverse cardiovascular events are being seen from the COVID-19 shots as this study clearly shows that the virus (infection) is not necessary to cause the damage, just the spike protein alone. And, that toxin is what the geniuses behind the development of the gene therapy that hundreds of millions of people are currently being injected with decided to force recipient's cells to make and distribute throughout people's bodies by the billions.

Pfizer under-reported the number of deaths in the vaccinated cohort in their clinical trial. The numbers extrapolated to all vaccinated individuals is massive

The six-month trial reporting date considered data up until March 13th, 2021. At that time Pfizer reported 15 deaths in the vaccinated group compared to 14 deaths in the placebo group.

"All cause mortality" is one of the most important data points to track in any drug or vaccine trial. By tracking all cause mortality over an extended period of time you can get an idea as to whether the intervention group has a higher risk of death from various causes over the course of months or years.

See the chart below on ALL-CAUSE MORTALITY that was originally reported from the Pfizer trial...

Reported Cause of Death[a]	BNT162b2 (N=21,926) n	Placebo (N=21,921) n
Deaths	15	14
Acute respiratory failure	0	1
Aortic rupture	0	1
Arteriosclerosis	2	0
Biliary cancer metastatic	0	1
COVID-19	0	2
COVID-19 pneumonia	1	0
Cardiac arrest	4	1
Cardiac failure congestive	1	0
Cardiorespiratory arrest	1	1
Chronic obstructive pulmonary disease	1	0
Death	0	1
Dementia	0	1
Emphysematous cholecystitis	1	0
Hemorrhagic stroke	0	1
Hypertensive heart disease	1	0
Lung cancer metastatic	1	0
Metastases to liver	0	1
Missing	0	1
Multiple organ dysfunction syndrome	0	2
Myocardial infarction	0	2
Overdose	0	1
Pneumonia	0	2
Sepsis	1	0
Septic shock	1	0
Shigella sepsis	1	0
Unevaluable event	1	0

Table S4 | Causes of Death from Dose 1 to Unblinding (Safety Population, ≥16 Years Old). a. Multiple causes of death could be reported for each participant. There were no deaths among 12–15-year-old participants.

file:///C:/Users/drpal/AppData/Local/Temp/media-1-1.pdf
But in the ***Summary Basis for Regulatory Action*** released **on November 8th, 2021** explaining why it approved the Pfizer product on August 23rd, 2021. On page 23 of the summary, the following was reported…

"From Dose 1 through the March 13, 2021 data cutoff date, there were a total of 38 deaths, **21 in the COMIRNATY group and 17 in the placebo group**. None of the deaths were considered related to vaccination." Why does this number conflict with what was reported in July as evidenced by the table above, considering the cut-off date for the data cited in both reports was March 13th, 2021? What changed? Where were the missing deaths? Wouldn't you think that would be THE most important metric to track?

How does that extrapolate to extra deaths in the entire vaccinated population?

The difference between 21 deaths and 17 deaths is 19% lower in the non-vaccinated. That doesn't sound like a big differential, but when you're comparing that number of deaths in that study population 2 what the potential difference in deaths would be for the general population it can be a significant difference. Currently there are 195,275,904 Americans fully vaccinated (59%) as of November 15th, 2021.
https://usafacts.org/visualizations/covid-vaccine-tracker-states/

Let's look at the math…

17/21 X 100 = 80.95% 100% – 80.95% = 19.05% lower in the unvaccinated group.

There were 21 deaths (all cause) in the vaccinated group- 21/21,720 people = 0.096%

There were 17 deaths (all cause) in the unvaccinated group- 17/21,728 people = 0.078%

Rounding the number of vaccinated Americans to 200 million.

- **Multiply that by the rate of all-cause death in the vaccinated group 0.096% = 19,200,000**

Taking the same number (200 million) unvaccinated to compare apples to apples…

- Multiply that by the rate of all-cause death in the unvaccinated group 0.078% = 15,600,000

Subtracting 15,600,000 from 19,200,000 = 3,600,000 (three million, six hundred thousand) more excess deaths in the vaccinated population than the same number of unvaccinated people. Now you can see how that difference of 4 people in that small number in the trial becomes HUGE when it is extrapolated to the real-world numbers. That is not saying that definitively 3.6 million people will have died from the vaccine by now, but it does beg the question, why would the all-cause deaths be so much higher in vaccinated people?

More questions

In another statement, a question remains…**Why were only 60% of the 2 groups participating in the trial followed for greater than 4 months?**

From the summary: (emphasis mine)

The population for the updated vaccine efficacy analysis per protocol included participants 16 years of age and older who had been enrolled from July 27, 2020 and followed for the development of COVID-19 during blinded

placebo-controlled follow-up through March 13, 2021, representing up to ~6 months of follow-up after Dose 2. **Overall, 60.8% of participants in the COMIRNATY group and 58.7% of participants in the placebo group had ≥4 months of follow-up time after Dose 2 in the blinded placebo-controlled follow-up period.** The overall VE against COVID-19 in participants without evidence of prior SARS-CoV-2 infection was 91.1% (95% CI: 88.8 to 93.1). The overall VE against COVID-19 in participants with or without evidence of prior SARS-CoV-2 infection was 90.9% (95% CI: 88.5 to 92.8).

https://www.fda.gov/media/151733/download

From Pfizer's website about the Phase 3 clinical trial…

Who participated or was able to participate in the landmark Phase 3 study?

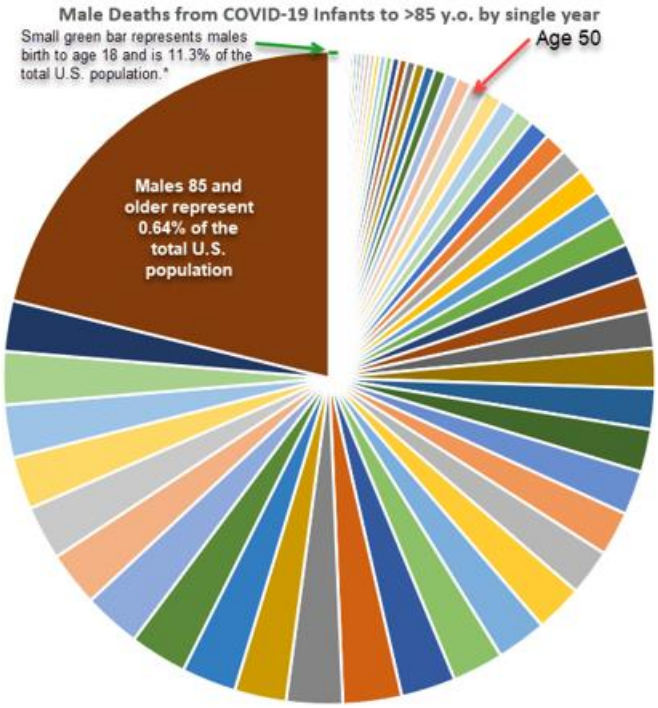
We enrolled 46,331 people in the trial, **with the majority of participants ranging from ages 16-56**. Additional trial populations included people as young as 12 years old and people with chronic, stable human immunodeficiency virus (HIV) (), Hepatitis C virus (HCV), or Hepatitis B virus (HBV) infections. We believe that doing so enabled more individuals who were at risk of COVID-19 disease to have the opportunity to participate in the study. As with the vaccine candidates we test in adult populations, we followed a careful, stepwise approach as we moved down to younger age groups.

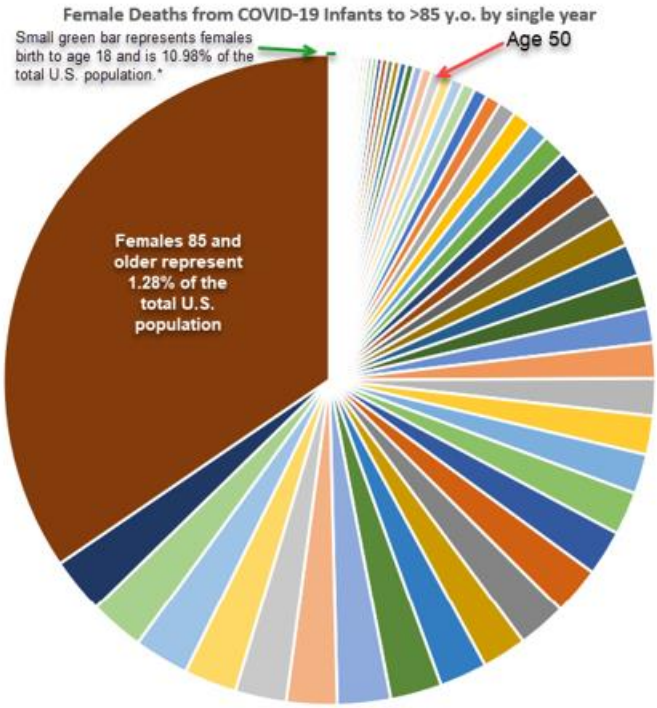
https://www.pfizer.com/science/coronavirus/vaccine/about-our-landmark-trial

What about the most vulnerable to COVID-19, the elderly?

As you can see from the portion I bolded in the last paragraph above, they didn't even test the vaccines in numbers that were proportional to the most vulnerable population, the elderly. Approximately 60% of the study subjects were younger than 57 years of age. As can be seen from the mortality (death from COVID-19) pie charts below which I highlighted in last month's newsletter, the deep brown largest piece of the pie for both males and females, represents the age demographic 85 years and older. Each slice after that large brown piece represents a single year of life. So, the first slice moving counterclockwise from the large deep brown piece is 84 years old, the second slice 83 years old, etc. Look at where I have marked the slice for age 50 and then just move 6 slices clockwise to that gray colored slice which represents age 56. Now consider the "majority" of the population in their clinical trial (16-56) was everything from that point counterclockwise to where the slices are so thin, they become invisible. Since the most vulnerable population is in excess of 70 years old, why wouldn't that demographic makeup the largest and most important part of the clinical trial? Since that population is by far the most impacted by the disease, wouldn't it make sense to see how effective the product was for them? And what the risks are for them? Unfortunately, as we've seen from the data since the release of the vaccines, the most elderly and frail are also at the greatest risk of death from the vaccines. Is it possible that they did not want to expose a larger percentage of the elderly test subjects that potential danger and risk a greater safety signal?

See the graph next page…





CDC data used: https://data.cdc.gov/resource/3apk-4u4f.csv

As of October 23rd, 2021…

Age 85 and over = 1.8% of the population yet accounts for 198,648 of the COVID-19 deaths.

Age birth to 18 = 22.3% of the population yet accounts for 558 of the COVID-19 deaths.

Co-morbidities

The other important consideration is that they chose people who were for the most part, healthy. That just does not represent the standard American. The United States has one of the highest rates of chronic disease in the world. Quite honestly, that is one of the main reasons why we have such a high mortality rate from COVID-19. Our rates of obesity, hypertension, diabetes, kidney disease and immunological deficiency diseases are some of the highest in the world. Since those individuals even if younger, are at greatest risk from COVID-19, wouldn't it have made perfect sense to select a representative population to test the vaccines on?

The trial reports said the following: “35% were obese (body mass index [the weight in kilograms divided by the square of the height in meters] of at least 30.0), and 21% had at least one coexisting condition.” If accurate, that is still short of the percentage of obese individuals in the U.S. The CDC’s website says that he US obesity prevalence was 42.4% in 2017 – 2018. https://www.cdc.gov/obesity/data/adult.html. In 2020, it is likely that it has increased from there. And, considering the statistics about weight gain during the lockdowns and gym closures. According to a CNBC article posted April 09, 2021, “42% of U.S. adults reported undesired weight gain due to Covid-19, according to a recent survey by the American Psychological Association. Average increase: 29 pounds.” When the Phase 3 trials were designed, it had become apparent that this trend was rising rapidly.

As far as the comment that the 21% of the study participants had at least "one coexisting condition", again that far undershoots both the national average for one chronic disease and 42% have more than one https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm . And consider the fact that the CDC now states that the average number of co-morbidities people that did not survive COVID-19 was four or more.

"Among 36,523 participants who had no evidence of existing or prior SARS-CoV-2 infection by the time of the immunizations…" There were 43,448 participants. That leaves 6,925 that have had COVID previously. I would like to know what group they went into. I could not find that information anywhere. If they were selected as part of the vaccine group, their natural immunity would certainly give them a major advantage against getting COVID during the trial.

Now that we have seen how minuscule the risk from COVID-19 is for children and teens, how about the risk from the vaccines?

Before I launch into this month's additions to the accumulating evidence that I have been providing over the last several months, I would like to make you aware of a free download I have on my web site. It looks at the risks from COVID-19 for children versus the risks of the vaccines. I just updated it the first part of November, so the data, the studies and the links have been updated. Download your copy here. Please feel free to share the link on social media. https://www.wellnessdoc.com/the-risk-vs-reward-of-the-covid-19-vaccines-for-children/

Brilliant presentation by Steve Kirsch at the October VRBPAC Meeting October 26th, 2021 on considering the COVID-19 shots for 5-11 year old children

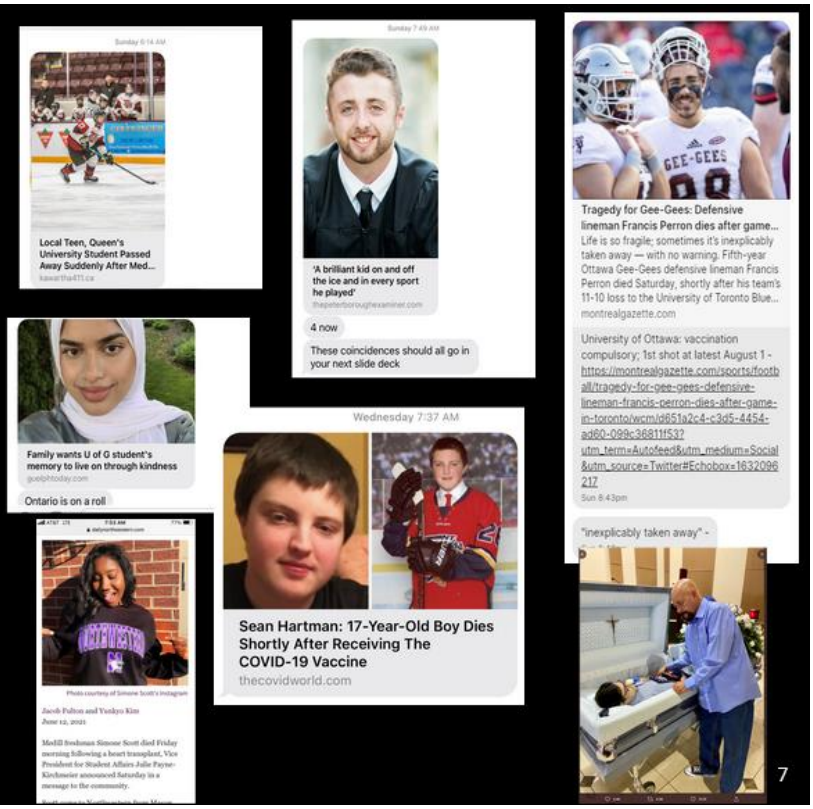
Steve Kirsch is the Executive Director of the ***COVID-19 Early Treatment Fund***. His presentation was 191 slides long and he did a beautiful job of making his case for denying approval of these shots for children. Unfortunately, these meetings never give the presenters enough time to present that volume of information, but he really nailed it with the time he had. And his presentation covers a massive amount of critical information for doctors, politicians, adults and parents of children to consider before deciding to inject anyone with these experimental products.

Now, let's get to it. To start I want to show you some slides from a presentation that Steve Kirsch did on October 26th, 2021, at the VRBPAC meeting to consider recommendations for approving the shots for 5-11 year-olds. Steve is the Executive Director of the ***COVID-19 Early Treatment Fund***. His presentation is excellent and I thought I would share just a few select slides with you to give you a flavor of the work that he has done. I'll put a link to the presentation at the end so you can access it.

Begin next page…

Why are kids **dropping like flies** right after getting vaccinated?

If they didn't die from the vaccine, then what killed all these kids?



Why did this 15 year-old die in his sleep?

Just 2 days after getting vaccinated.

VAERS ID: 1382906

Sonoma County Sheriff's Office
Mark Essick, Sheriff-Coroner
Coroner Investigations Unit
3336 Chanate Road, Santa Rosa, CA 95404
(707) 565-5070

DEATH INVESTIGATION SYNOPSIS REPORT

CORONER CASE #: 21-0000670

INCIDENT INFORMATION

LAW ENFORCEMENT AGENCY WITH JURISDICTION	REPRESENTATIVE TITLE AND NAME	AGENCY CR #: ☐ N/A
Santa Rosa Police Department	Officer Jose Andrade #568	21-0006115

MANNER OF DEATH	DATE/TIME RECEIVED
Undetermined	06/07/2021 14:35

DECEDENT INFORMATION

DECEDENT'S NAME (FIRST, MIDDLE, LAST)	AGE
[redacted]	15 yrs

DEATH INFORMATION

PLACE OF DEATH (Facility Name or Address Location)	DATE OF DEATH	TIME OF DEATH
[redacted]	06/07/2021 [Found]	14:04 [Found]

SYNOPSIS

The decedent was found unresponsive in his bedroom after his mother was checking on his welfare long after he was supposed to wake in the morning. The decedent was pronounced dead at the scene due to obvious death. The decedent had been in good health with no medical history and had received his second Pfizer COVID-19 Vaccination approximately two days before his death.

The decedent's body was transported to the Sonoma County Morgue Facility, where he was registered for a postmortem examination by a forensic pathologist.

After extensive research, additional testing, and collaboration with numerous other entities, the cause of death was determined to be: **"STRESS CARDIOMYOPATHY WITH PERIVASCULAR CORONARY ARTERY INFLAMMATION (hours to days),** due to, **UNKNOWN ETIOLOGY IN SETTING OF RECENT PFIZER-BIONTECH COVID-19 VACCINATION (days)."** There were no other significant conditions contributing to the death listed.

Since the etiology of the stress cardiomyopathy with perivascular coronary artery inflammation was unknown but was in the setting of a recent Pfizer-Biontech Covid-19 vaccination, I mannered this death as "**UNDETERMINED**," which was consistent with the circumstances and cause.

How can a healthy 16-year-old boy die in the middle of his zoom math class?

He was fine 20 minutes before he died.

lifesitenews.com

Healthy 16-year-old boy dies during online class after second Pfizer jab: VAERS database - ...

How did you miss all these safety signals?

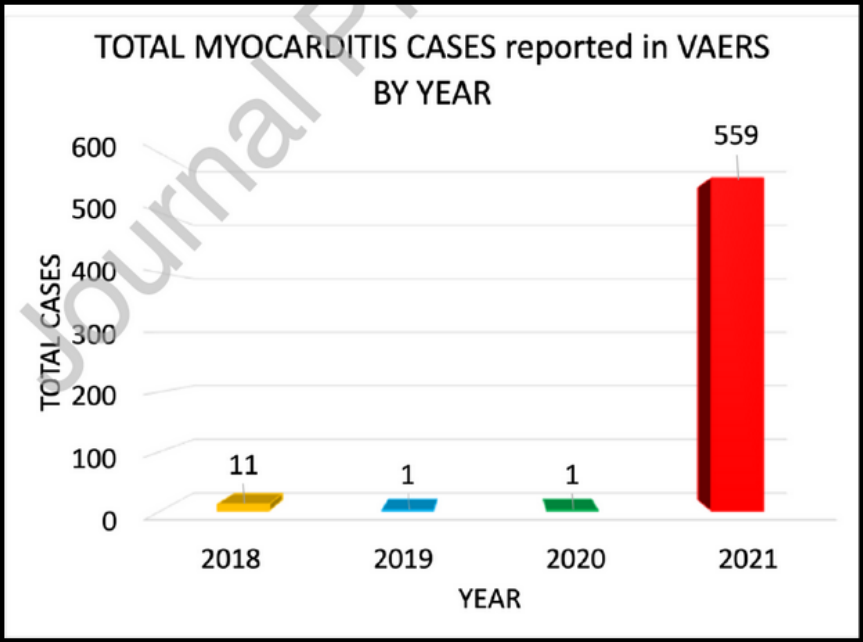
Doesn't this explain the deaths?

Note: this list is just a small subset of >1,000 symptoms that are elevated by these vaccines

Symptom	X factor
Pulmonary embolism	570
Thrombosis	360
Myocarditis	118
Ischaemic stroke	80
Deep vein thrombosis	72
Cardiac arrest	65
Aphasia	42
Blindness	32
Death	29
Haemorrhage intracranial	20

Increased VAERS reporting rate in 15-24 year olds vs. avg rate over 5 years computed from VAERS data on Oct 22, 2021 by Steve Kirsch

Is this what you mean by "slightly elevated" risk?

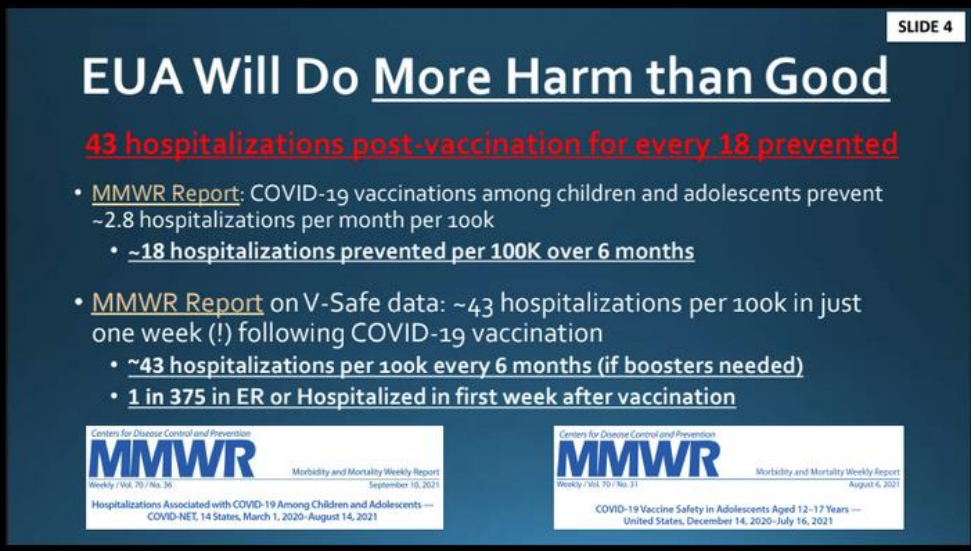


From the Rose paper

Guetzkow FDA presentation

We'll hospitalize more kids than we'll save from hospitalization.

Vaccines more dangerous to kids than COVID



https://tinyurl.com/HoldTheLineFDA

Do you find this recent UK headline troubling?

Children are up to 16 times more likely to die with Covid-19 if they've had the Covid Vaccine according to latest UK Health Security Agency report

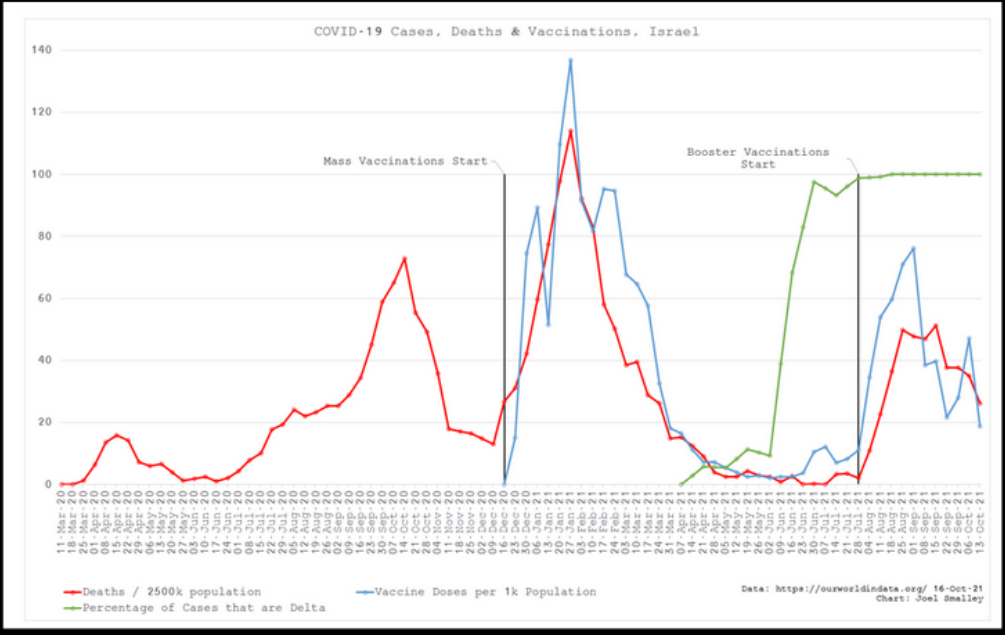
by Daily Expose

The latest report from the UK Health Security Agency shows that the Chief Medical Officer (CMO) for England's decision to recommend all children over the age of 12 should be vaccinated against Covid-19 was a huge mistake because the data shows children are 16 times more likely to die with Covid-19 if they have been [...]

Read more of this post

Source: https://theexpose.uk/2021/10/22/children-up-to-16-times-more-likely-to-die-with-covid-19-if-vaccinated/

How come deaths in Israel go up when vaccinations go up? And go down when vaccinations go down?



Why won't anyone at CDC or FDA disclose the VAERS underreporting factor (URF) for this year?

How can you do a proper risk benefit analysis if you don't know the URF?

URF?

Reason: John Su at the CDC never calculated it. He will never calculate it because it would blow the narrative. But the outside committees and mainstream media never ask about it so it is OK.

16

Using a URF of 41 (calculated using the CDC methodology), we find over 300,000 excess deaths in VAERS.

If the vaccine didn't kill them, what did?

300,000

Excess deaths

17

That's just a small sample of the 193 slides in his presentation!

You can access his slide show here… https://docs.google.com/presentation/d/1qJRRFt7PkLTJSv0P-JKWP6YUB4Axa2gtROqpMJ9HkYY/edit#slide=id.gfa0a9bff83_0_599

Does the vaccine efficacy study from Sweden I highlighted last month disclose an increased rise in deaths after the vaccines?

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. But does it also unintentionally signal something else?

Alex Berenson's Substack

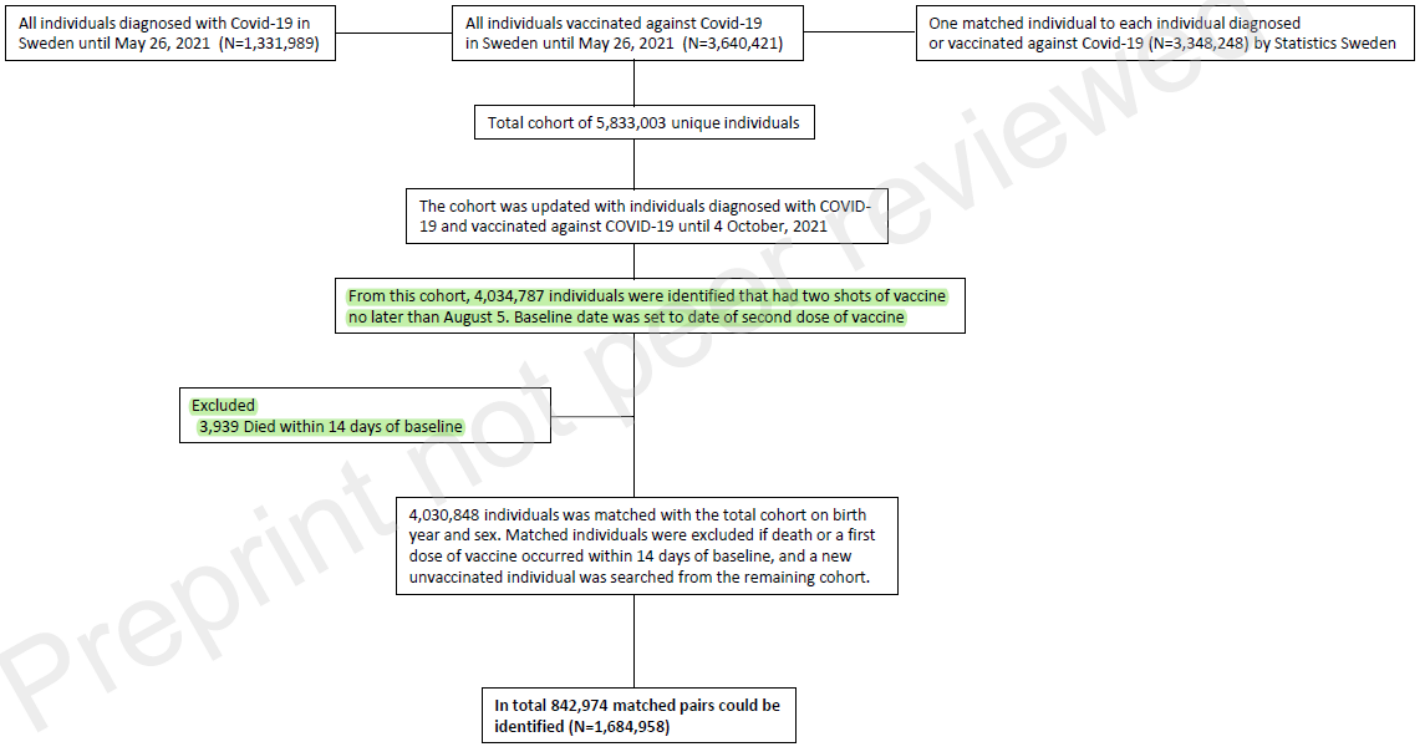
People appear to die at rates 20 percent or more above normal for weeks after receiving their second Covid vaccine dose, according to data from a huge Swedish study.

The figures are buried in a preprint paper on vaccine effectiveness released last month. The headline finding of the paper was that protection against Covid, including severe cases, plunged after six months.

The researchers did not explicitly examine deaths from all causes - which have risen since the summer in many countries that have highly vaccinated populations.

But on page 32 of the 34-page report, a chart shows that 3,939 of 4.03 million Swedes who received the second dose died less than two weeks later.

Figure 1, page 32



Over a one-year period, that rate of death would translate into an annual mortality rate of about 2.5 percent a year - 1 person in 40 - almost *three times* the overall Swedish average. In a typical year, about 1 in 115 Swedes dies.

Of course, that huge gap does not account for an important confounding factor: younger people, who have a much lower risk of death, were less likely to be vaccinated.

But Sweden also provides detailed data on overall deaths nationally, making a crude baseline comparison possible.

That data shows that from an average of about 1,650 Swedes died every week between 2015 and 2019 between April 1 and early August, the period in which almost all of those 4 million Swedes in the study received their second dose. Death rates hardly varied over those years.

(SOURCE: https://www.scb.se/en/finding-statistics/statistics-by-subject-area/population/population-composition/population-statistics/)

In other words, during the spring and summer, Sweden normally has about 3,300 deaths every two weeks - not just in the people who received vaccines, but in all 10.6 million of its people.

So let's make an incredibly conservative assumption, one that strongly favors the vaccines. (The next couple paragraphs are a bit tricky, but I hope the payoff is worth taking the time to read and think through them.)

Assume that the group of people who received vaccines were so much older and unhealthier than those who didn't that they would have accounted for *every single death* in Sweden whether or not they were vaccinated. In other words, assume that even if the vaccines did not exist, every person in Sweden who died would have been part of that group of 4.03 million people the researchers tracked - while not one other person would have died.

In that case, those 4.03 million people "should" have about 3,300 deaths every two weeks. They CANNOT HAVE MORE - because all of Sweden does not have more.

But the vaccines do exist. Those 4.03 million people received them. And in the two weeks after receiving the second vaccine dose, as a group, the researchers reported they had not about 3,300 deaths, but 3,939.

And 3,939 deaths is about 20 percent more deaths than "should" have occurred in those two post-vaccine weeks. Again, the 20 percent figure understates the real gap, because in the real world some deaths will occur in the 6.6 million unvaccinated people too, so the actual baseline number for the vaccinated group is not 3,300 deaths but somewhat lower.

Unfortunately, the researchers did not report any details on the deaths, so it is impossible to know if they are disproportionately cardiovascular. It is also impossible to know whether one particular vaccine was disproportionately linked to deaths. (Sweden used mostly the Pfizer mRNA vaccine, as well as some of AstraZeneca's DNA/AAV vaccine, which is not available in the United States, and a small amount of Moderna's mRNA vaccine.)

Of course, it is just possible the extra deaths are due to chance. Or that the handful of elderly Swedes who received vaccines in February and March accounted for a hugely disproportionate number of the post-vaccine deaths. (Because per-week Swedish death rates are higher in the winter, a large number of post-vaccine deaths in those months would somewhat reduce the strength of the signal, though it would still exist.)

But the caveats aside, the Swedish figures offer a very large real-world dataset apparently showing a notable increase in all-cause mortality directly following Covid vaccination.

They are yet another piece of evidence in an increasingly worrying picture - alongside case and anecdotal reports, a known link to heart inflammation in young men, the updated Pfizer clinical trial data revealing a numerical imbalance in deaths in vaccinated people, and most importantly the general rise in all-cause mortality in many countries.

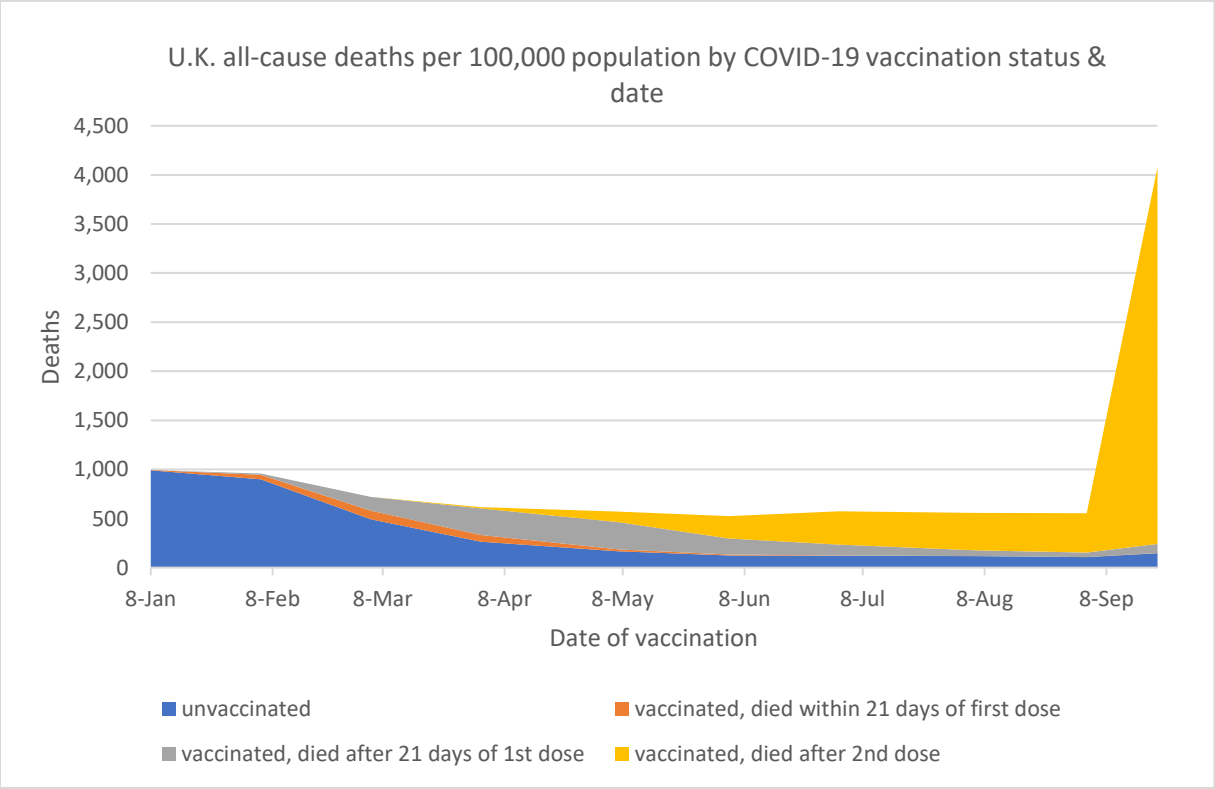
And all of these red flags come for vaccines that - if the Swedish data are correct - may actually raise the risk of Covid infection after about eight months. Yes, RAISE. See how that black line drops below the zero level on the top chart? That represents negative effectiveness, which is another way to say people who are vaccinated are MORE likely to be infected than those who aren't.

And, as the second chart shows, effectiveness against severe Covid infection is also spiraling towards zero.

Increase in all-cause deaths in the UK by vaccination status shows significant increase after the second dose

This data comes directly from the UK's Office for National Statistics (ONS). It shows a troubling trend of increasing all-cause mortality after people have had their second dose of the COVID-19 shots.

The data is described as… **Table 4: Weekly age-specific mortality rates by vaccination status for all deaths, per 100,000 people, England, deaths occurring between 2 January 2021 and 24 September 2021** [1,2,3,4,5,6,7,8]



https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsbyvaccinationstatusengland

***Percentages of population vaccinated for this next section** come from https://ourworldindata.org/covid-vaccinations and choosing only the UK.

As of the 10th of January, the UK only had 3% of their population partially vaccinated and 0.6% fully vaccinated. That is why at the beginning or left side of this graph you cannot see any color other than blue denoting the all-cause deaths in the unvaccinated population. Naturally 100% of all-cause deaths per 100,000 people would be in unvaccinated individuals.

On the above chart, May 15th, 2021, appears to be the point at which approximately the same number of all-cause deaths came from both the unvaccinated population and the population that was fully vaccinated. Yet only 29% of the population was fully vaccinated at that point.

A Dramatic shift in deaths in the vaccinated population

What is most concerning about the data coming out of the UK is that as time goes on, we see a dramatic acceleration of the number of all caused deaths in the vaccinated population. The graph above is a visual representation of that, **but what do the real numbers look like between August 6th and September 21st?**

What percentage of the population is fully vaccinated?

As of August 6th, 58% of the UK's population had been fully vaccinated. By September 24th, that number rose to 65%.

What is the difference in all-cause mortality of the vaxxed vs. unvaxxed during that period?

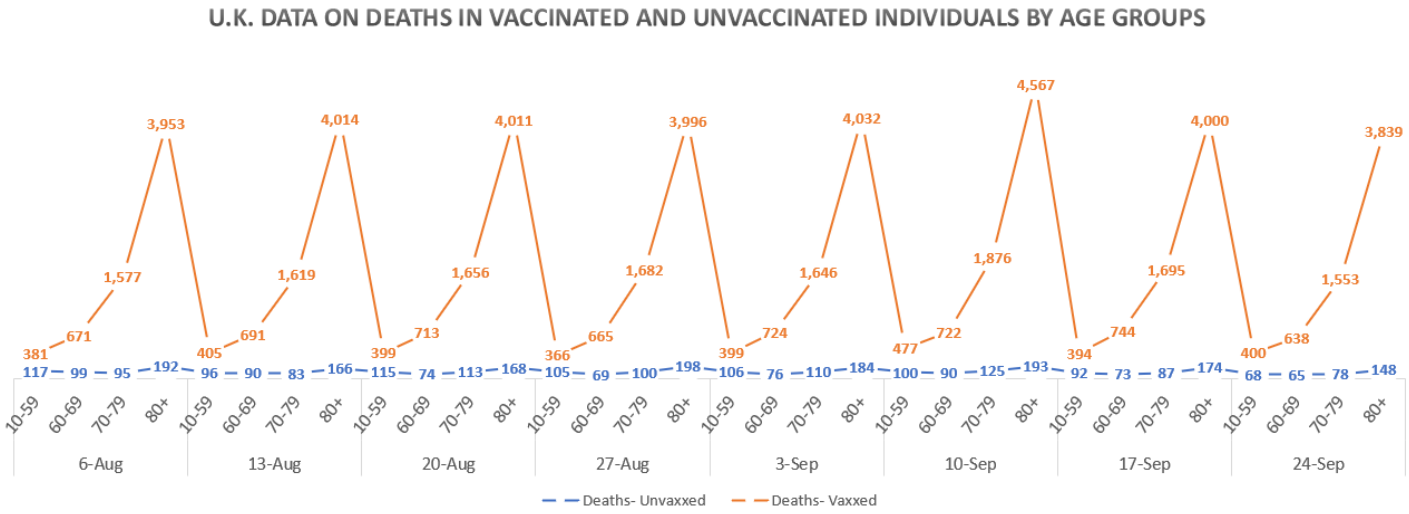
- The number of all cause deaths in the unvaccinated population between those dates was 3,649, or 6.27% of all-cause deaths.

- The number of all caused deaths in the fully vaccinated population between those dates was 54,505, or 93.73% of all-cause deaths.

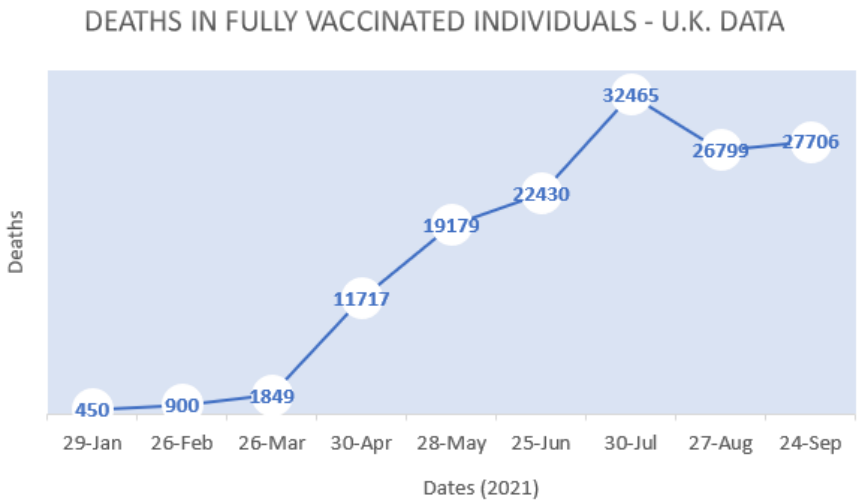
For the portion of the population that is fully vaccinated (at 68% as of November 28th, 2021), to represent nearly 94% of all deaths in the UK for all age groups is a safety signal that something is seriously wrong!

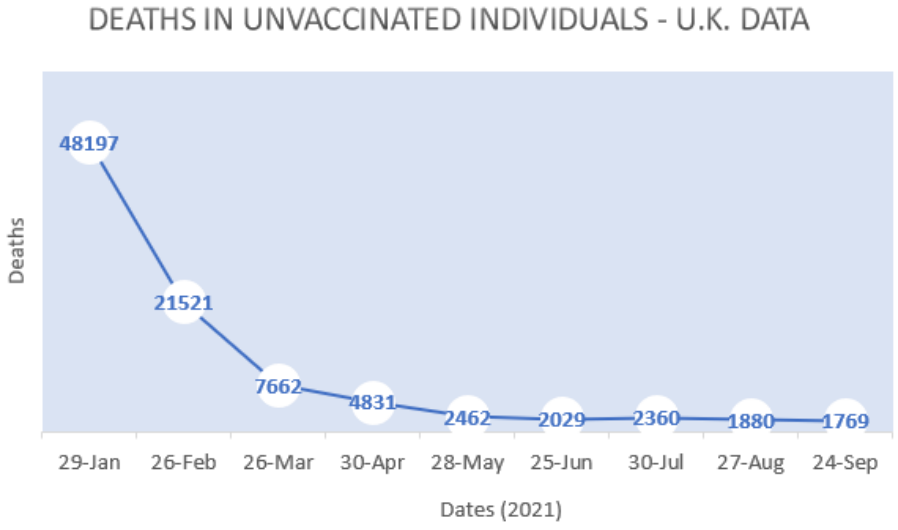
Another way to look at this of course is that unvaccinated people at around 32% of the population account for just over 6% of total deaths. And keep in mind that the countries where this is happening are one to two months ahead of the United States in their vaccine programs. Fortunately, the government of the United Kingdom is being forthright in their reporting. It gives countries like the United States the opportunity to change course, but only if the leadership observes the warning signs and does so. Think about it like two ships at sea traveling through a storm, with the ship in the rear charting the same course as the one ahead. And a distress signal being radioed by the one ahead that they have just hit a reef and run aground. The fate of that second ship is in the hands of the captain who must make a decision as to continue the same course or to deviate and avoid sure destruction. Will our government take the evasive action necessary to avoid a calamity?

A graphic example of what that looks like…



How does the data look when comparing vaccinated and unvaccinated individuals throughout 2021 up to September 24th, 2021?





Before releasing this month's issue, I decided to look at the very latest ***Public Health England Surveillance Report number 47***, reporting data between weeks 43 and 46.

This is a disclaimer that they have on the page. It attempts to rationalize the higher numbers for vaccinated individuals. This is what it says.

In the context of very high vaccine coverage in the population, even with a highly effective vaccine, it is expected that a large proportion of cases, hospitalisations and deaths would occur in vaccinated individuals, simply because a larger proportion of the population are vaccinated than unvaccinated and no vaccine is 100% effective. This is especially true because vaccination has been prioritised in individuals who are more susceptible or more at risk of severe disease. Individuals in risk groups may also be more at risk of hospitalisation or death due to non-COVID-19 causes, and thus may be hospitalised or die with COVID-19 rather than because of COVID-19.

Let's see if that explanation stands up.

I looked at table numbers 10a and 10b and crunched some numbers.

Public Health England Surveillance Report 0n COVID-19 deaths for week 47 by age & vax status

Death within 60 days post diagnosis						**Death within 28 days post diagnosis**			
	unvaxxed	**vaxxed**				**unvaxxed**	**vaxxed**		
Under 18	10	0				8	0		
18-29	9	5				9	2		
30-39	32	15				28	11		
40-49	62	61				51	46		
50-59	134	158				108	126		
60-69	181	452				154	380		
70-79	175	996				163	846		
80 and up	207	1787				187	1492		
	810	3474	Total =	4284		708	2903	Total =	3611
Percent of 4284	18.91	81.09			Percent of 3611	19.61	80.39		

It appears that about 81% of the deaths are in vaccinated individuals across all age demographics. With the percentage of the population hovering around 66 to 68% during this time frame, that is an inordinate percentage of the COVID-19 deaths occurring in the vaccinated. Isn't lowering chances of severe disease or death the default narrative that they went to when they had to finally admit that the shots don't stop infection or transmission? That you are still as likely to get infected if you are vaccinated? This should be the final nail in the coffin of the "vaccine" program. But don't expect any of them to come clean on any of this any time soon.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1036047/Vaccine_surveillance_report_-_week_47.pdf

Here are the two tables for easy comparison to my spreadsheet…

Table 10. COVID-19 deaths (a) within 28 days and (b) within 60 days of positive specimen or with COVID-19 reported on death certificate, by vaccination status between week 43 and week 46 2021
Please note that corresponding rates by vaccination status can be found in Table 11.
(a)

Death within 28 days of positive COVID-19 test by date of death between week 43 and week 46 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]
	[These data should be interpreted with caution. See information below in footnote about the correct interpretation of these figures]					
Under 18	9	1	8	0	0	0
18-29	13	0	9	0	2	2
30-39	44	1	28	0	4	11
40-49	104	3	51	0	4	46
50-59	250	5	108	0	11	126
60-69	555	3	154	0	18	380
70-79	1025	6	163	1	9	846
≥80	1,726	7	187	5	35	1,492

*individuals whose NHS numbers were unavailable to link to the NIMS
** number of deaths of people who had had a positive test result for COVID-19 and either died within 60 days of the first positive

(b)

Death within 60 days of positive COVID-19 test by date of death between week 43 and week 46 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]
	[These data should be interpreted with caution. See information below in footnote about the correct interpretation of these figures]					
Under 18	12	1	10	0	1	0
18-29	16	0	9	0	2	5
30-39	52	1	32	0	4	15
40-49	132	4	62	0	5	61
50-59	312	6	134	0	14	158
60-69	658	5	181	0	20	452
70-79	1,195	7	175	1	16	996
≥80	2,054	7	207	6	47	1,787

*individuals whose NHS numbers were unavailable to link to the NIMS

** number of deaths of people who had had a positive test result for COVID-19 and either died within 60 days of the first positive test or have COVID-19 mentioned on their death certificate

Reporting of vaccine effectiveness uses a deceptive tactic to make it sound better than it really is

I have covered this topic in the past looking at the dishonest way that relative risk reduction (RRR) is used when describing the effectiveness of a drug or vaccine. By selectively choosing that metric and leaving out the absolute risk reduction (ARR) and number needed to treat or to vaccinate (NNT or NNV), it portrays a completely disingenuous and inflated appearance of benefit. I ran across the following article this month that discusses much of this again, plus adds some really great nuances to it.

The article written by investigative journalist and PhD Mary Anne Demasi and published on her site November 11th is titled, **COVID-19 vaccine benefits exaggerated say experts**.

In February, Federal Health Minister Greg Hunt boasted that AstraZeneca's COVID-19 vaccine offered "100% protection" against death in the primary analysis of phase III trials.

It was repeated by the CEO of AstraZeneca and uncritically reported by the mainstream media in what seemed to be an impressive achievement.

The published study in ***The Lancet***, however, revealed a more nuanced picture.

In the trial of 23,848 subjects across the UK, Brazil, and South Africa, there was **one death** in the placebo group and **no deaths** in the vaccinated group.

One less death out of a total of one, indeed, was a relative reduction of **100%** but the absolute reduction was **0.01%**. (1/11,724 – 0/12,021)

Similarly, in February the CDC director Rochelle Walensky co-authored a publication in JAMA, which stated unequivocally:

"Clinical trials have shown that the vaccines authorized for use in the US are highly effective against COVID-19 infection, severe illness, and death."

However, there were too few deaths recorded in the controlled trials at the time to arrive at such a conclusion.

The 6 month follow up data from the blinded Pfizer trial found there were **15 deaths** in the vaccine group and **14 deaths** in the placebo group. (see table S4)

Reported Cause of Death[a]	BNT162b2 (N=21,926) n	Placebo (N=21,921) n
Deaths	15	14
Acute respiratory failure	0	1
Aortic rupture	0	1
Arteriosclerosis	2	0
Biliary cancer metastatic	0	1
COVID-19	0	2
COVID-19 pneumonia	1	0
Cardiac arrest	4	1
Cardiac failure congestive	1	0
Cardiorespiratory arrest	1	1
Chronic obstructive pulmonary disease	1	0
Death	0	1
Dementia	0	1
Emphysematous cholecystitis	1	0
Hemorrhagic stroke	0	1
Hypertensive heart disease	1	0
Lung cancer metastatic	1	0
Metastases to liver	0	1
Missing	0	1
Multiple organ dysfunction syndrome	0	2
Myocardial infarction	0	2
Overdose	0	1
Pneumonia	0	2
Sepsis	1	0
Septic shock	1	0
Shigella sepsis	1	0
Unevaluable event	1	0

Table S4 | Causes of Death from Dose 1 to Unblinding (Safety Population, ≥16 Years Old). a. Multiple causes of death could be reported for each participant. There were no deaths among 12–15-year-old participants.

NOTE: In the open label phase, another 5 deaths occurred in the vaccine group (2 were in the original placebo group but swapped to the vaccine group after unblinding).

Last week, at a roundtable meeting in the US Capitol, Prof Peter Doshi, associate editor of *The BMJ* raised concerns about the statements made by the CDC director. *(**My comment:** That was the meeting/hearing I highlight in this issue, that Senator Ron Johnson from Wisconsin held to bring attention to the problem with COVID-19 vaccine injuries and deaths. In addition, the complete shunning of the people that have been injured or have died by our government agencies).*

"The trials did not show a reduction in deaths, even for Covid deaths. The evidence was flimsy," said Prof Doshi.

"Those who claimed the trials showed that the vaccines were highly effective in saving lives were wrong. The trials did not demonstrate this."

Prof Doshi was not passing judgement on the vaccines. Instead, he was critical of the way authorities had portrayed trial data to the public.

All the public announcements about the vaccines were initiated by the vaccine manufacturers in highly curated press releases, and it significantly shaped the public narrative, setting the stage for high expectations.

For example, Pfizer published a press release claiming the vaccine was "95% effective against COVID-19." Several weeks later, the actual trial results were published in the *New England Journal of Medicine*.

- In the vaccine group, 8 out of 18,198 people had COVID-19 symptoms (0.04%)
- In the placebo group, 162 out of 18,325 people had COVID-19 symptoms (0.88%)

The vaccine reduced the baseline risk from 0.88% down to 0.04% after two months. That is, a 'relative risk reduction (RRR) of **95%** but an absolute risk reduction (ARR) of **0.84%**.

Hence, if someone's baseline risk of COVID-19 is very low to begin with (as it is for most people under 50 years), a 100% reduction in risk is trivial.

An editorial in *The Lancet* compared the RRR of each vaccine to the ARR:

Vaccine	Relative Risk Reduction (RRR)	Absolute Risk Reduction (ARR)
Pfizer	95%	0.84%
Moderna	91%	1.2%
AstraZeneca	67%	1.3%

Notably, when quoting the vaccine's harms, authorities will use the smaller percentage, ARR, presumably to minimise public concern about adverse events.

If authorities are using different metrics to convey the harms and benefits of a medical therapy, it is misleading the public.

Exaggerate the benefits?

It is well established that only quoting RRR without quoting the ARR, can inflate or exaggerate an intervention's effect size and clinical importance, as well as increase people's willingness to receive the treatment.

It has been referred to as the first “sin” against transparent communication by Gerd Gigerenzer, director of the Harding Centre for Risk Literacy at the Max Planck Institute. He says it can be used as “a deliberate tactic to manipulate or persuade people.”

“Many physicians, patients, health journalists and politicians do not understand health statistics. This collective statistical illiteracy has resulted in serious consequences for health,” Gigerenzer says.

John Ioannidis, Professor at Stanford University and the most cited physician scientist, agrees.

“In my experience, innumeracy is widely prevalent,” says Prof Ioannidis.

“This is not happening just for vaccines. Over many decades, RRR has been the dominant way of communicating results of clinical trials. Almost always, RRR looks nicer than absolute risk reductions.”

When asked if there was any justification for misleading the public about the vaccine’s benefits to encourage uptake, Prof Ioannidis rejected the notion.

“I don't see how one can increase uptake by using misleading information. I am all in favour of increasing uptake, but this needs to use complete information, otherwise sooner or later incomplete information will lead to misunderstandings and will backfire,” says Ioannidis.

The way authorities have communicated risk to the public, is likely to have misled and distorted the public’s perception of the vaccine’s benefit and underplayed the harms.

This, in essence, is a violation of the ethical and legal obligations of informed consent.

End of article

https://maryannedemasi.com/publications/f/covid-19-vaccine-benefits-exaggerated-say-experts

Here’s a perfect example of how the media spin IS THE MISINFORMATION

More trouble for the credibility of the vaccine trials as a whistleblower's accounts including emails, documents and recordings of violations are disclosed in a *British Medical Journal* Investigative Report

A ***BMJ INVESTIGATION*** as reported by Paul D. Thacker titled, **Covid-19: Researcher blows the whistle on data integrity issues in Pfizer's vaccine trial**. Revelations of poor practices at a contract research company helping to carry out Pfizer's pivotal covid-19 vaccine trial raise questions about data integrity and regulatory oversight.

Excerpts from the article

In autumn 2020 Pfizer's chairman and chief executive, Albert Bourla, released an open letter to the billions of people around the world who were investing their hopes in a safe and effective covid-19 vaccine to end the pandemic. "As I've said before, we are operating at the speed of science," Bourla wrote, explaining to the public when they could expect a Pfizer vaccine to be authorised in the United States.1

But, for researchers who were testing Pfizer's vaccine at several sites in Texas during that autumn, speed may have come at the cost of data integrity and patient safety. A regional director who was employed at the research organisation Ventavia Research Group has told *The BMJ* that the company falsified data, unblinded patients, employed inadequately trained vaccinators, and was slow to follow up on adverse events reported in Pfizer's pivotal phase III trial. Staff who conducted quality control checks were overwhelmed by the volume of problems they were finding. After repeatedly notifying Ventavia of these problems, the regional director, Brook Jackson, emailed a complaint to the US Food and Drug Administration (FDA). Ventavia fired her later the same day. Jackson has provided *The BMJ* with dozens of internal company documents, photos, audio recordings, and emails.

In a recording of a meeting in late September2020 between Jackson and two directors a Ventavia executive can be heard explaining that the company wasn't able to quantify the types and number of errors they were finding when examining the trial paperwork for quality control. "In my mind, it's something new every day," a Ventavia executive says. "We know that it's significant."

Ventavia was not keeping up with data entry queries, shows an email sent by ICON, the contract research organisation with which Pfizer partnered on the trial. ICON reminded Ventavia in a September 2020 email: "The expectation for this study is that all queries are addressed within 24hrs." ICON then highlighted over 100 outstanding queries older than three days in yellow. Examples included two individuals for which "Subject has reported with Severe symptoms/reactions … Per protocol, subjects experiencing Grade 3 local reactions should be contacted. Please confirm if an UNPLANNED CONTACT was made and update the corresponding form as appropriate." According to the trial protocol a telephone contact should have occurred "to ascertain further details and determine whether a site visit is clinically indicated."

Worries over FDA inspection

Documents show that problems had been going on for weeks. In a list of "action items" circulated among Ventavia leaders in early August 2020, shortly after the trial began and before Jackson's hiring, a Ventavia executive identified three site staff members with whom to "Go over e-diary issue/falsifying data, etc." One of them was "verbally counseled for changing data and not noting late entry," a note indicates. At several points during the late September meeting Jackson and the Ventavia executives discussed the possibility of the FDA

showing up for an inspection (box 1). “We’re going to get some kind of letter of information at least, when the FDA gets here . . . know it,” an executive stated. The next morning, 25 September 2020, Jackson called the FDA to warn about unsound practices in Pfizer’s clinical trial at Ventavia. She then reported her concerns in an email to the agency. In the afternoon Ventavia fired Jackson—deemed “not a good fit,” according to her separation letter. Jackson told *The BMJ* it was the first time she had been fired in her 20 year career in research.

Concerns raised

In her 25 September email to the FDA Jackson wrote that Ventavia had enrolled more than 1000 participants at three sites. The full trial (registered under NCT04368728) enrolled around 44 000 participants across 153 sites that included numerous commercial companies and academic centres.

She then listed a dozen concerns she had witnessed, including:

- **Participants placed in a hallway after injection and not being monitored by clinical staff**

- Lack of timely follow-up of patients who experienced adverse events
- Protocol deviations not being reported
- Vaccines not being stored at proper temperatures
- Mislabelled laboratory specimens, and
- Targeting of Ventavia staff for reporting these types of problems.

Within hours Jackson received an email from the FDA thanking her for her concerns and notifying her that the FDA could not comment on any investigation that might result. A few days later Jackson received a call from an FDA inspector to discuss her report but was told that no further information could be provided. She heard nothing further in relation to her report.

In Pfizer’s briefing document submitted to an FDA advisory committee meeting held on 10 December 2020 to discuss Pfizer’s application for emergency use authorisation of its covid-19 vaccine, the company made no mention of problems at the Ventavia site. The next day the FDA issued the authorisation of the vaccine.8

In August this year, after the full approval of Pfizer’s vaccine, the FDA published a summary of its inspections of the company’s pivotal trial. Nine of the trial’s 153 sites were inspected. Ventavia’s sites were not listed among the nine, and no inspections of sites where adults were recruited took place in the eight months after the December 2020 emergency authorisation.

My comment: I had to red-light this section, because to me it shines a huge spotlight on the lack of oversight and quality control by the FDA. Mind you, this is the FDA’s own summary admitting this lack of surveillance of what could arguably be the most important duty in the history of the agency. When a product is being rushed to market in 10% of the time it typically takes to run proper safety and efficacy trials, it should be incumbent of the “watchdog” of public health to step up and go above and beyond their usual lackluster performance. I say that because as I reported in a previous issue, the FDA has always been significant understaffed and biologics facilities under inspected. See the excerpts from that report after this story.

Also, in this BMJ investigation this section titled “Box 1” exposes exactly what I’m talking about…

Box 1: A history of lax oversight

When it comes to the FDA and clinical trials, Elizabeth Woeckner, president of Citizens for Responsible Care and Research Incorporated (CIRCARE),3 says the agency's oversight capacity is severely under-resourced. If the FDA receives a complaint about a clinical trial, she says the agency rarely has the staff available to show up and inspect. And sometimes oversight occurs too late.

In one example CIRCARE and the US consumer advocacy organisation Public Citizen, along with dozens of public health experts, filed a detailed complaint in July 2018 with the FDA about a clinical trial that failed to comply with regulations for the protection of human participants.4 Nine months later, in April 2019, an FDA investigator inspected the clinical site. In May this year the FDA sent the triallist a warning letter that substantiated many of the claims in the complaints. It said, "[I]t appears that you did not adhere to the applicable statutory requirements and FDA regulations governing the conduct of clinical investigations and the protection of human subjects."5

"There's just a complete lack of oversight of contract research organisations and independent clinical research facilities," says Jill Fisher, professor of social medicine at the University of North Carolina School of Medicine and author of *Medical Research for Hire: The Political Economy of Pharmaceutical Clinical Trials*. **Ventavia and the FDA**

A former Ventavia employee told *The BMJ* that the company was nervous and expecting a federal audit of its Pfizer vaccine trial.

"People working in clinical research are terrified of FDA audits," Jill Fisher told *The BMJ*, but added that the agency rarely does anything other than inspect paperwork, usually months after a trial has ended. "I don't know why they're so afraid of them," she said. But she said she was surprised that the agency failed to inspect Ventavia after an employee had filed a complaint. "You would think if there's a specific and credible complaint that they would have to investigate that," Fisher said.

In 2007 the Department of Health and Human Services' Office of the Inspector General released a report on FDA's oversight of clinical trials conducted between 2000 and 2005. The report found that the FDA inspected only 1% of clinical trial sites.6 Inspections carried out by the FDA's vaccines and branch have been decreasing in recent years, with just 50 conducted in the 2020 fiscal year.7

Other employees' accounts

In recent months Jackson has reconnected with several former Ventavia employees who all left or were fired from the company. One of them was one of the officials who had taken part in the late September meeting. In a text message sent in June the former official apologised, saying that "everything that you complained about was spot on."

Two former Ventavia employees spoke to *The BMJ* anonymously for fear of reprisal and loss of job prospects in the tightly knit research community. Both confirmed broad aspects of Jackson's complaint. One said that she had worked on over four dozen clinical trials in her career, including many large trials, but had never experienced such a "helter skelter" work environment as with Ventavia on Pfizer's trial.

"I've never had to do what they were asking me to do, ever," she told *The BMJ*. "It just seemed like something a little different from normal—the things that were allowed and expected."

She added that during her time at Ventavia the company expected a federal audit but that this never came.

After Jackson left the company problems persisted at Ventavia, this employee said. In several cases Ventavia lacked enough employees to swab all trial participants who reported covid-like symptoms, to test for infection. Laboratory confirmed symptomatic covid-19 was the trial's primary endpoint, the employee noted. (An FDA review memorandum released in August this year states that across the full trial swabs were not taken from 477 people with suspected cases of symptomatic covid-19.)

"I don't think it was good clean data," the employee said of the data Ventavia generated for the Pfizer trial. "It's a crazy mess."

A second employee also described an environment at Ventavia unlike any she had experienced in her 20 years doing research. She told *The BMJ* that, shortly after Ventavia fired Jackson, Pfizer was notified of problems at Ventavia with the vaccine trial and that an audit took place.

Since Jackson reported problems with Ventavia to the FDA in September 2020, Pfizer has hired Ventavia as a research subcontractor on four other vaccine clinical trials (covid-19 vaccine in children and young adults, pregnant women, and a booster dose, as well an RSV vaccine trial; NCT04816643, NCT04754594, NCT04955626, NCT05035212). The advisory committee for the Centers for Disease Control and Prevention is set to discuss the covid-19 paediatric vaccine trial on 2 November.

End of excerpts

Excerpts from my previous report…

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 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 starting on page 135, 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.

Why is the FDA trying to hide the Pfizer trial data from the public for 55 years? And then later extending the effort to hide it to 75 years.

Attorney Aaron Siri's Substack story shines light on the egregious and frankly unbelievable request by the FDA to bury the Pfizer trial data until 2176. This unprecedented effort begs the question. What in the world are they trying to hide?

The article…

FDA Asks Federal Judge to Grant it Until the Year 2076 to Fully Release Pfizer's COVID-19 Vaccine Data
The fed gov't shields Pfizer from liability. Gives it billions of dollars. Makes Americans take its product. But won't let you see the data supporting its safety/efficacy. Who does the gov't work for?

The FDA has asked a federal judge to make the public wait until the year 2076 to disclose all of the data and information it relied upon to license Pfizer's COVID-19 vaccine. That is not a typo. It wants 55 years to produce this information to the public.

As explained in a prior article, the FDA repeatedly promised "full transparency" with regard to Covid-19 vaccines, including reaffirming "the FDA's commitment to transparency" when licensing Pfizer's COVID-19 vaccine.

With that promise in mind, in August and immediately following approval of the vaccine, more than 30 academics, professors, and scientists from this country's most prestigious universities requested the data and information submitted to the FDA by Pfizer to license its COVID-19 vaccine.

The FDA's response? It produced nothing. So, in September, my firm filed a lawsuit against the FDA on behalf of this group to demand this information. To date, almost three months after it licensed Pfizer's vaccine, the FDA still has not released a single page. Not one.

Instead, two days ago, the FDA asked a federal judge to give it until 2076 to fully produce this information. The FDA asked the judge to let it produce the 329,000+ pages of documents Pfizer provided to the FDA to license its vaccine at the rate of 500 pages per month, which means its production would not be completed earlier than 2076. The FDA's promise of transparency is, to put it mildly, a pile of illusions.
It took the FDA precisely 108 days from when Pfizer started producing the records for licensure (on May 7, 2021) to when the FDA licensed the Pfizer vaccine (on August 23, 2021). Taking the FDA at its word, it

conducted an intense, robust, thorough, and complete review and analysis of those documents in order to assure that the Pfizer vaccine was safe and effective for licensure. While it can conduct that intense review of Pfizer's documents in 108 days, it now asks for over 20,000 days to make these documents available to the public.

So, let's get this straight. The federal government shields Pfizer from liability. Gives it billions of dollars. Makes Americans take its product. But won't let you see the data supporting its product's safety and efficacy. Who does the government work for?

The lesson yet again is that civil and individual rights should never be contingent upon a medical procedure. Everyone who wants to get vaccinated and boosted should be free to do so. But nobody should be coerced by the government to partake in any medical procedure. Certainly not one where the government wants to hide the full information relied upon for its licensure until the year 2076!

End of article

In typical fashion, the people on the committee deciding whether children are exposed to these shots and parent's right to protect their children's bodily autonomy all have ties to Big Pharma

Children's Health Defense published an article on November 24th titled, **14 ACIP Members Who Voted to Jab Your Young Children — and Their Big Ties to Big Pharma**-

Subheading: On Nov. 2, members of the Centers for Disease Control and Prevention's vaccine advisory committee voted 14–0 to recommend Pfizer's pediatric COVID shot for children 5 –11 years old. Were their decisions driven by science and conscience — or their ties to drugmakers?

From the article

Neither the disgracefully unscientific vote nor CDC Director Rochelle Walensky's prompt endorsement came as a surprise. Though billed as "independent," the 14 ACIP members — like the 17 members of FDA's VRBPAC who voted the same way the previous week — have deep ties to pharma, with careers that hinge on promoting and rubber-stamping the United States' destructive one-size-fits-all vaccination agenda.

Describing the VRBPAC and ACIP meetings as "a total sham," Children's Health Defense President Mary Holland said, "Sadly, approval from these committees means nothing in terms of safety."

Political scientist Toby Rogers agreed, stating the ACIP meeting "was not a scientific review. It was banal bureaucrats announcing plans for a Blitzkrieg and the bought white coats were cheering them on."

With their vote to give young children the dangerous injections, ACIP members signaled that they, too, deserve to be shunned, along with the powerful institutions with which they are affiliated. The latter include the nation's top universities and leading pediatric hospitals.

The article goes on to list the various members and their pharmaceutical connections.

You can read the entire article here…
https://childrenshealthdefense.org/defender/cdc-acip-pfizer-pediatric-covid-vaccine-big-pharma/

An attorney's op-ed in the Wall Street Journal explains why it is illegal to mandate these shots on children

Despite the corruption in the approval process for these shots for kids, some solace maybe gained by the opinion given by this attorney about the legality of mandating these shots for children. Despite the unlawful attempts that will come to require these shots for children entering school, parents need to push back and the legal system needs to uphold the law and prevent mandating these EUA experimental products.

The Opinion piece by Jenin Younes- Nov. 9, 2021

Now that the Food and Drug Administration has authorized the Pfizer -BioNTech vaccine for 5- to 11-year-olds, expect a wave of Covid-19 vaccine mandates for children. San Francisco announced last week that the city will require children in that age group to show proof of vaccination to enter restaurants, sporting events, swimming pools and more. New York's School of American Ballet informed parents via email on Nov. 4 that all students—the school enrolls children as young as 6—must receive a Covid vaccine by January.

While parents may choose to vaccinate their own children, these mandates are unethical and unlawful. Advocates of mandating Covid vaccines equate them with standard childhood shots against polio, chickenpox, TDaP (tetanus, diphtheria and pertussis) and MMR (measles, mumps and rubella). But those decades-old vaccines have gone through the full FDA testing regime. The Covid vaccine has received only emergency-use authorization for this age group, meaning its safety and efficacy have not yet been established to the FDA's satisfaction.

he Covid-19 vaccines are too new to have been studied for long-term effects. There are no studies of whether it is safe to vaccinate children who have recovered from Covid-19. Many states don't require vaccinating children against diseases they have already had, like measles or chickenpox, because they acquire natural immunity. Why should Covid be any different?

The emergency-use authorization of the Covid vaccine also creates a legal distinction. Federal law requires, among other things, that potential recipients of EUA products be informed "of the option to accept or refuse administration of the product, of the consequences, if any, of refusing administration of the product, and of the alternatives to the product that are available and of their benefits and risks."

Put plainly, this means that patients—in this case children—may not be forced, coerced or pressured into taking EUA products and are entitled by law to refuse them. Another statute authorizes the president to require members of the armed services to take EUA products, and President Biden has invoked this power to require Covid vaccination. No law authorizes such mandates outside the military. Conditioning access to education and participation in public life on treatment with an unapproved vaccine is the antithesis of free and informed consent and is therefore unlawful. Private institutions that force an EUA drug on children could face lawsuits.

A new statute permitting mandates for EUA products would be unconstitutional as well. Children have a right to bodily autonomy and to refuse unnecessary medical treatment, which their parents exercise on their behalf. The government can't conscript them as guinea pigs or vessels to protect adults. Young children face virtually no risk from Covid-19 and the mandates mainly serve to assuage adult fear. Young children rarely infect adults, who in any event have had access to vaccines for many months. And children pose no threat to anyone if they have natural immunity.

Children's rights and needs have taken a back seat during the past 18 months. Let's not make forced vaccination of young children, which is unconstitutional and illegal under federal law, the next way in which we disregard their interests to mollify adults' irrational fears.

Ms. Younes is litigation counsel at the New Civil Liberties Alliance.

Article exposes false narratives about the origins of SARS-CoV-2 variants and the failure of Dr. Fauci and his cohorts to allow doctors to treat patients early

A Substack article by James Lyons Weiler published on November 19th, 2021, titled **Where Do New Variants REALLY Come From? Most Variants of Concern Pre-date the Vaccine and Could Not Have Come from "The Unvaccinated". So Where Does Science Say They Really Come From?** is an excellent explanation of some very important aspects of the COVID-19 narrative. It also appeals for people to rally around Dr. Paul Marik in his fight to preserve a doctor's right to treat patients based on their clinical judgment, training, experience and expertise. That is threatened in today's medical-corporate, non-individualized, one-size-fits-all, protocol-based medicine.

Consider subscribing to James Lyons Weiler's Substack at https://popularrationalism.substack.com

Article

The molecular clock is a wonderful tool. It allows us to put a date on the emergence of new species, or in the case of viruses, new viral lineages.

Luckily, we have the public record to tell us when variants were first detected. The Delta variant, for example, was first detected in late 2020, long before any COVID-19 vaccination program.

That did not stop vaccine zealots from launching a half-hearted attempt to blame the "Unvaccinated" as the source of new variants.

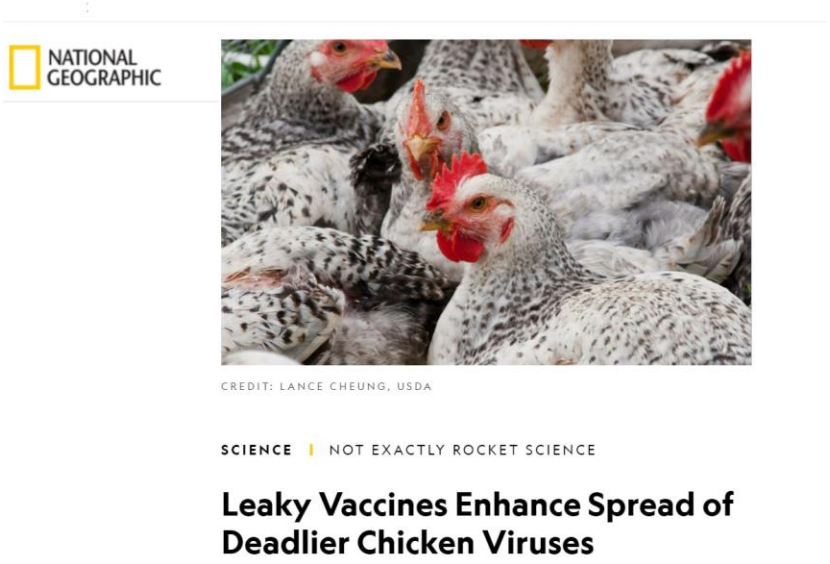
Since we know variants emerged before there were "Vaccinated" or "Unvaccinated" categories of people, the emergence and spread of new variants requires no special explanation. Evolution happens. But there are a few factors that are in place that are helping the emergence of new variants.

Factor 1. Leaky Vaccines

It is widely known from animal science that when a virus is widespread in a flock or herd, vaccinating during the outbreak against viruses can be disastrous. Due to high numbers of infected individuals with high viremia

(blood levels of infectious virus), a lot of genetic diversity can exist. And the vaccine immunity can interact with virus in a process known as antibody-dependent enhancement, a form of pathogenic priming.

This factor is so well-known that National Geographic reports “Not Exactly Rocket Science”.



This was the factor that Nobel Laureate Luc Montagnier was referencing in the French documentary “Hold-Up” he said (about vaccinating during a pandemic):

“It's an enormous mistake, isn't it? A scientific error as well as a medical error. It is an unacceptable mistake.”

He also said

"The history books will show that because it is the vaccination that is creating the variants“.

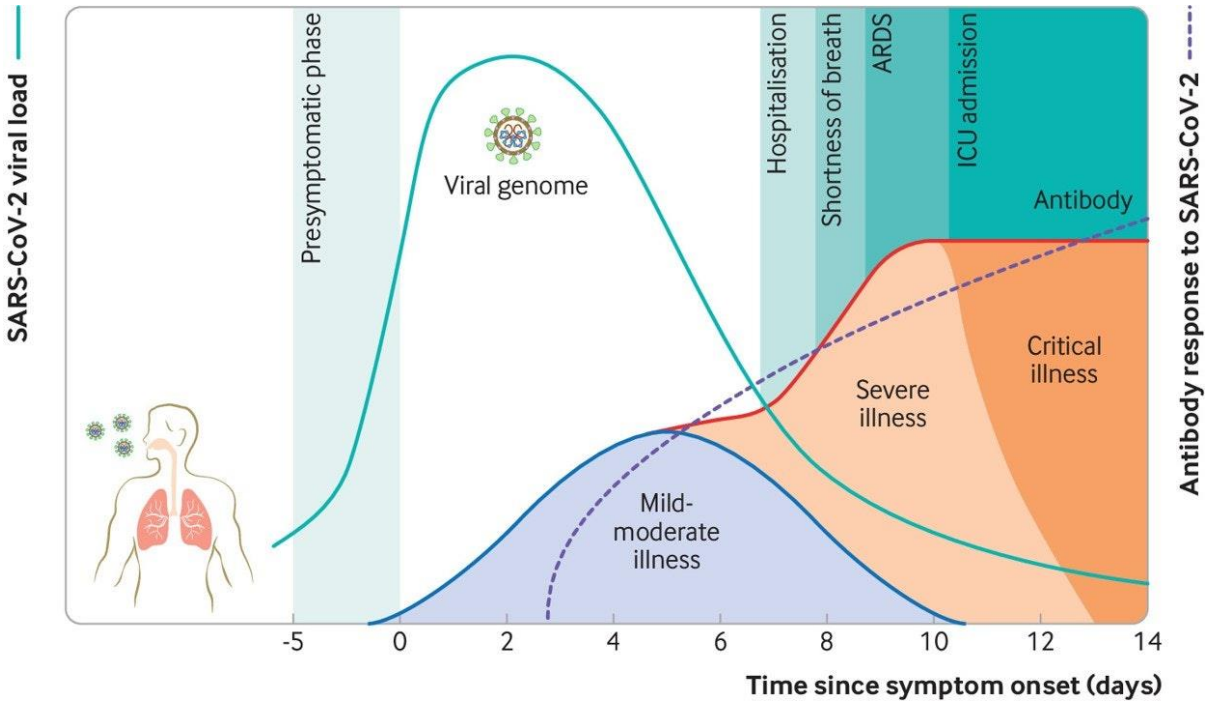
and that many epidemiologists know this, but remain silent about the problem known as antibody-dependent enhancement.

Factor 2. Fauci Medicine

From the onset, CDC insisted that “PCR+ = ‘COVID-19’”. I (and others) have addressed the issue with the many flaws of using PCR as applied to the diagnosis of COVID-19 in many places. But the issue with “PCR+ = ‘COVID-19’” became an even more serious problem when tied with the public health version of medical care for COVID-19, which is “Go Home and Isolate for 10 to 14 Until You’re Sick Enough for Emergency Care”.

This figure, from the BMJ, shows the timeline from infection to resolution or serious COVID-19:

My comment: I just love this graphic! It really provides a great snapshot of the phases of, infection, viral replication, progression of illness and the adaptive immune system’s antibody response. It also clearly exposes the missed opportunity for early treatment and the tragic mistake of sending people home from the hospital without anti-viral medication, allowing the virus to incubate in their bodies unchecked often leading to a state of severe illness.



Under Fauci Medicine, patients who have mild COVID-19 and those who develop serious COVID-19 become in-home incubators of the SARS-CoV-2 virus.

To date, there have been 47.5 Million cases of COVID-19 reported to CDC. That means that **Fauci Medicine has allowed 1.2 Million Person-Years of viremia.**

Why do I say Fauci Medicine did this? Because of Factor 3.

Factor 3. Fauci Medicine Part 2.

The rest of Fauci Medicine, of course, is to send people home with no instructions on outpatient care. Dr. Paul Marik, one of the most ethical physicians in the US, is currently embattled in court for daring to actually practice medicine, daring to treat patients with COVID-19, and for daring to save lives.

He and other physicians who have provided the early effective treatments have also helped reduce viremia in COVID-19 infection - as well as the duration of illness. Both factors reduce the risk transmission.

Fauci, by contrast, has destroyed public confidence in Science as well as awareness of the fact of the efficacy and safety of available early treatments.

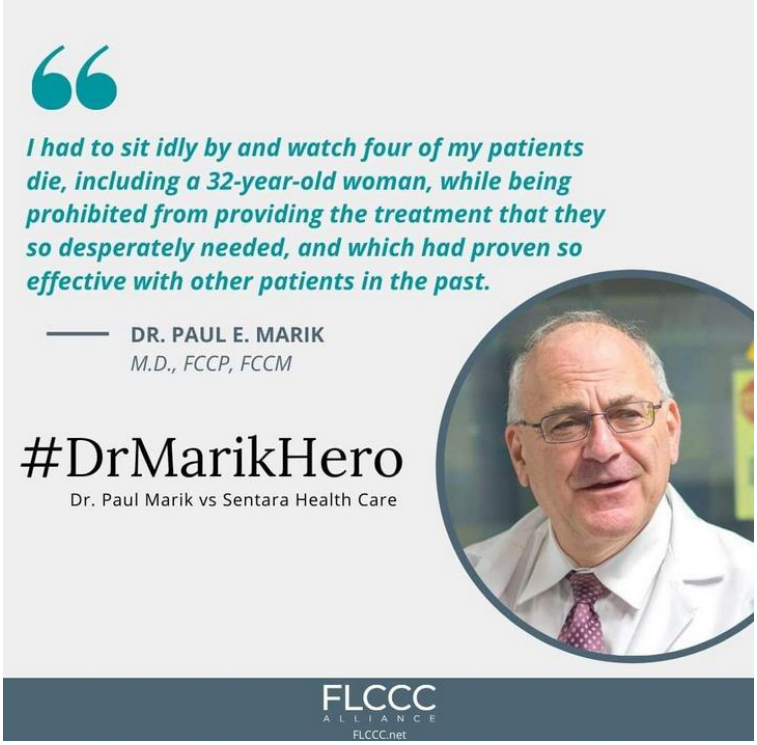
The denial of early treatment and the millions of episodes of people incubating at home has led to variants. To the extent that the unvaccinated develop high viremia - well, if the disinformation campaign against early treatment had not been so pervasive, infiltrating each and every mainstream media channel, the unvaccinated no doubt would have had greater awareness - and access to- effective early treatments.

Usually my articles end with buttons to Subscribe. Today I'd like everyone to support Dr. Paul Marik via this petition - sent to me by Dr. Pierre Kory.

Your support of Dr. Marik will help ethical physicians everywhere to become free of the yoke of Fauci Medicine.

Click on the image below and share this article with #WeStandWithMarik and #DrMarikHero.

Let Doctors Be Doctors!



https://popularrationalism.substack.com/p/where-do-new-variants-really-come

A caveat to the origins of the variant… There has been evidence presented that the major variance of concern have originated in countries where there were major clinical trials for the various vaccines. The speculation is that the large numbers of vaccinees put selective pressure on the virus and caused it to mutate. There may be some validity to that theory.

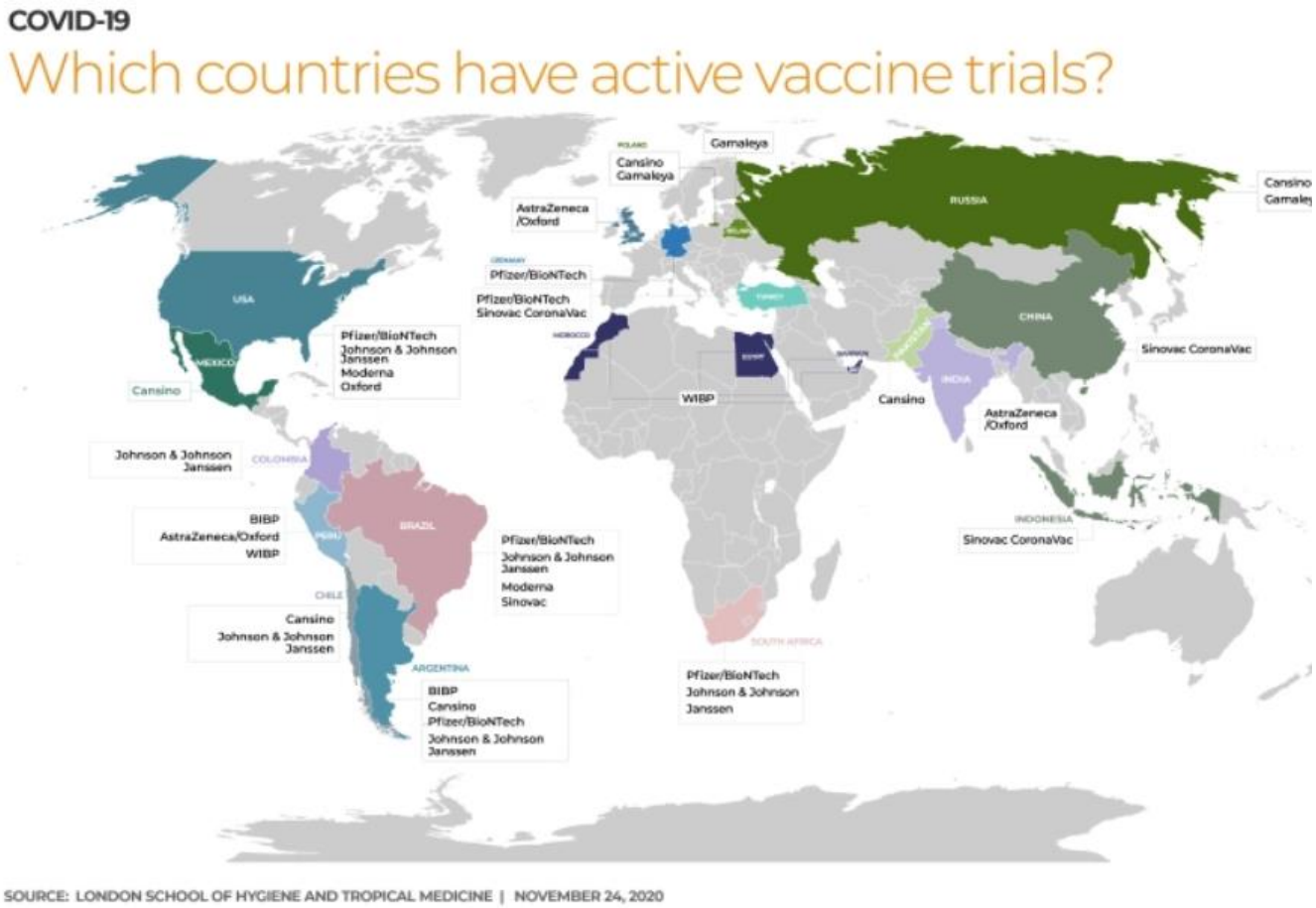
Here are some of the main variants that were first discovered in certain countries.

- **The U.K. or Alpha variant (B.1.1.7)**
- **The South African or Beta variant (B.1.351)**
- **The Brazilian or Gamma variant (P.1)**
- **The United States variants (B.1.427 and B.1.429 or Epsilon, B.1.525 or Eta, B.1.526 or Iota)**
- **The Indian variants (B.1.617.1 or Kappa, B.1.617.2 or Delta)**
- **The Columbian or Mu variant (B.1.621)**
- **The Peru or Lambda variant (C.37)**
- The Russian variant (AT.1)

https://pubmed.ncbi.nlm.nih.gov/34314723/

https://www.ecdc.europa.eu/en/covid-19/variants-concern

Here is a map of the countries that hosted vaccine trials.



It is incredibly ironic that these countries are all sites for the major COVID-19 vaccine clinical trials.

The latest variant fear-porn, the omicron variant. Is there a reason for concern?

Key points from a CNBC article titled, **A heavily mutated Covid variant emerges in southern Africa: Here's what we know so far**:

- **The World Health Organization said a heavily mutated version of the virus that causes Covid-19 poses a possible increased risk of reinfection.**
- The WHO named the strain omicron and labeled it a variant of concern.
- South African scientist Tulio de Oliveira said in a media briefing that the variant contains more than 30 mutations to the spike protein, the component of the virus that binds to cells.

A couple comments on these "key points"

- **The worry about re-infection should be less for those that have had a previous SARS-CoV-2 infection and recovered. Natural immunity recognizes the whole virus and numerous protein sequences, not just the spike as with vaccine produced antibody recognition.**

- If this version of the virus now has more than 30 mutations to the spike protein, the chances of vaccine escape are that much greater. The original vaccine is still geared for the original spike protein from the original Wuhan virus, making it more and more obsolete as the virus mutates away from that original strain.

- As viruses mutate, the norm is for them to become more transmissible but less lethal. However, if the viruses are mutating to escape the leaky "vaccines", the more we vaccinate the more they will be pushed to evade. As they are pushed in this way, the vaccinated will become increasingly at-risk for developing ***Antibody Dependent Enhancement (ADE)***, leading to more serious disease and deaths in those that have been on the vaccine merry-go-round that is the current and future game plan of the myopic approach we have seen throughout. This is already happening in the most highly vaccinated populations as highlighted in this and previous issues of this newsletter.

https://www.cnbc.com/2021/11/26/covid-variant-emerges-in-south-africa-heres-what-we-know-so-far.html

One possibility:

A consideration is, as these variants develop numerous mutations that are more and more different from the original Wuhan virus, the possibility exists they will become unstable and may disappear more quickly. This is common in highly mutated viruses. In the meantime, until we see plan on a 24/7 barrage of fear-mongering.

Another possibility:

As more mutations develop, many of them will occur on the spike protein (currently 30 mutations) and affect the receptor binding domain (RBD), which is how the virus attaches to our cells. This makes it unable to infect the cell.

Interestingly, the first 4 cases that were reported were all fully vaccinated.

The following are portions of a Tweet by the Highwire on November 25th, 2021.

One day before the WHO's VOC statement, the Government of Botswana's Presidential COVID-19 Task Force Coordinator Dr. K. Basupu released their statement regarding the variant detected in the country.

Notably, the statement read, "The four (4) cases were detected among travelers who tested SARS-COV-2 positive on routine pre travel testing." The statement went on to read "The preliminary report revealed that all four had been fully vaccinated for COVID-19."

The chairwoman of the South African Medical Association has described the travel restrictions imposed on the country as "hasty" and the reaction from other countries as "a storm in a teacup".
Dr Angelique Coetzee told BBC News: "We think it is a premature decision that has been taken, I think it is a hasty decision.

"I would understand if it was two weeks later and we know much more about this viral infection that is going around, or this mutation, but for now, it is like a storm in a teacup.

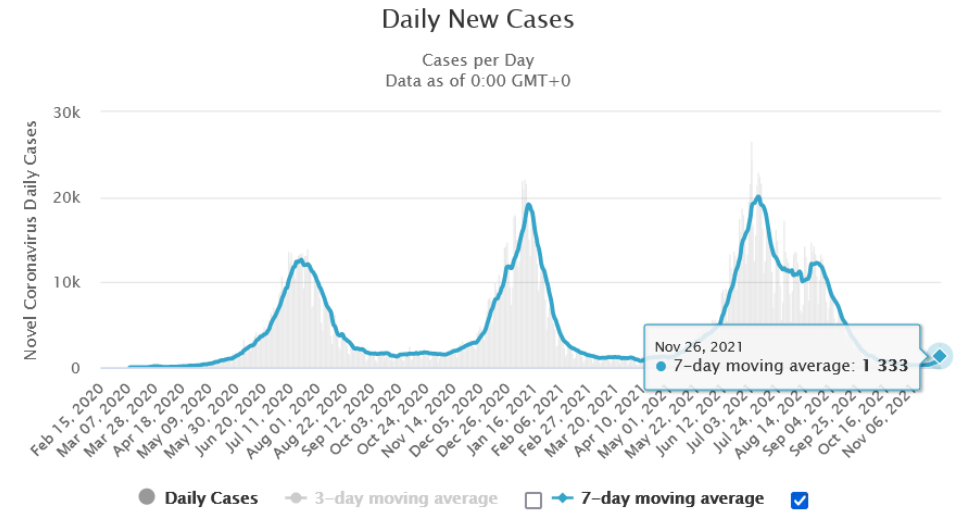
“We have only become aware of this viral mutation, or the new strain we are seeing, last week.”
She added: “From us as medical practitioners, we picked up, last week, the different clinical pictures, we looked at the advisory committees and so far what we have seen is very mild cases. [I’m] not sure why we are all up in arms.

The new variant, reportedly having the most mutations so far of any variant, is also allegedly demonstrating “immune evasion and enhanced transmissibility” reports CNN. Could this be the exact scenario the likes of which Vaccinologist, Geert Vanden Bossche, Ph.D., D.V.M. and other top scientists have warned about? Watch the breaking new interview below as one of the world’s top vaccine experts warns of a COVID catastrophe.

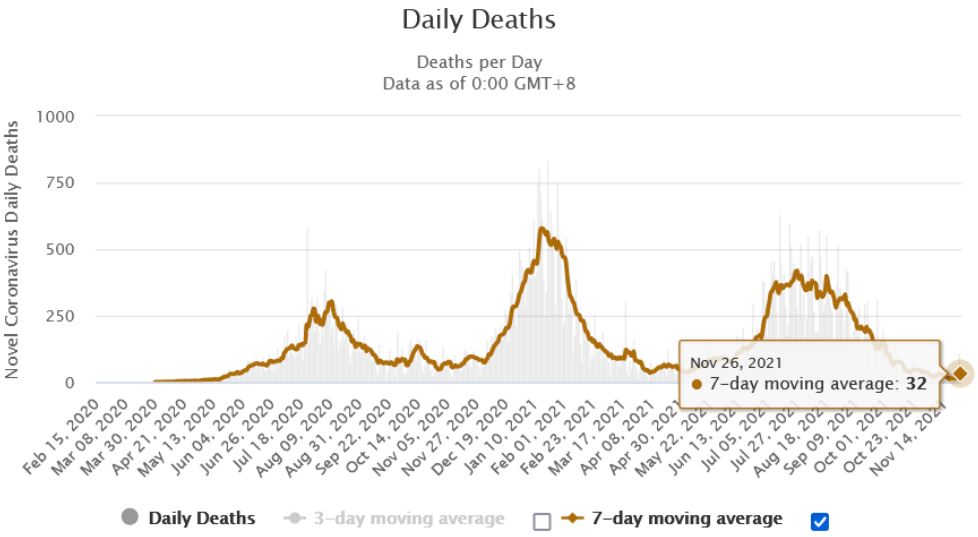
https://thehighwire.com/news/developing-variant-of-concern-mutation-first-detected-in-4-vaccinated-people-says-govt/

This is what is currently happening in South Africa, where the variant has originated.

Daily New Cases in South Africa



Daily New Deaths in South Africa



Just in time for the new variant, Pfizer to the rescue with a new vaccine. Couldn't have seen that one coming!

In a Yahoo article posted November 27th, 2021, titled, **Pfizer said an updated version of its COVID-19 vaccine will be 'ready in 100 days' if the new Omicron variant is resistant to its current vaccine**, the drugmaker generously says that it can make a new "vaccine" for the variant and make tens of billions of dollars, to bail out the world from their failed vaccine (which they have made an estimated $$$$$$$).

Key points from the article

- Pfizer said it can update its COVID-19 vaccine if the Omicron variant is found to be resistant to its current vaccine.
- The company said it can update its current vaccine within 100 days.
- Pfizer expects to know within two weeks whether the variant is resistant, a spokesperson told Reuters. **My comment:** Vegas odds are 100,000 to 1 for resistance.

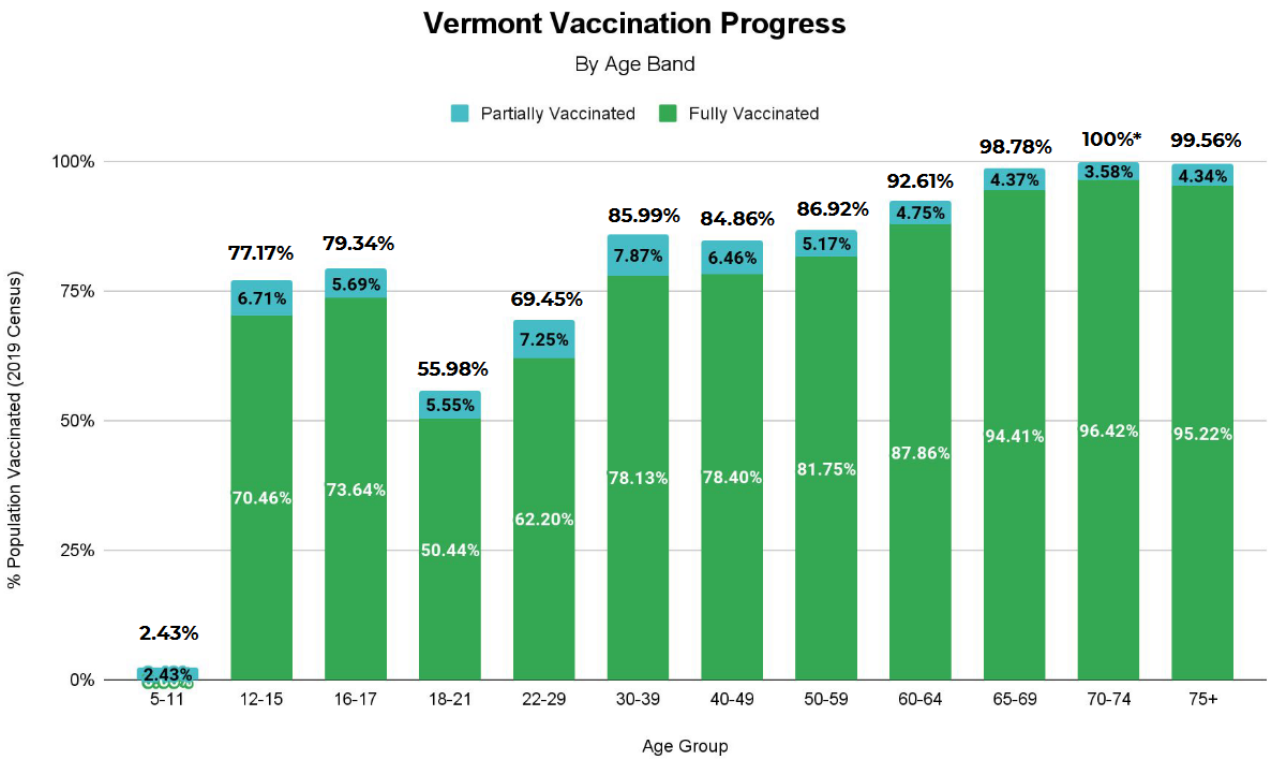
https://news.yahoo.com/pfizer-said-updated-version-covid-153353672.html

Vermont, with the highest vaccination rate in the country is reeling from all-time high cases, hospitalizations and deaths, especially in the fully vaccinated

Vermont CDC Vaccine Scorecard

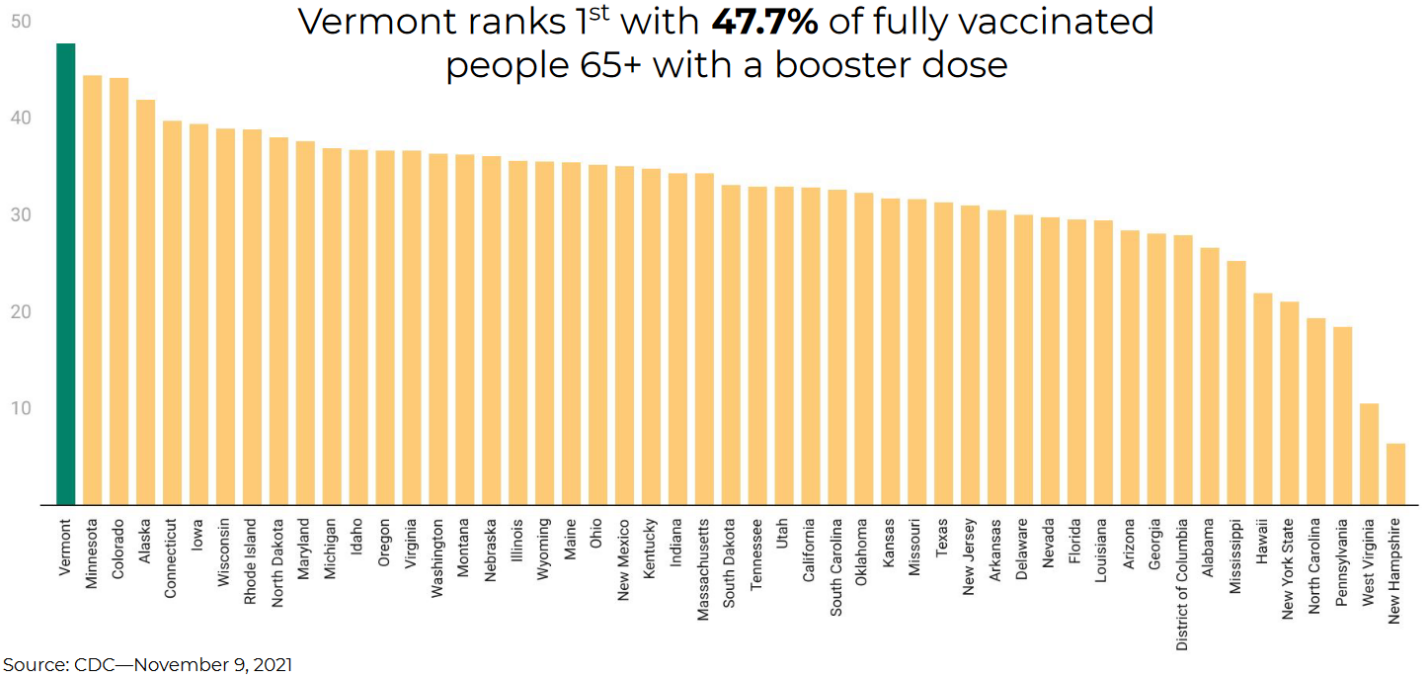
Metric	Figure	State Ranking
Doses Administered per 100K	163,427	1
% At Least 1 Dose (Eligible Population)	91.1%	5
% Fully Vaccinated (Eligible Population)	81.2%	3
% At Least 1 Dose (Full Population)	80.6%	2
% Fully Vaccinated (Full Population)	71.7%	1
% Fully Vaccinated (65 & Over)	97.9%	1

Source: CDC—November 9, 2021



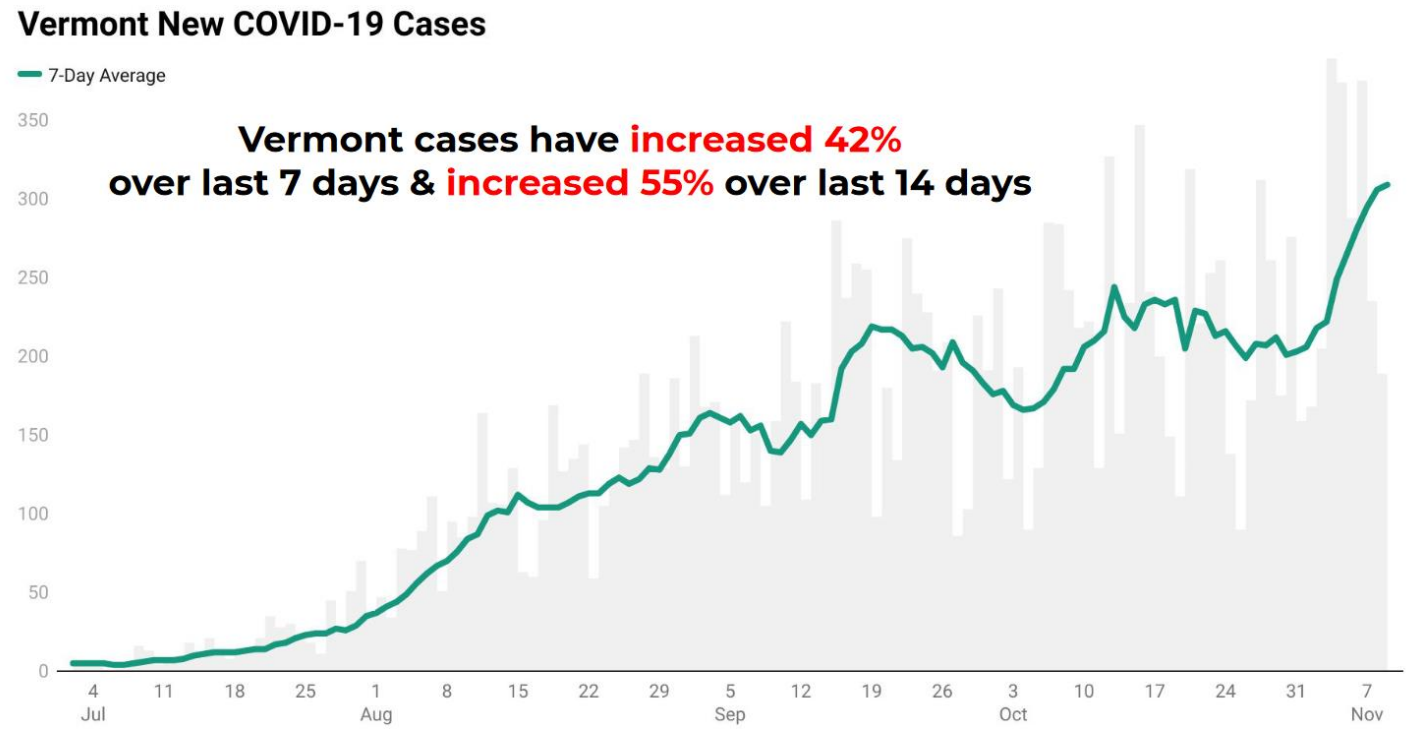
Source: Vermont Dept. of Health—November 9, 2021; *based on 2019 census estimates; state data may differ from CDC reporting

Percent of Fully Vaccinated People 65+ with Booster Dose

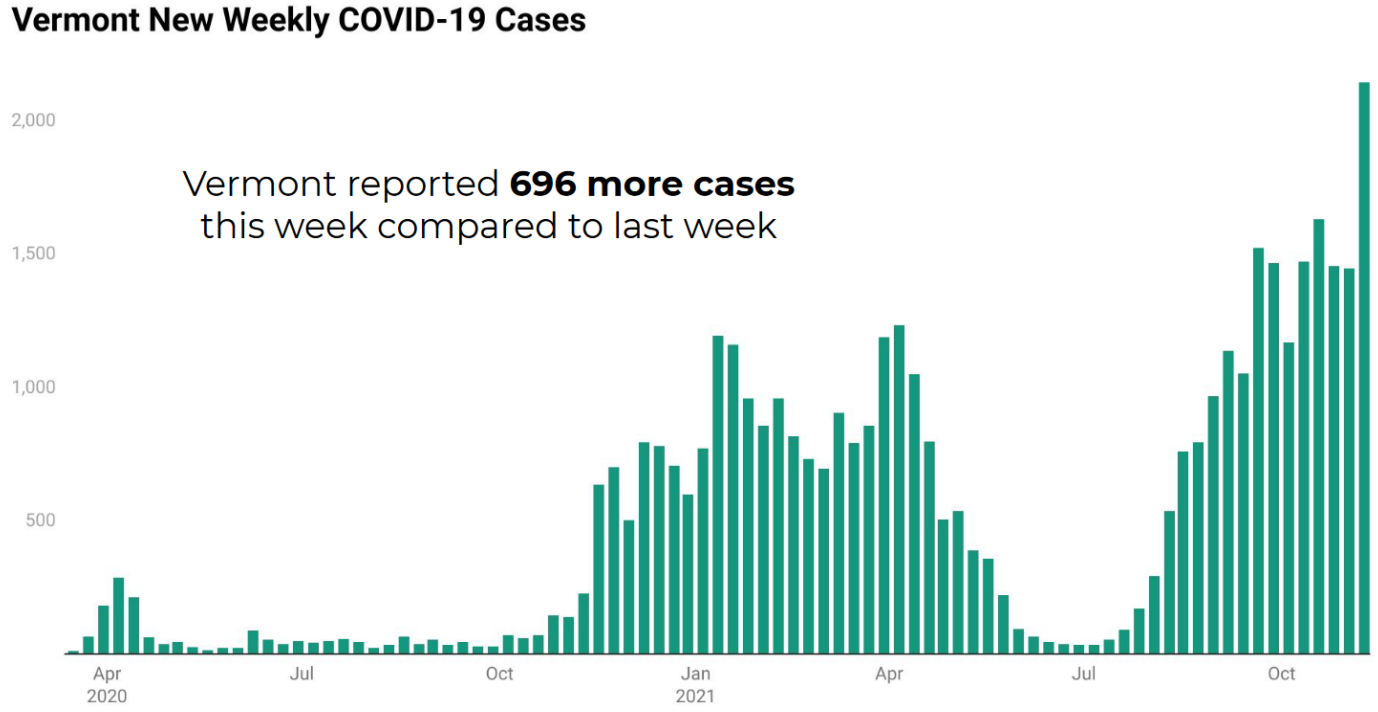


Source: CDC—November 9, 2021

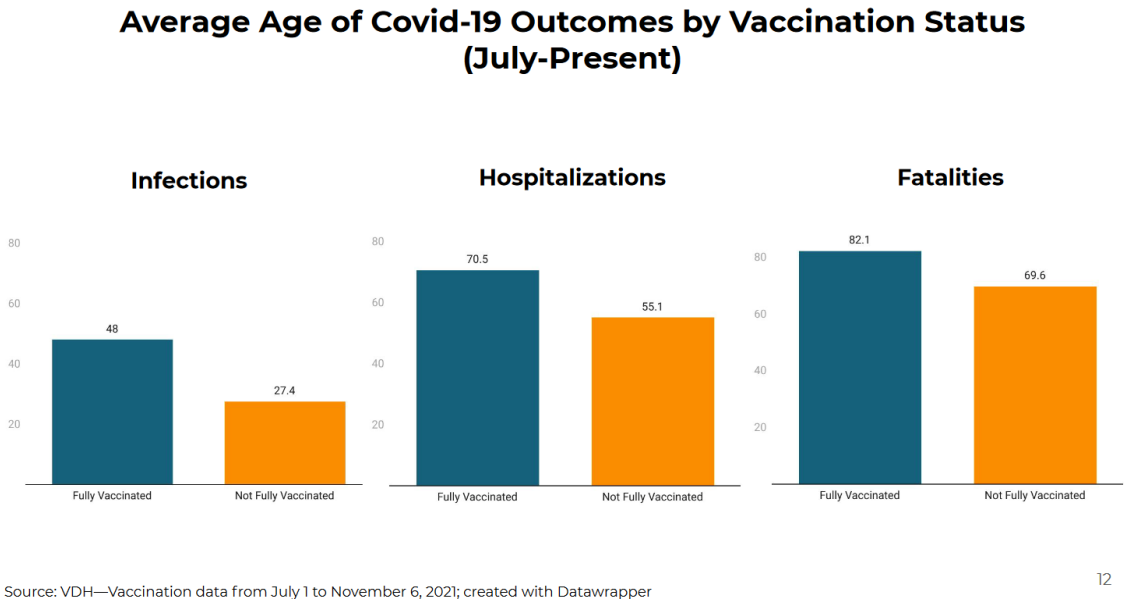
Now look at these graphs and tell me how effective you think these shots really are…



Source: Vermont Dept. of Health—November 9, 2021; created with Datawrapper



Source: Vermont Dept. of Health—November 9, 2021; created with Datawrapper



Trend lines

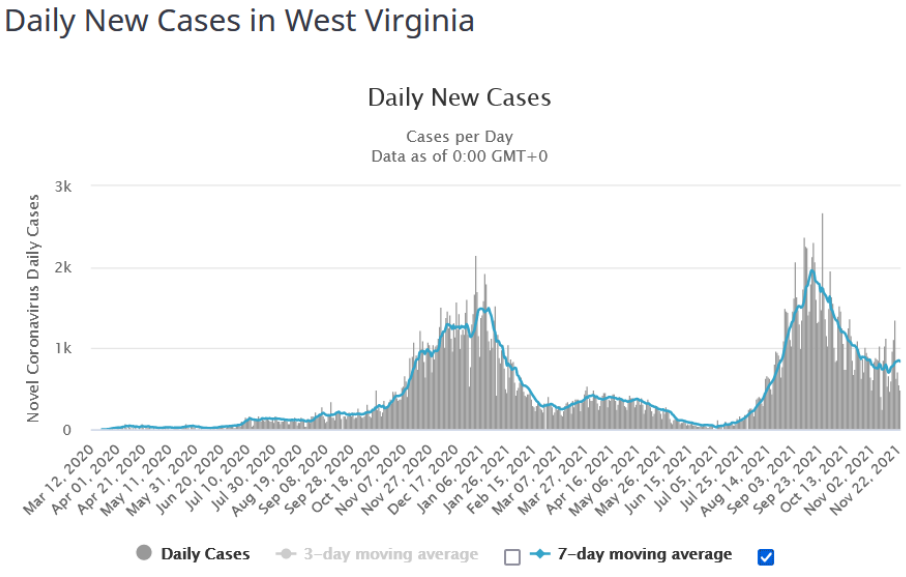
The not fully vaccinated admission rate has **decreased 15%** in the last 7 days

The fully vaccinated admission rate has **increased 8%** during the same period

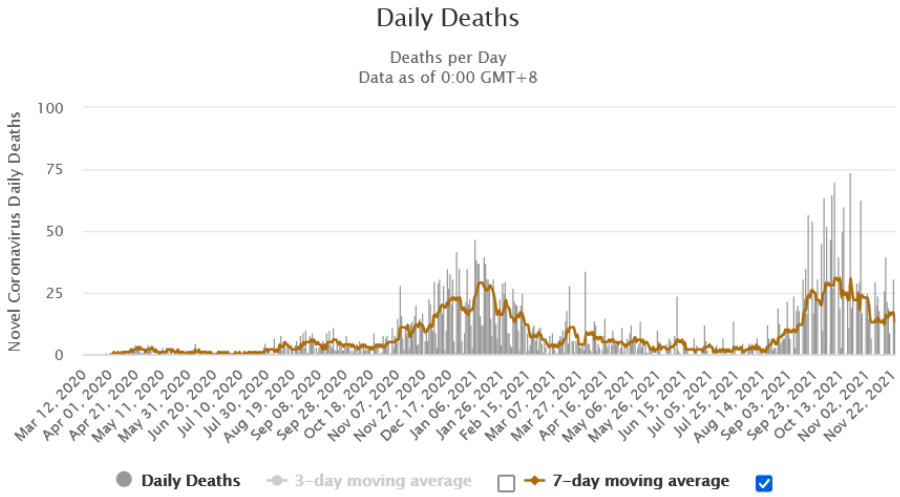
https://dfr.vermont.gov/sites/finreg/files/doc_library/dfr-covid19-modeling-110921.pdf

Now consider West Virginia, the state with the lowest vaccination rate in the country

West Virginia has the lowest vaccination rates in the country at 41.5% of their population fully vaccinated. Yet looking at these graphs you will see how cases and deaths are in decline over the last 30 days, in direct contrast to what we saw in Vermont in the previous section.



Daily New Deaths in West Virginia



Israeli news reporting serious concerns about the trends in rise of vaccinated hospitalizations and deaths

As reported previously, Israel is a couple of months ahead of the U.S. in the vaccine program. Even the CEO of Pfizer has said if you want to see what will happen in the U.S., look at Israel because they are about 2 months ahead with their program.

So, what is happening in Israel now? Israeli television reports are concerning. Here are some quotes from clips that were broadcast on Israeli television.

Israeli spokesperson… "In this wave we're seeing infection and illness in vaccinated individuals. We're seeing vaccinated individuals that are sick and arrive at the hospital in serious condition. And, we're seeing death as well. The increase in the seriously ill who have been vaccinated is an increase that we have seen over the last few days very significantly."

Broadcasters… "The almost vast majority of the deceased are vaccinated people that seemingly have gone through "immune-erosion" 83 dead in just the past month."

Interviewed patient in the hospital… "Between if I, as someone that has been vaccinated with two doses, got sick so, so badly, so what does it matter if you take the vaccines or not?"

Doctor… "Certainly it is starting to bother us."

Newscasters… "Meanwhile we are becoming aware of the fact that the Director General of the Sheba Hospital, Professor Yitzhak Kreiss. He was, if you recall, the third person to get vaccinated (in Israel), after the Prime Minister and Minister of Health. He has also become sick with COVID despite being vaccinated. Do you have a clear position Professor, regarding what they call the boost?"

Professor… "We must say decisively, even that there isn't any medical basis, as of today, for massive and bulk vaccination of the population with a third vaccine, with a booster. We really are not at the point in time that we need to vaccinate the bulk of the population with a third dose."

https://twitter.com/EliseiNicole/status/1461441345877389319

Several studies warning of enhanced or fatal disease in animals vaccinated for SARS-CoV-1 when later exposed to the wild virus, may be what we are seeing now in highly vaccinated countries

I would like to highlight one article and give citations for several others that had sounded the alarm bells over the last 15 years.

This first article is a 2012 one titled, **Immunization with SARS Coronavirus Vaccines Leads to Pulmonary Immunopathology on Challenge with the SARS Virus**.

The abstract- (emphasis mine)

Background: Severe acute respiratory syndrome (SARS) emerged in China in 2002 and spread to other countries before brought under control. Because of a concern for reemergence or a deliberate release of the SARS coronavirus, vaccine development was initiated. Evaluations of an inactivated whole virus vaccine in ferrets and nonhuman primates and a virus- like-particle vaccine in mice induced protection against infection but challenged animals exhibited an immunopathologic- type lung disease.

Design: Four candidate vaccines for humans with or without alum adjuvant were evaluated in a mouse model of SARS, a VLP vaccine, the vaccine given to ferrets and NHP, another whole virus vaccine and an rDNA-produced S protein. Balb/c or C57BL/6 mice were vaccinated IM on day 0 and 28 and sacrificed for serum antibody measurements or challenged with live virus on day 56. On day 58, challenged mice were sacrificed and lungs obtained for virus and histopathology.

Results: All vaccines induced serum neutralizing antibody with increasing dosages and/or alum significantly increasing responses. Significant reductions of SARS-CoV two days after challenge was seen for all vaccines and prior live SARS-CoV. **All mice exhibited histopathologic changes in lungs two days after challenge including all animals vaccinated** (Balb/C and C57BL/6) or given live virus, influenza vaccine, or PBS suggesting infection occurred in all. Histopathology seen in animals given one of the SARS-CoV vaccines was uniformly a Th2-type immunopathology with prominent eosinophil infiltration, confirmed with special eosinophil stains. The pathologic changes seen in all control groups lacked the eosinophil prominence.

Conclusions: These SARS-CoV vaccines all induced antibody and protection against infection with SARS-CoV. **However, challenge of mice given any of the vaccines led to occurrence of Th2-type immunopathology suggesting hypersensitivity to SARS-CoV components was induced. Caution in proceeding to application of a SARS-CoV vaccine in humans is indicated.**

https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0035421&type=printable

This is just one of many studies between the year 2000 and today showing either antibody dependent enhancement (ADE) or TH2 type immunopathology in animals after vaccinating for coronavirus disease. That is the reason clinical trials had never progressed to humans prior to the coronavirus pandemic we are currently experiencing. The clinical trials for these current vaccines omitted careful and important animal studies prior to human exposure. This is something that has been warned against in many of these prior attempts at creating a coronavirus vaccine.

One of the reasons that ADE can develop is that coronavirus vaccines cause two different types of antibodies to be produced.

Neutralizing antibodies- also referred to as immunoglobulin G (IgG) antibodies. These fight the infection by neutralizing the ability of the virus to gain entry into the cells.

Binding antibodies- also known as non-neutralizing antibodies that cannot prevent viral infection. Instead of preventing viral infection, binding antibodies can trigger an abnormal immune response known as "paradoxical immune enhancement." In this case, your immune system is working against itself and may actually enhance the ability of the virus to infect cells.

And as is the case with the COVID-19 vaccines, the first dose produces mostly binding antibodies and insufficient neutralizing antibodies. Thus, increasing the concern over future development of ADE when individuals that have been vaccinated are later exposed to the virus or a variant of the virus.

Other studies showing this phenomenon on ADE and Th2 immunopathology after vaccination for coronavirus disease:

Anti–spike IgG causes severe acute lung injury by skewing macrophage responses during acute SARS-CoV infection- ***JCL Insight*** 2019
https://insight.jci.org/articles/view/123158

Enhanced inflammation in New Zealand white rabbits when MERS-CoV reinfection occurs in the absence of neutralizing antibody- ***PLOS Pathogens*** 2017
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5574614/

Antibody Response and Disease Severity in Healthcare Worker MERS Survivors- ***Emerging Infectious Diseases*** 2016
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4880093/

Antibody-dependent SARS coronavirus infection is mediated by antibodies against spike proteins- ***Science Direct*** 2014
https://www.sciencedirect.com/science/article/pii/S0006291X14013321

Antibody-dependent infection of human macrophages by severe acute respiratory syndrome coronavirus- ***Virology Journal*** 2014
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4018502/

Immunization with SARS Coronavirus Vaccines Leads to Pulmonary Immunopathology on Challenge with the SARS-CoV-2 Virus- ***PLOS One*** 2012
https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0035421&type=printable

Neutralizing Antibody Response and SARS Severity- ***Emerging Infectious Diseases*** 2005
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3367364/

A summary of various studies on coronavirus vaccines that caused immunopathology is found on the next page…

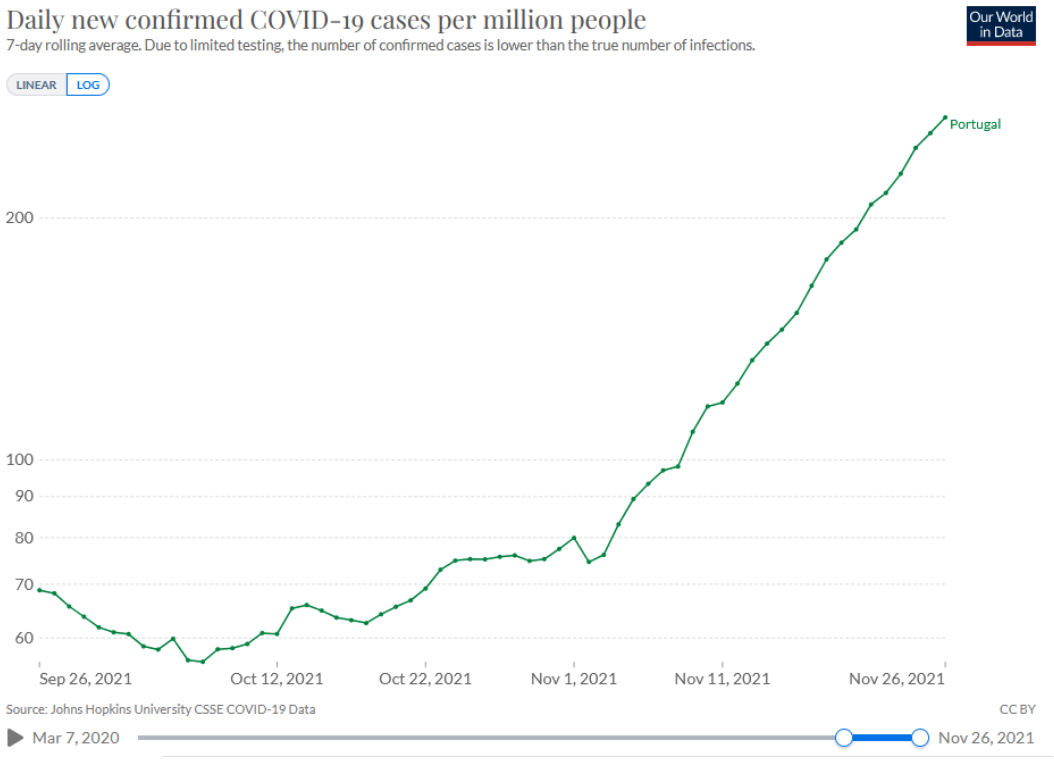
Coronavirus Vaccines.

Animal Model	Vaccine[1]	Protection[2]	Immunopathology[3]
Mice	Whole virus[tr]		
	w alum	Yes	Yes
	Whole virus[25,tr]		
	w alum	Yes	Yes
	wo alum	Yes	Yes
	VLP[17,tr]		
	w alum	Yes	Yes
	wo alum	Yes	Yes
	S Protein[tr]		
	w alum	Yes	Yes
	wo alum	Yes	Yes
	VEE Vector[15]		
	for N protein	No	Yes
	for S protein	Yes	No
	Vaccinia vector[18]		
	for N protein	No	Yes
	for S protein	Yes	?No
Ferrets	Whole virus[11]		
	w alum	Yes	Yes
Nonhuman Primate[4]	Whole virus[11]		
	w alum	Yes	Yes
Hamsters	Whole virus[22]		

Considering the upward trend of hospitalizations and deaths in countries that are most highly vaccinated, one would think that public health officials around the world would be concerned and called for a pause in the mass vaccination campaign. Unfortunately, as is often the case, when people are hyper-committed to and invested in a cause and the results are failing miserably, they are unwilling or even unable to see the obvious even if it smacked them right in the face. And in the meantime, the casualties pile up.

Portugal, the 4th most highly vaccinated country in the world and having delivered over 900,000 booster shots is seeing a large uptick in cases and new restrictions.

Portugal has vaccinated 89.04% of its population (https://ourworldindata.org/covid-vaccinations), as of November 15th, yet as the graph below shows, the cases have risen dramatically in the last 60 days.



Excerpts from Yahoo News article November 5th, 2021, titled, **Portugal returns to COVID restrictions despite high jab rate**…

LISBON, Portugal (AP) — Portugal is bringing back some tight pandemic restrictions, less than two months after scrapping most of them when the goal of vaccinating 86% of the population against COVID-19 was reached.

From Dec. 1, wearing a face mask will once again be mandatory in enclosed spaces; a digital certificate proving vaccination or recovery from the coronavirus must be shown to enter restaurants, cinemas and hotels; and even inoculated people must have a negative test to visit hospitals, elderly care homes, sports events and bars and discos.

The General Directorate for Health officially reported 3,150 new cases Thursday, with 691 people in hospital, 103 in intensive care units and 15 deaths. The number of patients requiring hospitalization was the highest since September.

End of excerpts

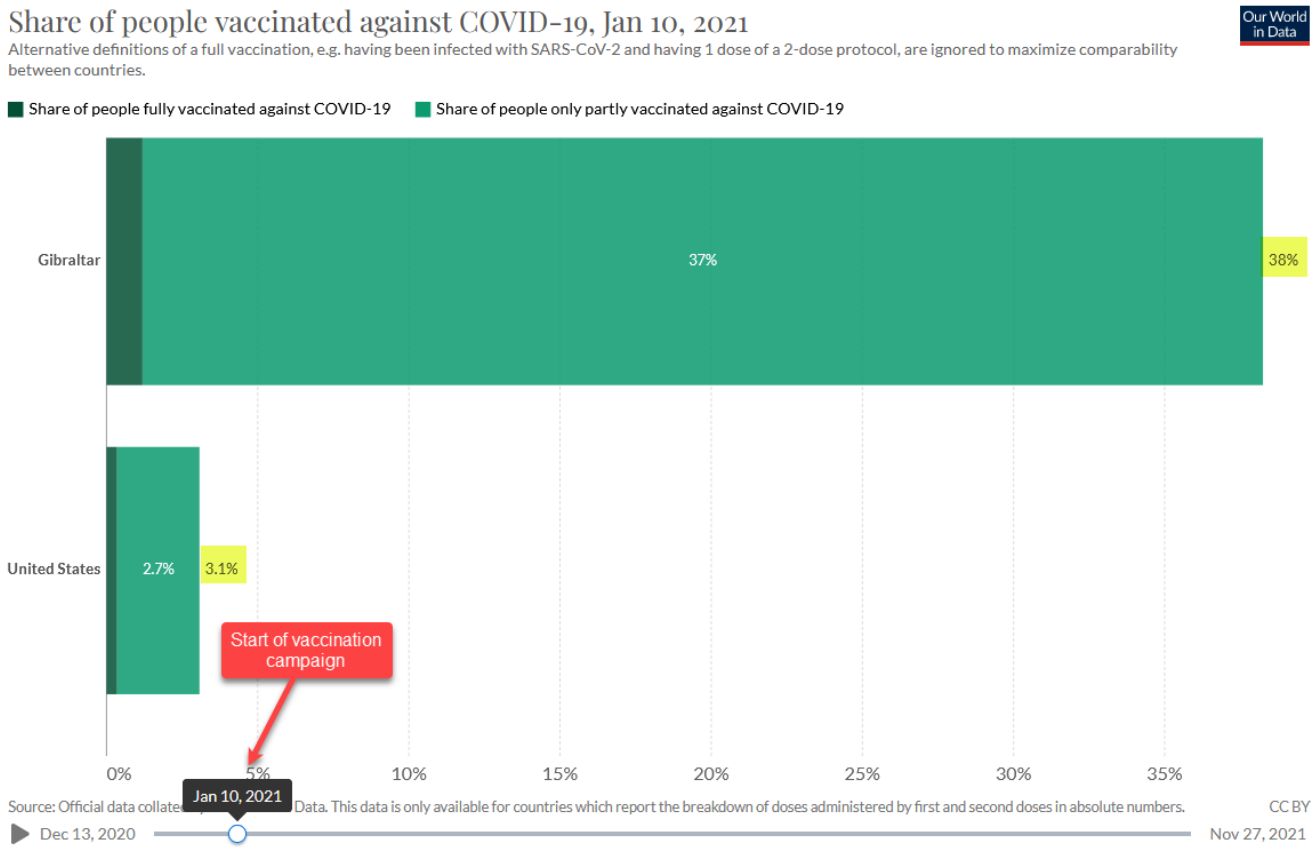
https://news.yahoo.com/portugal-returns-covid-restrictions-despite-182239913.html

Gibraltar, the most highly vaccinated country in the world at 121% has been seeing an uptick in cases as of late

Gibraltar is a tiny British Territory located at the southern tip of Spain with a population of 33,680. As a small nation, it has been easy for government officials to mass vaccinate the entire population rapidly. One of the things that accounts for the greater than 100% of the population vaccinated is that they have a substantial workforce that comes in from outside the country, and those individuals were immediately required to be fully vaccinated also.

Let's also not forget what happened when Gibraltar launched its COVID-19 vaccination campaign like it was shot out of a cannon…

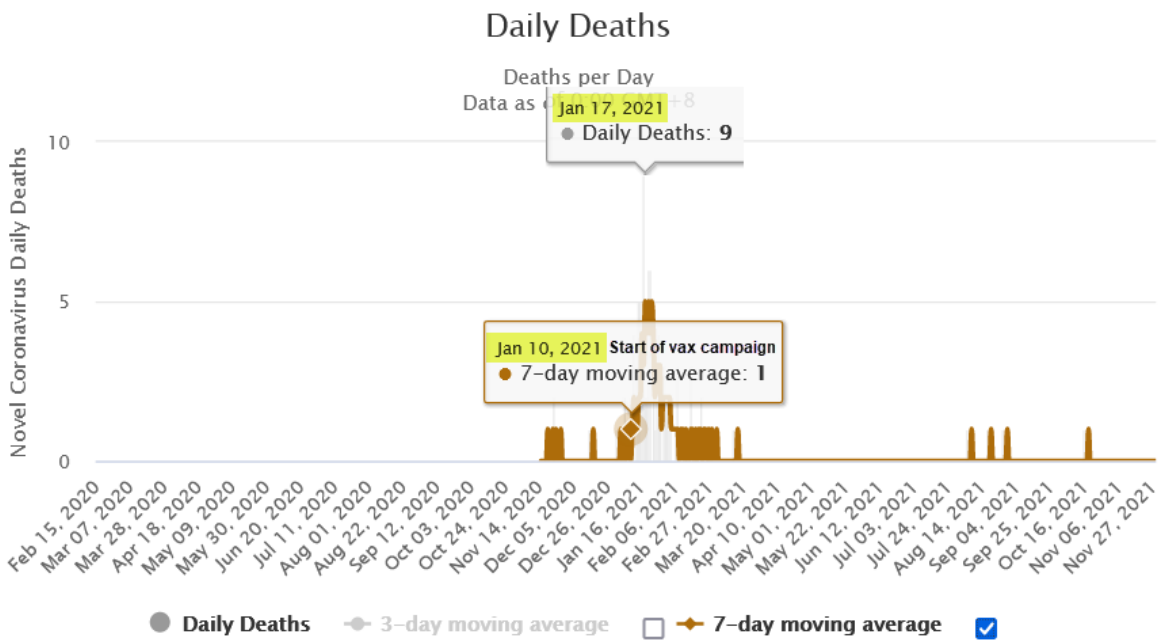
Very early into their COVID-19 vaccination campaign which started with the elderly, Gibraltar already had 38% of its population vaccinated with at least 1 shot. Contrast that to the U.S. with a mere 3.1% at the same point in time.



https://ourworldindata.org/covid-vaccinations

So, what happened to the death rate in Gibraltar at the point of their mass vaccination program? Bear in mind there had been only 10 deaths total in the 11 months prior to the launch of their COVID-19 vaccine campaign.

Daily New Deaths in Gibraltar



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

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.

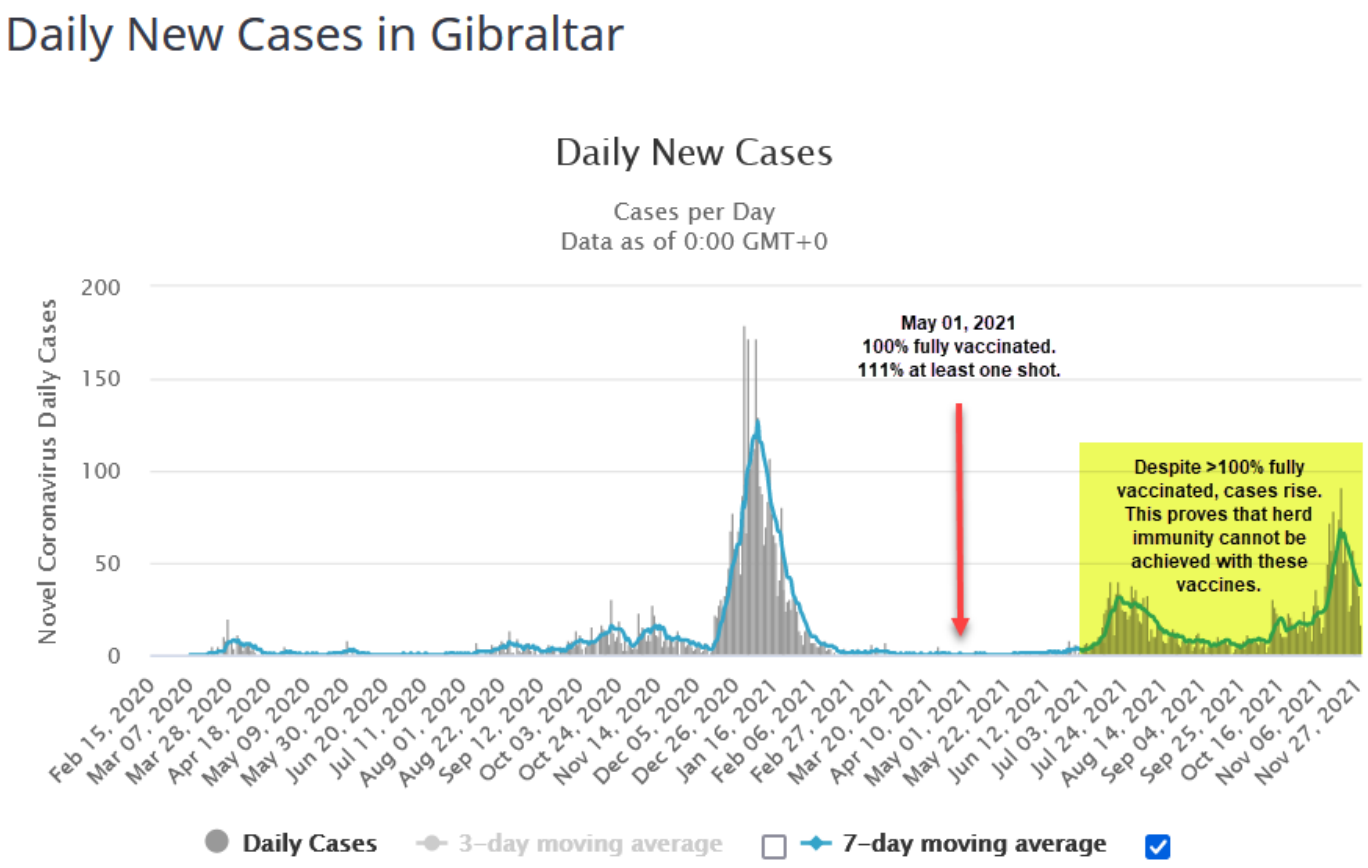
After the first week of vaccination, Chief Minister Fabian Picardo said, "This is now the worst loss of life of Gibraltarians in over 100 years. Even in war, we have never lost so many in such a short time."

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

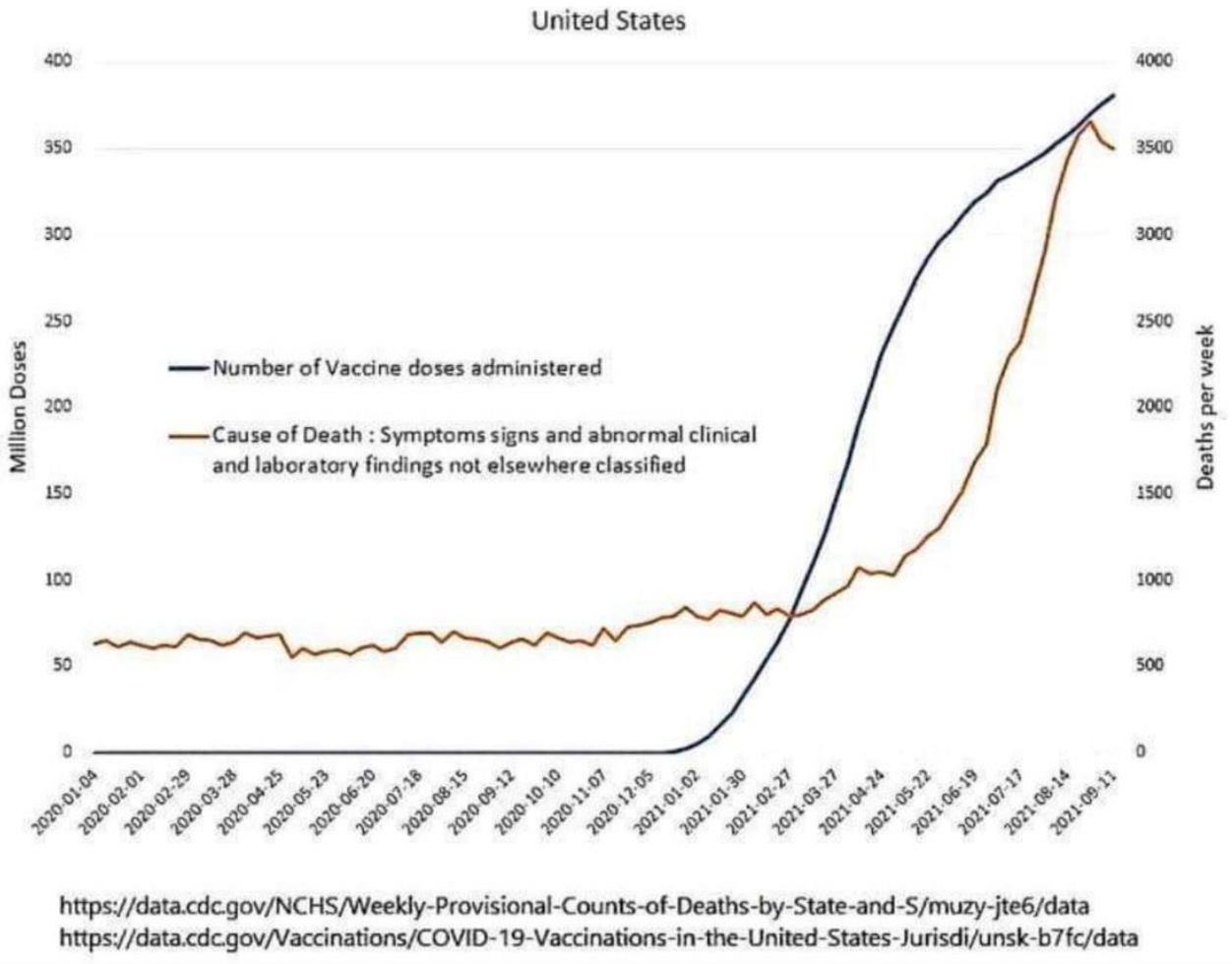
vaccination, and sometimes minutes after, these seniors shared similar side effects, including but not limited to: persistent malaise and extreme exhaustion; severe allergic, including anaphylactic, reactions; multi-system inflammatory syndrome; psychological disturbances; seizures; convulsions; and 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/

The more recent state of affairs in Gibraltar



Shocking graph shows CDC U.S. data of obscure cause of death diagnosis code titled “Symptoms signs and abnormal clinical and laboratory findings not elsewhere classified”, cross-referenced and following COVID-19 vaccine doses administered



When deaths occur, there is no explanation as to cause and no autopsy is done, this is a code that is often utilized. It is sometimes called a “garbage can code”. The question is, why was there such a huge jump in the use of those codes following and tracking along with the rise in vaccination doses administered?

New England Journal of Medicine reports on a mechanism for spike protein driven antibody reaction that may lead to adverse reactions including immune-suppression, myocarditis and autoimmune disease…a possible explanation for some vaccine caused reactions and disease

An article published in the New England Journal of medicine on November 24th, 2021, titled **A Possible Role for Anti-idiotype Antibodies in SARS-CoV-2 Infection and Vaccination** proposes a mechanism by which infection or vaccine induced adverse reactions and long-term complications may occur. This may be one for those that like to geek-out on the science.

The article in its entirety

The development of multiple efficacious vaccines has been critical in the control of the pandemic, but their efficacy has been limited by the appearance of viral variants, and the vaccines can be associated with rare off-target or toxic effects, including allergic reactions, myocarditis, and immune-mediated thrombosis and thrombo-cytopenia in some healthy adults. Many of these phenomena are likely to be immune-mediated.3 How can we understand this diversity in immune responses in different persons?

One way of thinking about the complexity of the immune response is through the lens of anti-idiotype immune responses. The Network Hypothesis, formulated in 1974 by Niels Jerne, described a mechanism by which the antibody responses to an antigen themselves induced downstream antibody responses against the antigen-specific antibody.4 Every antibody that is induced and specific for an antigen (termed “Ab1” antibody) has immunogenic regions, particularly in their variable-region antigen-binding domains, that are unique as a result of genetic recombination of immunoglobulin variable, diversity, and joining (VDJ) genes; VDJ recombination results in new and therefore immunogenic amino acid sequences called idiotopes, which are then capable of inducing specific antibodies against Ab1 antibodies as a form of down-regulation. A simi-lar paradigm has been proposed for T cells. How-ever, these regulatory immune responses are also capable of doing much more. The paratopes, or antigen-binding domains, of some of the resulting anti-idiotype (or “Ab2”) antibodies that are specific for Ab1 can structurally resemble that of the original antigens themselves. Thus, the Ab2 antigen-binding region can potentially represent an exact mirror image of the initial targeted antigen in the Ab1 response, and Ab2 antibodies have even been examined for potential use as a surrogate for the antigen in vaccine studies. However, as a result of this mimicry, Ab2 anti-bodies also have the potential to bind the same receptor that the original antigen was targeting (Fig. 1). Ab2 antibodies binding to the original receptor on normal cells therefore have the potential to mediate profound effects on the cell that could result in pathologic changes, particularly in the long term — long after the original antigen itself has disappeared.

See large graphic on the next page…

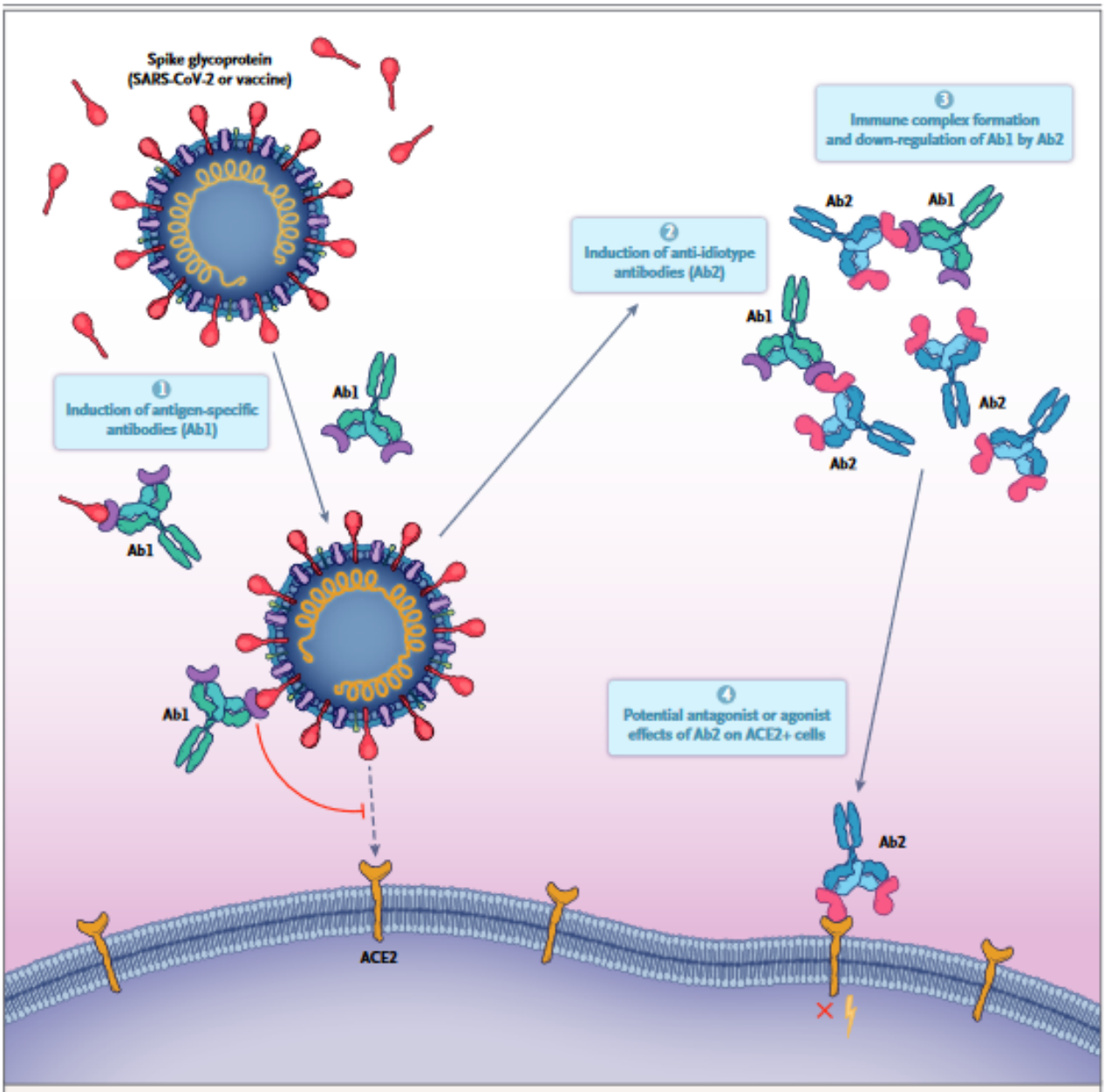


Figure 1. Anti-idiotype Antibodies and SARS-CoV-2.

Both severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection and the vaccines against it elicit antibodies to the spike protein that the virus uses to bind to the angiotensin-converting–enzyme 2 (ACE2) receptor on target cells. The receptor is widely expressed. These antibodies are called Ab1. The idiotype portions of Ab1 that bind and neutralize the spike protein have distinctive sequences in complementarity-determining region 3 (CDR3), and those antibody-binding regions can themselves elicit antibody responses called anti-idiotype (Ab2) antibodies as a means of down-regulation. Ab2 antibodies can act in several ways. They can bind to the protective neutralizing Ab1 antibody, resulting in immune-complex formation and clearance, thus impairing Ab1 efficacy. Some of the Ab2 binding regions, or paratopes, can also mirror the spike protein itself and bind to the same target as the spike protein, the ACE2 receptor. That binding could, in theory, exert several different — but not necessarily mutually exclusive — effects on the cell, depending on the nature of the Ab2 antibodies and the role of the receptors in the cell: for example, it could potentially block ACE2 function by competitively inhibiting normal ligand interactions. Alternatively, it could stimulate ACE2 function by triggering the receptor, affect expression of ACE2 after binding by down-regulating or internalizing ACE2, or, after binding the cells, induce a complement-mediated or immune-cell attack on ACE2-expressing cells.

NOTE- The lightning bolt and red X near the bottom right of the diagram indicates the two possible responses of the Ab2 binding with the ACE-2 receptor as described in the last two sentences of the Figure 1 description.

This aspect of regulation of immune-cell responses was postulated by Plotz in 1983 as a possible cause of autoimmunity arising after viral infection5 and has since been supported experimentally by direct transfer of

anti-idiotype antibodies. Ab2 antibodies generated against the enterovirus coxsackievirus B3 in mice can bind myocyte antigens, resulting in autoimmune myo-carditis, and anti-idiotype responses can act as acetylcholine receptor agonists, leading to myasthenia gravis symptoms in rabbits. In addition, by displaying the mirror image of the viral anti-gen, Ab2 alone can even mimic the deleterious effects of the virus particle itself, as has been shown with bovine viral diarrhea virus antigen.

For SARS-CoV-2 infection, attention centers on the spike (S) protein and its critical use of the angiotensin-converting–enzyme 2 (ACE2) receptor to gain entry into the cell. Given its critical role in regulating angiotensin responses, many physiological effects can be influenced by ACE2 engagement. The S protein itself has a direct effect on suppressing ACE2 signaling by a variety of mechanisms and can also directly trigger toll-like receptors and induce inflammatory cytokines. Anti-idiotype responses may affect ACE2 function, resulting in similar effects. However, preclinical and clinical assessments of antibody responses to SARS-CoV-2 vaccines have focused solely on Ab1 responses and virus-neutralizing efficacy. The delineation of potential anti-idiotype responses has inherent difficulties because of the polyclonal nature of responses, dynamic kinetics, and the concurrent presence of both Ab1 and Ab2 antibodies. Furthermore, ACE2 expression within cells and tissues can be variable. The different vaccine constructs (RNA, DNA, adeno-viral, and protein) are also likely to have differential effects on Ab2 induction or in the mediation of vaccine effects that differ from responses to infection. Some off-target effects may not be directly linked to Ab2 responses. The association of thrombotic events with some SARS-CoV-2 vaccines in young women and the etiologic role of anti–platelet factor 4–polyanion antibodies may be the result of the adenoviral vector. However, the reported occurrence of myocarditis after vaccine administration bears striking similarities to the myocarditis associated with Ab2 antibodies induced after some viral infections. Ab2 anti-bodies could also mediate neurologic effects of SARS-CoV-2 infection or vaccines, given the ex-pression of ACE2 on neuronal tissues, the specific neuropathologic effects of SARS-CoV-2 infection, and the similarity of these effects to Ab2-mediated neurologic effects observed in other viral models.

It would therefore be prudent to fully characterize all antibody and T-cell responses to the virus and the vaccines, including Ab2 responses over time. Using huACE2 transgenic mice and crossing them with strains that are predisposed to autoimmunity or other human pathologic conditions can also provide important insights. An understanding of potential Ab2 responses may also provide insights into Ab1 maintenance and efficacy and into the application of antibody-based therapeutic agents. However, much more basic science research is needed to determine the potential role idiotype-based immunoregulation of both humoral and cell-mediated responses may play both in antiviral efficacy and in unwanted side effects of both SARS-CoV-2 infection and the vaccines that protect us from it.

End of article

https://www.nejm.org/doi/full/10.1056/NEJMcibr2113694

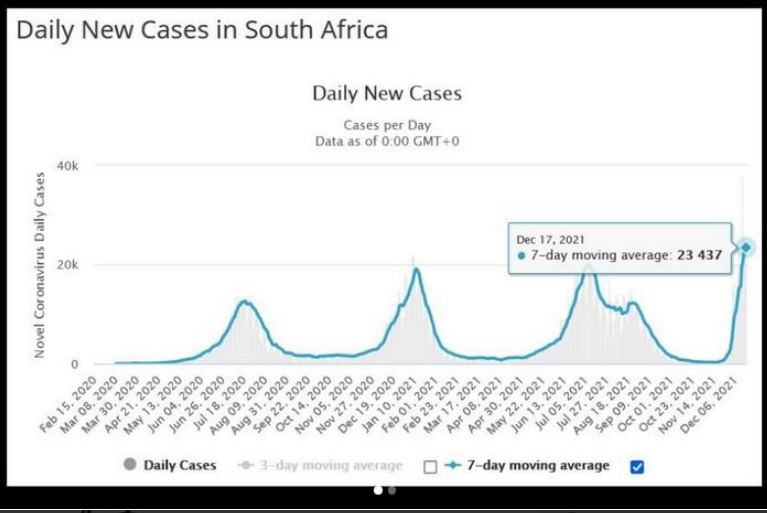
Updates January 1st, 2022

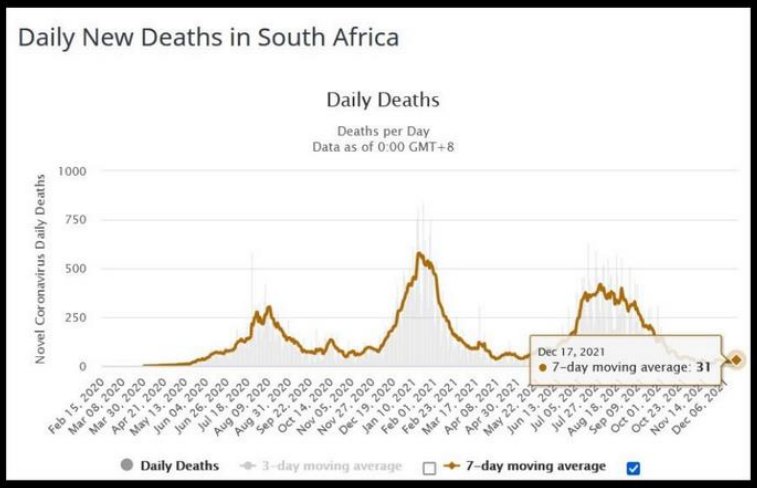
Omicron- The latest excuse for more endless fear-mongering. What are the FACTS?

This is an Instagram post from me providing a visual representation of the absurdity of the narrative.

Dr. Alan Palmer
@1200studies

Compare these two graphs and tell me how they can create such hysteria and fear-porn out of Omnicron





7-day average of daily cases at an all-time high and
Daily deaths at an all-time low

OMG it Omnicron!!! 😱

My comment with the post

It never ceases to amaze me how our government officials and the media can take what appears to be good news; a variant that by all indications produces mild illness (and natural immunity building towards population herd immunity) into the next monster that justifies more drastic freedom suppressing measures. Welcome to the next phase of their idea of totalitarian Nirvana.

You can follow me here: 1200 studies

Bear in mind that South Africa has a low vaccination rate. As of December 17th, 2021, just 26% of their population has been fully vaccinated.

Omicron sweeps across the world in record time

As always, a word of caution in interpreting cases…Peaks in cases throughout the course of the pandemic can simply be bases on the number of tests performed.

As an example. If 10,000 people in a town of 20,000 people have the infection and tests are available and performed on 5,000 people who then tested positive, it would appear as 5,000 "cases" in that town. In that case, 25% of the town would be said to have COVID-19 (which isn't technically accurate. But I digress).

If on the other hand only 50 tests were available and 50 people were tested as positive, it would appear that just 0.25% or a quarter of 1,000 of the town had COVID-19, an amount 100 times less than the previous example. The truth is that the same number of people had the infection in either example, but it appeared like there were many more cases because of the testing availability. It just goes to show you that appearances can be deceiving.

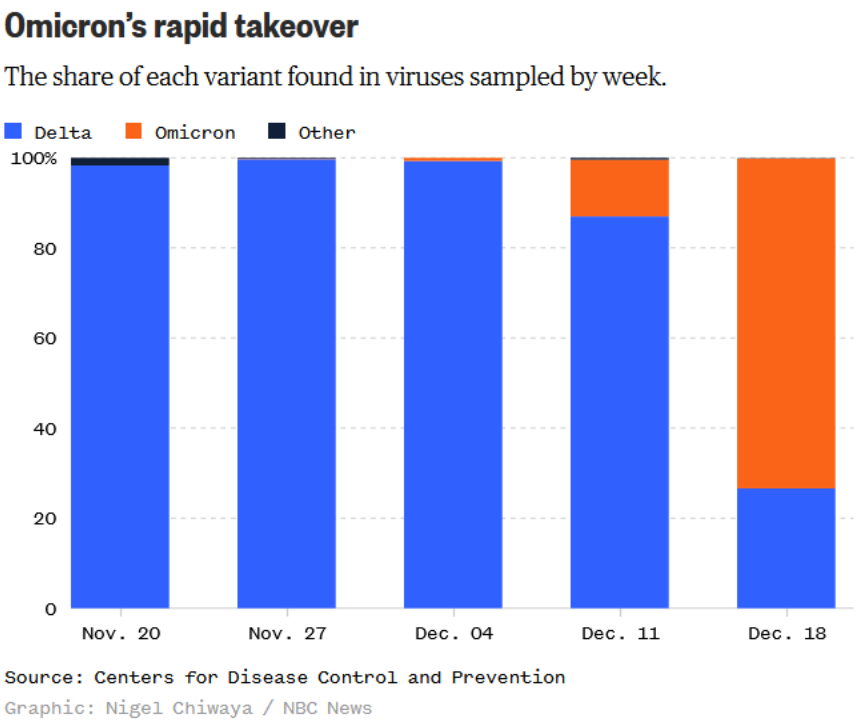
On that note, the Biden administration just announced this past week that they were ordering 500 million tests to make them available in the United States. As these tests are rolled out and used by many more people will the numbers reported by the media be a reflection of how many people are diagnosed with COVID-19 in the United States, or just the fact that there ae a record number of tests available ready to deploy.

An article from ***NBC News*** posted December 20th 2021 titled, **Omicron variant accounts for 73 percent of new Covid cases in U.S.** describes just how fast the omicron variant has spread across the country.

From the article

The omicron variant has overtaken delta as the dominant coronavirus variant in the United States: As of Friday, more than 73 percent of new cases in the country were caused by omicron, according to data the Centers for Disease Control and Prevention posted Monday.

Here is a chart showing the incredible speed at which Omicron is becoming the dominant variant in the U.S.

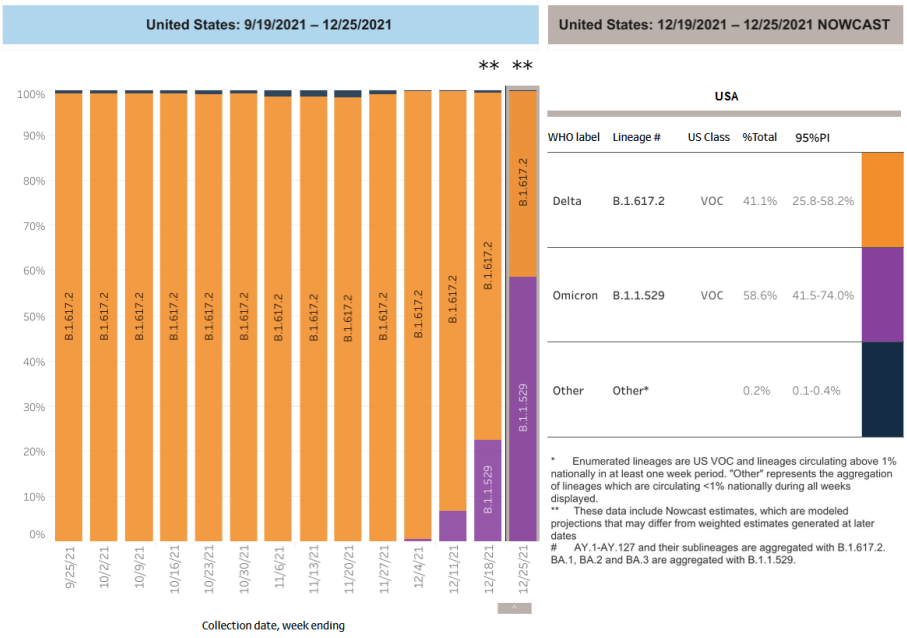


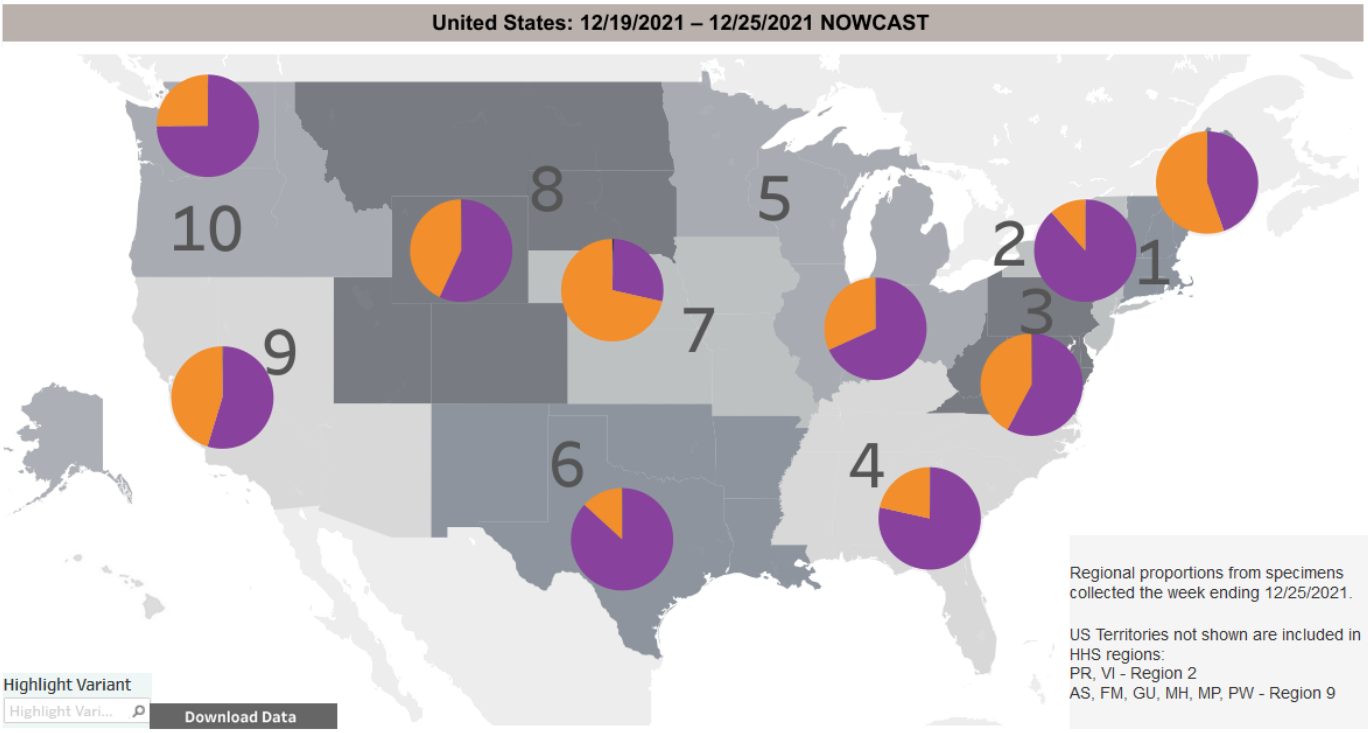
In certain areas of the country, the omicron variant accounts for more than 90 percent of new cases, including New York and New Jersey, as well as parts of the Midwest, the South and the Pacific Northwest.

"This sharp rise in omicron cases was expected and is similar to what has been seen worldwide," the CDC said in a statement.

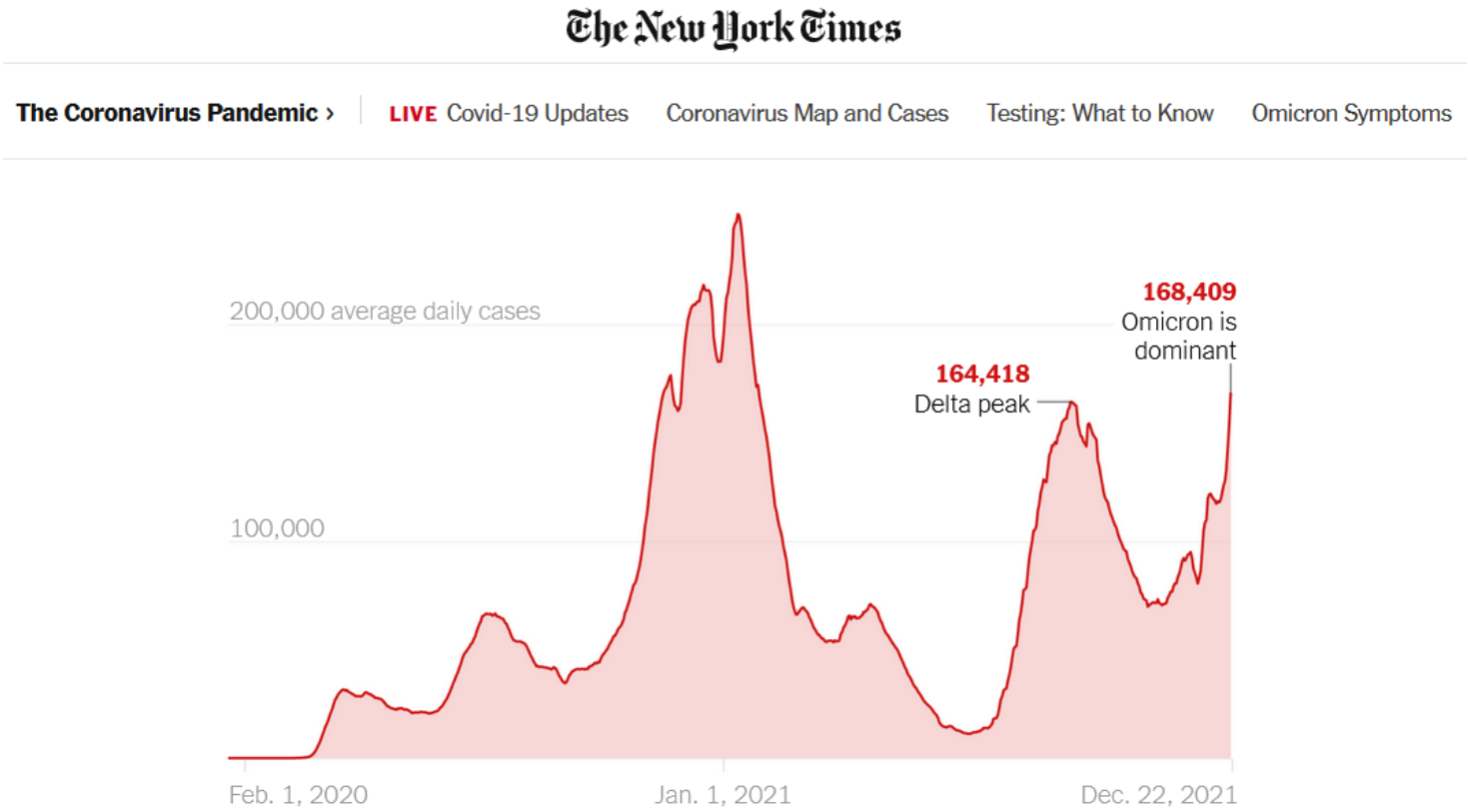
https://www.nbcnews.com/health/health-news/omicron-variant-accounts-73-percent-new-covid-cases-us-rcna9434

The CDC's real-time variant tracker





Another look at the rise of Omicron



https://www.nytimes.com/interactive/2021/12/23/us/omicron-case-count.html

Omicron Cases Explode in Arizona: See Latest CDC Data

The omicron spike comes three weeks after the variant was detected half a world away and days before Americans gather for the holidays, sparking fears among health officials that COVID-19 cases could return to early pandemic levels.

In the federal Center for Disease Control and Prevention's Region 9, which includes Arizona, omicron variant cases outpace the delta variant, according to the CDC.

In Region 9, as of Saturday (December 18th), the omicron variant made up 59 percent of reported cases of COVID-19, while the delta variant made up 40 percent of cases, according to CDC data.

The CDC numbers reported Monday show how quickly omicron is spreading. Nationwide, omicron variant cases increased six-fold in only a week.

As of Dec. 11, the omicron variant accounted for only 4.1 percent of cases in Region 9, and the delta variant made up 95.4 percent of cases, according to the CDC.

The CDC's Region 9 includes Arizona, California, Nevada and Hawaii.

https://patch.com/arizona/phoenix/omicron-cases-explode-arizona-see-latest-cdc-data

A December 17th study theorizes why Omicron is less lethal even though it is much less more transmissible

Ravi Gupta is ***Professor of Clinical Microbiology Department of Medicine University of Cambridge***. He was named in the TIME100 Most Influential Globally in 2020. He was the lead scientist on the team that looked at the reasons why the Omicron variant seems to be less dangerous. The title of the study is **SARS-CoV-2 Omicron spike mediated immune escape, infectivity and cell-cell fusion.**

First the abstract from the study (just submitted to pre-print). Then I will show their Twitter feed with some summaries and conclusions.

Abstract

The Omicron variant emerged in southern Africa in late 2021 and is characterised by multiple spike mutations across all spike domains. Here we show that the Omicron spike confers very significant evasion of vaccine elicited neutralising antibodies that is more pronounced for ChAdOx-1 adenovirus vectored vaccine versus BT162b2 mRNA vaccine. Indeed neutralisation of Omicron was not detectable for the majority of individuals who had received two doses of ChAdOx-1. Third dose mRNA vaccination rescues neutralisation in the short term. Despite three mutations predicted to favour spike S1/S2 cleavage, observed cleavage efficiency is lower than for wild type Wuhan-1 D614G and Delta. We demonstrate significantly lower infectivity of lung organoids and Calu-3 lung cells expressing endogenous levels of ACE2 and TMPRSS2 but similar infection as compared to Delta when using H1299 lung epithelial cells. Importantly, fusogenicity of the Omicron spike is significantly impaired, leading to marked reduction in syncitia formation. These observations

highlight that Omicron has gained immune evasion properties whilst compromising on properties associated with replication and pathogenicity.

My comment:

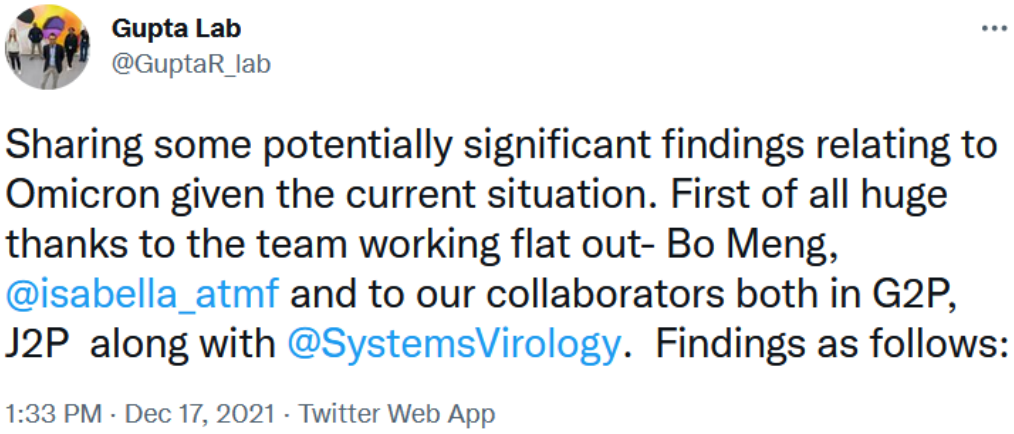
This shows that there is escape from the neutralizing antibodies produced by vaccines. I consider the last three sentences key in that it describes the finding that this variant has greater affinity for infection of cells in the upper respiratory tract but not in the lungs. it also indicates that It has lower ability for replication of the virus and pathogenicity or harm. If you think about the 30 or so mutations just along the spike protein itself including the receptor binding domain which is where the virus attaches to our cells, these mutations may be inhibiting the viruses ability to infect the cells because of its decreased ability to cleave the furin site and dock with the ACE-2 receptors of the cell.

Case in point, from the study

Omicron spike is relatively poorly cleaved, and impaired in mediating cell-cell fusion and syncytia formation. This reduced cleavage is also associated with poorer entry into target lung organoids or cell lines expressing endogenous levels of receptors.

https://www.biorxiv.org/content/10.1101/2021.12.17.473248v1.full.pdf

Now for the Twitter feed from Gupta Lab about their findings…

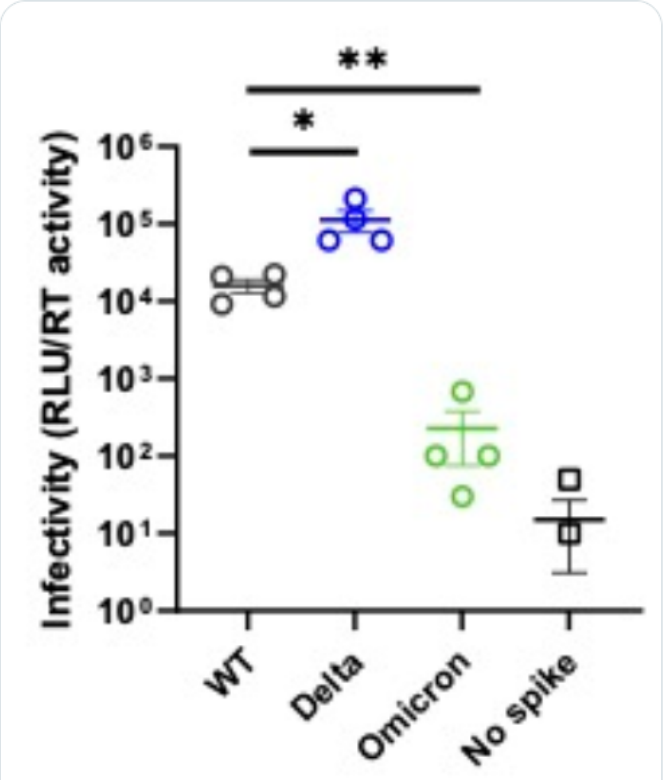


Continued on the next page…

Gupta Lab @GuptaR_lab · Dec 17

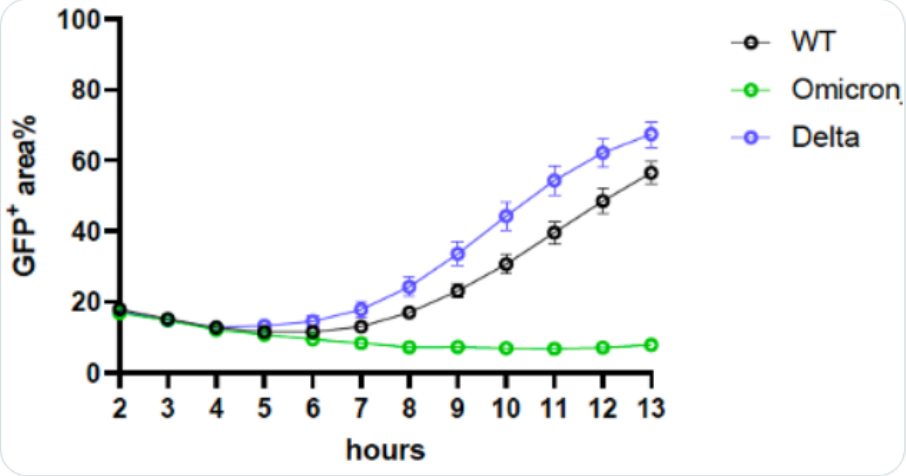
Replying to @GuptaR_lab

1. Omicron Spike protein mediates deficient cell entry and is inefficiently cleaved compared to Delta spike. We tested viral entry mediated by Wild Type, Delta and Omicron spikes using a pseudotyped virus system, infecting primary 3D lung alveolar organoids.



Gupta Lab @GuptaR_lab · Dec 17

2. Omicron Spike protein induces relatively poor cell-cell fusion compared to WT and Delta. We expressed spike in cells stably expressing split GFP, so that Green signal could be measured over time upon cell-cell fusion and syncitia formation. The difference is significant.

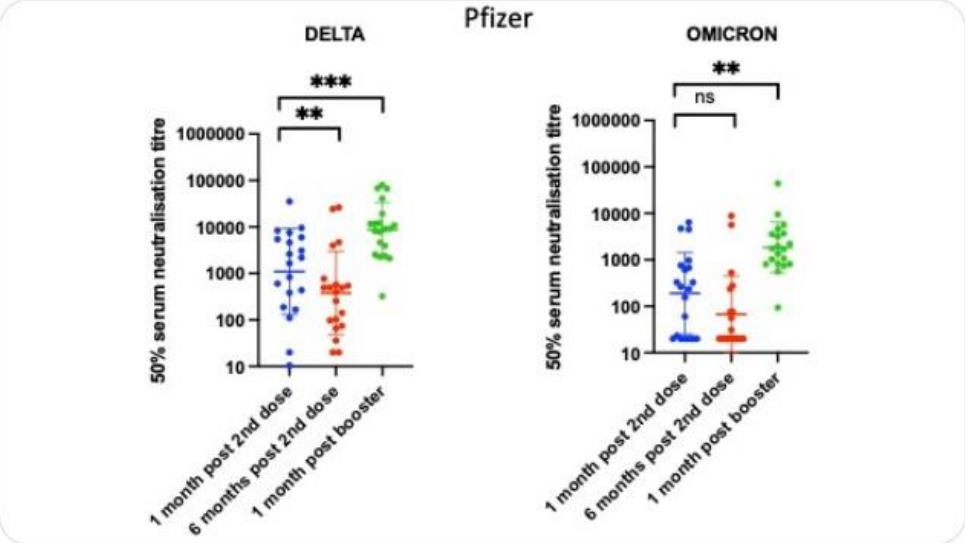


Gupta Lab @GuptaR_lab · Dec 17

3. What does this all mean? Efficient infection of lung cells could correlate with severity of lung disease. Syncitia or fused cells are often seen in respiratory tissues taken following severe disease. Delta was very good at both, in contrast to Omicron. Further work is needed

Gupta Lab @GuptaR_lab · Dec 17

4. We also tested how well antibodies from vaccinated individuals neutralised Omicron v Delta. We found that Omicron was poorly neutralised after two doses of mRNA or Ad vectored vaccine compared to Delta, but that the third dose (mRNA vaccine) rescued this at an early time point



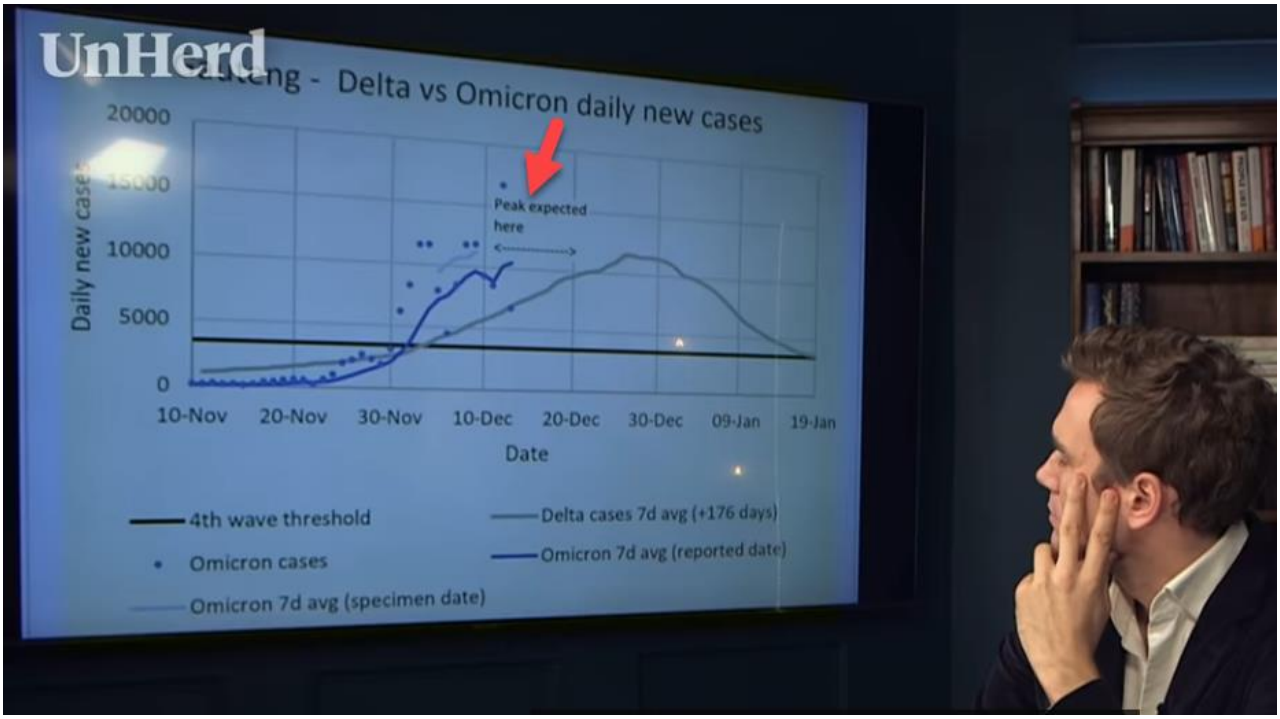
Gupta Lab @GuptaR_lab · Dec 17

5. In summary this work suggests that Omicron does appear to have become more immune evasive, but that properties associated with disease progression *may* be attenuated to some extent. The significant growth of Omicron nevertheless represents a major public health challenge.

Current status of Omicron in South Africa

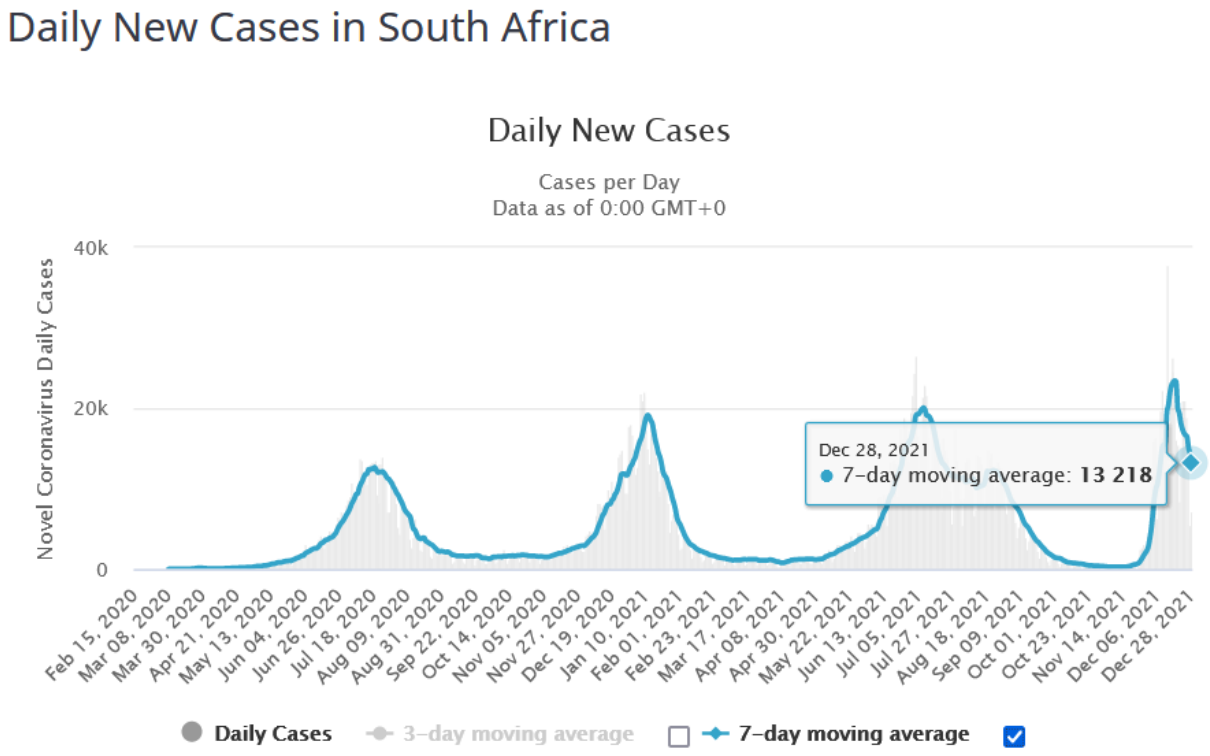
These graphs really say it all. Even two weeks after the peak of cases, deaths never increased. And now, the cases are dropping precipitously as predicted in a great interview with a researcher at the University of Johannesburg on December 15th, 2021. https://www.youtube.com/watch?v=RWrjX1ty2EU

Here is a screen capture from that interview with the predicted peak of the Omicron wave in South Africa (below the red arrow). Then as you will see just below that picture, the prediction appears to be right on.

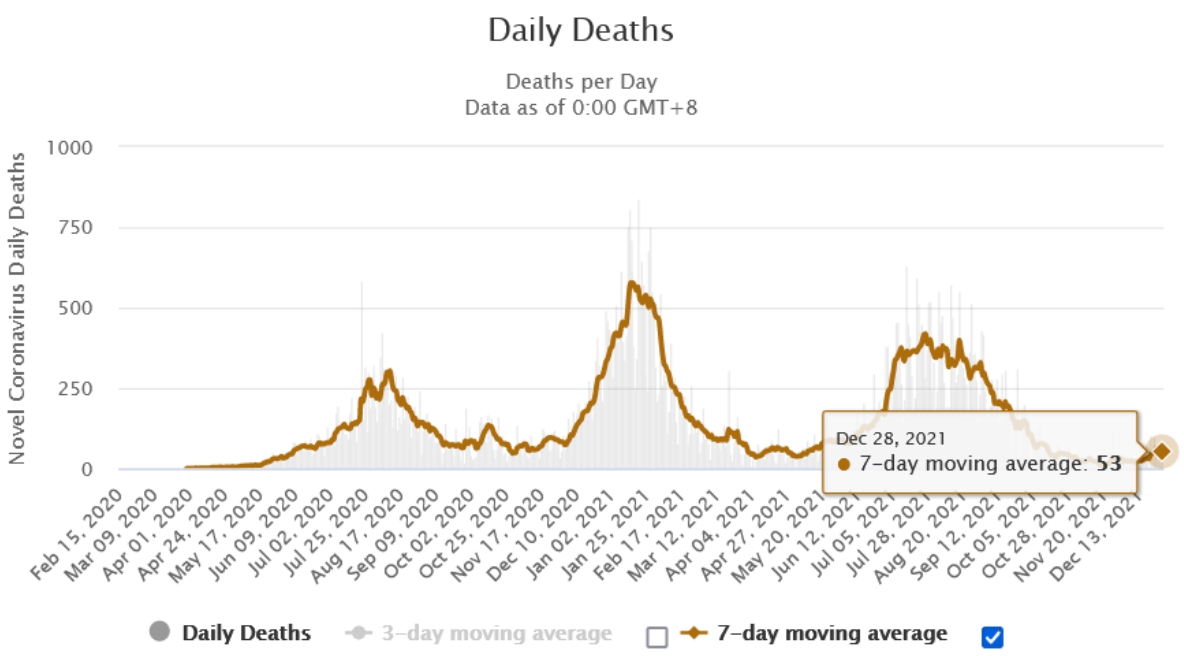


NOTE: The gray line representing the delta wave is simply to show the gradient of that wave which occurred six months prior. You can see that the omicron wave rises much more steeply than delta did. That's because of the increased rate of transmissibility of omicron. But, as you will see from the graph below the omicron wave drops off much more precipitously as well.

As we see the success reflected in South Africa, one important thing to keep in mind is that South Africa is only 26% vaccinated.



Daily New Deaths in South Africa



The great take-away from this, is that as cases reached a record high and hospitalizations stayed at a record low, it signals that Omicron may be the break that we have all been waiting for, a way out of this pandemic. Well, at least for all of us who aren't being enriched by thew suffering and misery of others. If large numbers of healthy people can catch what seems to amount to a cold, gain natural immunity and in doing so continue to build that wall brick by brick that will ultimately protect the elderly and the vulnerable, that will ultimately be our way out. It's the way humans have survived for thousands of years, even before the notion that we needed fancy new "vaccines" to save us.

The Great Divide

Once again, we see the great divide between the growing number of uncompromised scientists, medical doctors and health experts that have been following the data and the science (let's call them group A) and the public health bureaucrats, pharma pawns and their minions in the media (group B).

Group A looks at Omicron

and sees this…

Group B looks at Omicron

and sees this…

If this little characterization makes you cringe, please understand the context in which I'm using it. Unfortunately, even a milder version of the virus like omicron can be serious for some people. This is not to make light of that. It is simply to say that if there was one thing that could help us get through this horrific event, it would be a version of the virus that would affect an even greater majority of people like the common cold than the original version did and then give them natural immunity. With the original version, approximately 99.98% of all people combined survived. Maybe Omicron would improve that to 99.999%. And beyond that, would send far fewer people into the hospital alleviating stress on our already stretched medical resources. This would be a huge win!

Omicron's mutations have not only escaped the "vaccines", they may have also escaped the previously effective monoclonal antibody treatments

An ABC News article published December 19th, 2021 titled, **Omicron may sideline two leading drugs against COVID-19**, warns that two of the three monoclonal antibody treatments may not be as effective against Omicron.

WASHINGTON – As strained U.S. hospitals brace for a new surge of COVID-19 cases caused by the fast-spreading omicron variant, doctors are warning of yet another challenge: the two standard drugs they've used to fight infections are unlikely to work against the new strain.

For more than a year antibody drugs from Regeneron and Eli Lilly have been the go-to treatments for early COVID-19, thanks to their ability to head off severe disease and keep patients out of the hospital.

But both drugmakers recently warned that laboratory testing suggests their therapies will be much less potent against omicron, which contains dozens of mutations that make it harder for antibodies to attack the virus. And while the companies say they can quickly develop new omicron-targeting antibodies, those aren't expected to launch for at least several months.

A third antibody from British drugmaker GlaxoSmithKline appears to be the best positioned to fight omicron. But Glaxo's drug is not widely available in the U.S., accounting for a small portion of the millions of doses purchased and distributed by the federal government. U.S. health officials are now rationing scarce drug supplies to states.

"I think there's going to be a shortage," said Dr. Jonathan Li, director of the Harvard/Brigham Virology

Specialty Laboratory. “We’re down to one FDA-authorized monoclonal antibody” with omicron because of the reduced effectiveness of Regeneron and Lilly’s drugs.

Glaxo’s drug, developed with Vir Biotechnology, was specifically formulated to bind to a part of the virus that is less likely to mutate, according to the companies. Early studies of laboratory-simulated omicron by the drugmakers and outside researchers show promising results.

Supply of the drug is “extremely limited, and additional doses of the product will not be available until the week of January 3rd,” the U.S. Department of Health and Human Services said in an statement posted online. After pausing distribution last month to conserve supply, HHS is now shipping 55,000 doses of the drug, called sotrovimab, to state health departments, with the doses arriving as early as Tuesday. An additional 300,000 are expected in January.

The agency said it is distributing the drug to states based on their levels of infections and hospitalizations. HHS recommends states conserve the drug for the highest risk patients who are most likely to have omicron infections, either based on laboratory testing that can identify the variant or elevated levels of omicron spread in local communities, identified as 20% and higher.

End of excerpts

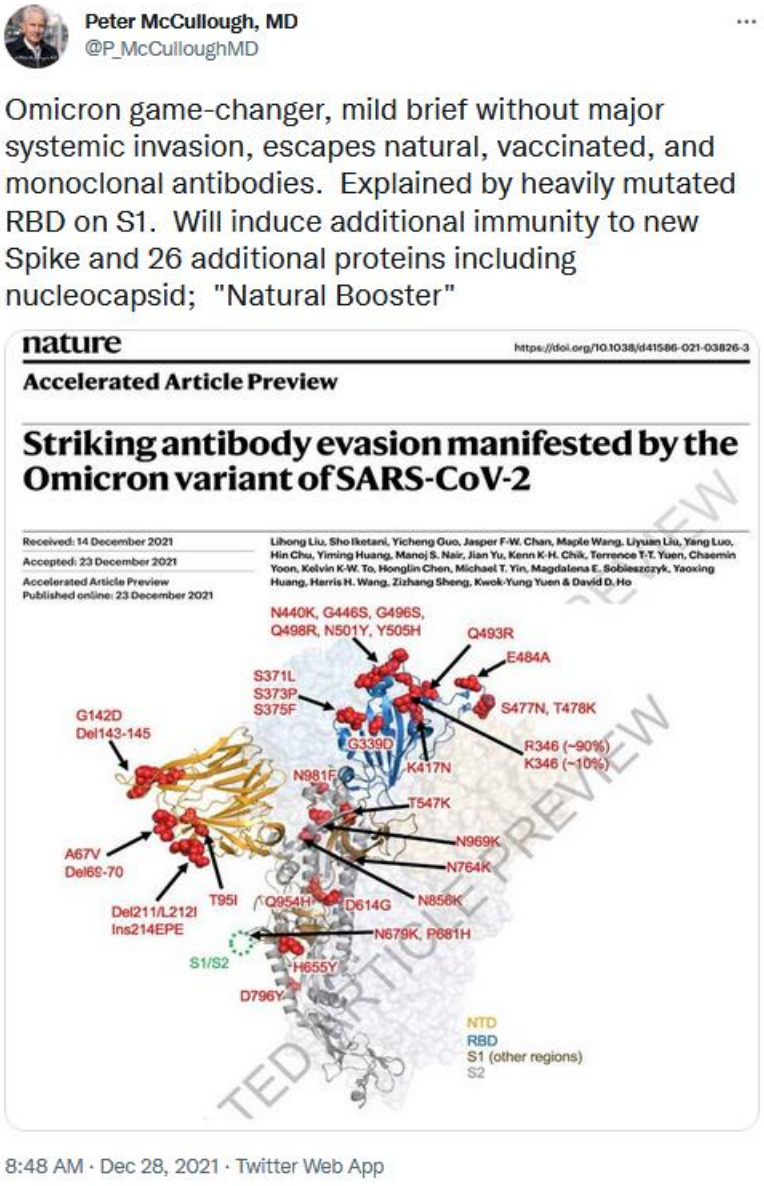
https://abcnews.go.com/Technology/wireStory/omicron-sideline-leading-drugs-covid-19-81844019

If what many vaccine experts warning that the mass vaccine program is driving the variants is true, it signals another unintended consequence of the disastrous world vaccination program. Fortunately, Omicron appears to be less lethal, but what if new mutations driven by the vaccines become more lethal?

Continued on the next page…

A December 23rd, 2021 article in *Nature* discusses the implications of the Omicron regarding vaccine, monoclonal antibody treatment and immune escape

Dr. Peter McCullough Tweeted about this new research saying the following…



Abstract

The Omicron (B.1.1.529) variant of SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2) was only recently detected in southern Africa, but its subsequent spread has been extensive, both regionally and globally. It is expected to become dominant in the coming weeks, probably due to enhanced transmissibility. A striking feature of this variant is the large number of spike mutations that pose a threat to the efficacy of current COVID-19 (coronavirus disease 2019) vaccines and antibody therapies. This concern is amplified by the findings from our study. We found B.1.1.529 to be markedly resistant to neutralization by serum not only from convalescent patients, but also from individuals vaccinated with one of the four widely used COVID-19 vaccines. Even serum from persons vaccinated and boosted with mRNA-based vaccines exhibited substantially diminished neutralizing activity against B.1.1.529. By evaluating a panel of monoclonal antibodies to all known

epitope clusters on the spike protein, we noted that the activity of 17 of the 19 antibodies tested were either abolished or impaired, including ones currently authorized or approved for use in patients. In addition, we also identified four new spike mutations (S371L, N440K, G446S, and Q493R) that confer greater antibody resistance to B.1.1.529. The Omicron variant presents a serious threat to many existing COVID-19 vaccines and therapies, compelling the development of new interventions that anticipate the evolutionary trajectory of SARS-CoV-2.

From the study

The scientific community has chased after SARS-CoV-2 variants for a year. As more and more of them appeared, our interventions directed to the spike became increasingly ineffective. The Omicron variant has now put an exclamation mark on this point. It is not too far-fetched to think that this SARS-CoV-2 is now only a mutation or two away from being pan-resistant to current antibodies, either monoclonal or polyclonal. We must devise strategies that anticipate the evolutional direction of the virus and develop agents that target better conserved viral elements.

End of excerpts

https://www.nature.com/articles/d41586-021-03826-3

To many that sounds frightening and maybe even hopeless to some. That would be for those who put their hope and faith in what man can devise. But remember, and I think this was Dr. McCullough's point in the last sentence of his Tweet, that natural immunity will build a defense to THIS configuration of the virus and develop a Taylor-made response for the next time it or a similar downstream variant is encountered… "Will induce additional immunity to new Spike and 26 additional proteins including nucleocapsid; "Natural Booster"."

How early into the vaccination program was it discovered that the variants were significantly evading the vaccines? This study may surprise you.

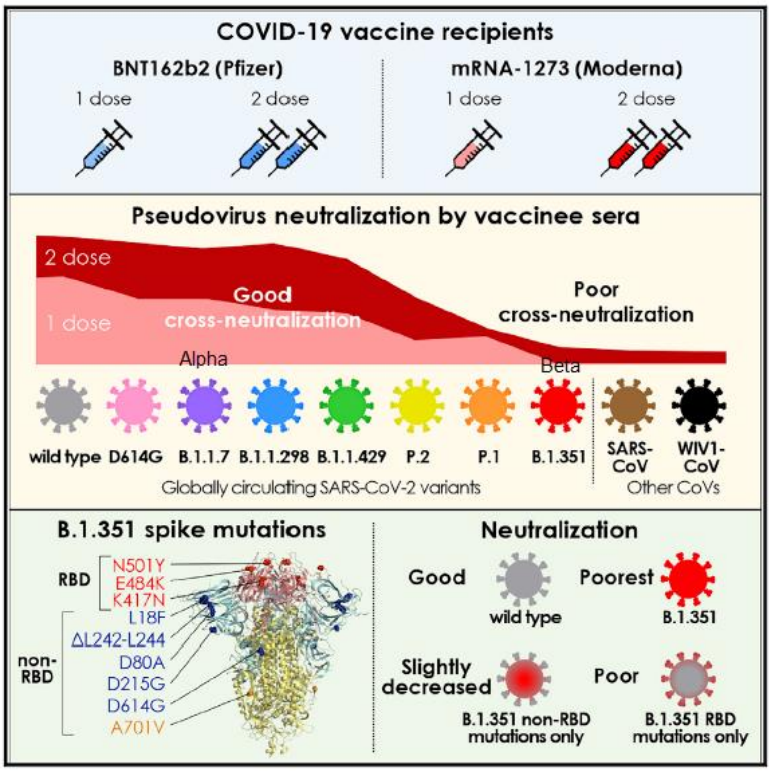
In an April 29th, 2021 study published in the highly respected journal ***Cell*** titled, **Multiple SARS-CoV-2 variants escape neutralization by vaccine-induced humoral immunity**, it became acutely obvious that even the beta strain originating in South Africa, which was the second variant of concern to arise had mutations that affected the Receptor Binding Domain (RBD) and significantly evaded the vaccines. This was only four months into the vaccine program.

SUMMARY – (Emphasis mine)

Vaccination elicits immune responses capable of potently neutralizing SARS-CoV-2. However, ongoing surveillance has revealed the emergence of variants harboring mutations in spike, the main target of neutralizing antibodies. To understand the impact of these variants, we evaluated the neutralization potency of 99 individuals that received one or two doses of either BNT162b2 ***(Pfizer)*** or mRNA-1273 ***(Moderna***) vaccines against pseudoviruses representing 10 globally circulating strains of SARS-CoV-2. Five of the 10 pseudoviruses, harboring receptor binding domain mutations, including K417N/T, E484K, and N501Y, were highly resistant to neutralization. Cross-neutralization of B.1.351 ***(Beta)*** variants was comparable to SARS-CoV and bat-derived

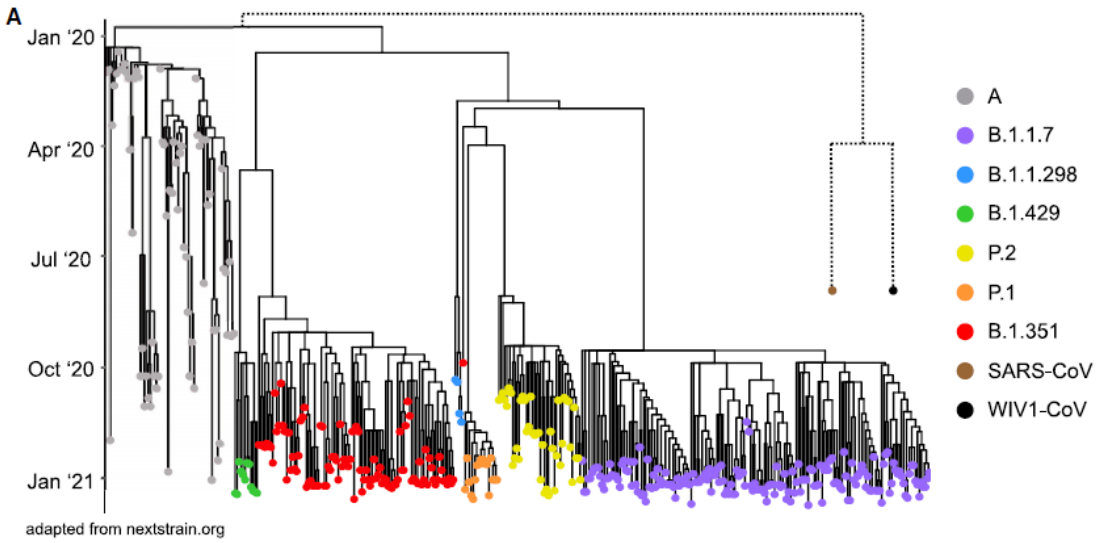
WIV1-CoV, **suggesting that a relatively small number of mutations can mediate potent escape from vaccine responses.** While the clinical impact of neutralization resistance remains uncertain, these results highlight the potential for variants to escape from neutralizing humoral immunity and emphasize the need to develop broadly protective interventions against the evolving pandemic.

Notice how dramatically the neutralization of the virus had dropped by the time the Beta variant appeared.

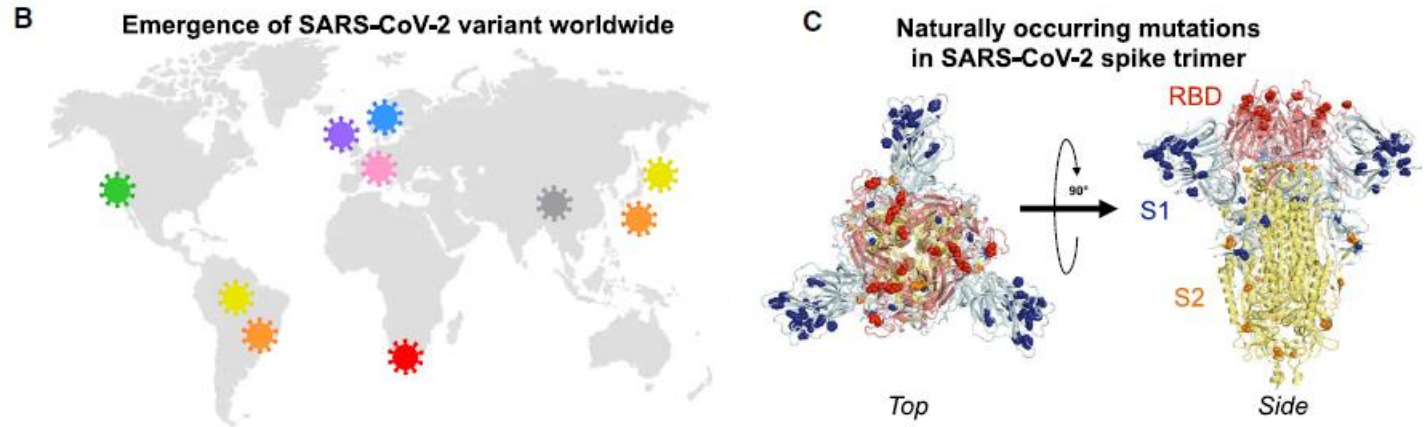


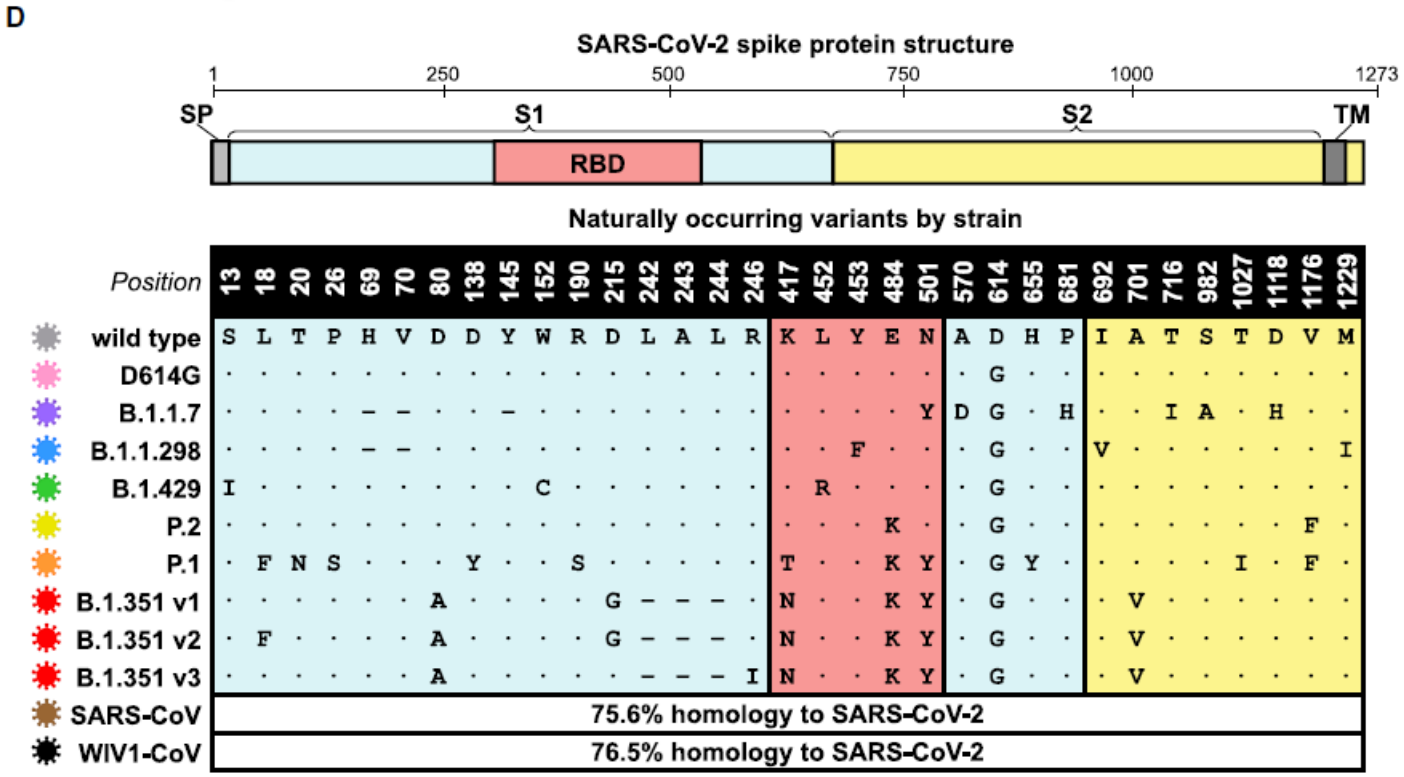
[I have tagged two of them Alpha (U.K.) and Beta (S. African)]
Also, P1 is the Gamma or "Brazilian"

My comment: One thing I find fascinating is how the virus underwent several minor mutations over the course of the first several months of circulation, and then there was what seemed like an explosion of mutations all occurring at nearly the same time starting in October 2020 and originating in various countries.



My observation and not those of the authors:
I have covered interviews in previous issues with various vaccine developers and specialists suggesting that this mass vaccination program with a leaky vaccine unable to prevent infection or transmission during a pandemic will drive the development of greater mutations. We know the worldwide vaccine program started in December and January of 2020/2021 for most countries, so some of these variants developed prior to that. During the clinical trials there were tens of thousands of people who were vaccinated in different countries around the globe. It's interesting to note that the United States, Great Britain, South Africa and Brazil were some of the main locations for those clinical trials. These countries are also countries where major variants emerged prior to the mass vaccination program of the public. And interestingly, those vaccine projects were occurring just prior to the emergence of these escape mutant variants. Looking at the above graphic, one can't help but wonder what the association may be.





The letters to the right of variant represent the substitution "errors" made while making copies of the amino acid sequences as the virus is replicating inside the cells of the body. You can see how the P1 and the B.1.351

versions have the most mutations in zone of the Receptor Binding Domain (RBD), as shown by the pink color. According to the authors this is one of the key things that makes that South African or Beta variant so resistant to the vaccines are the mutations in that part of the spike protein. The vaccines train the immune system to only target the spike protein. So if the virus can alter those portions the immune system is targeting, it's a big win for the virus. Nature always finds a way.

Key point by the authors on natural immunity…

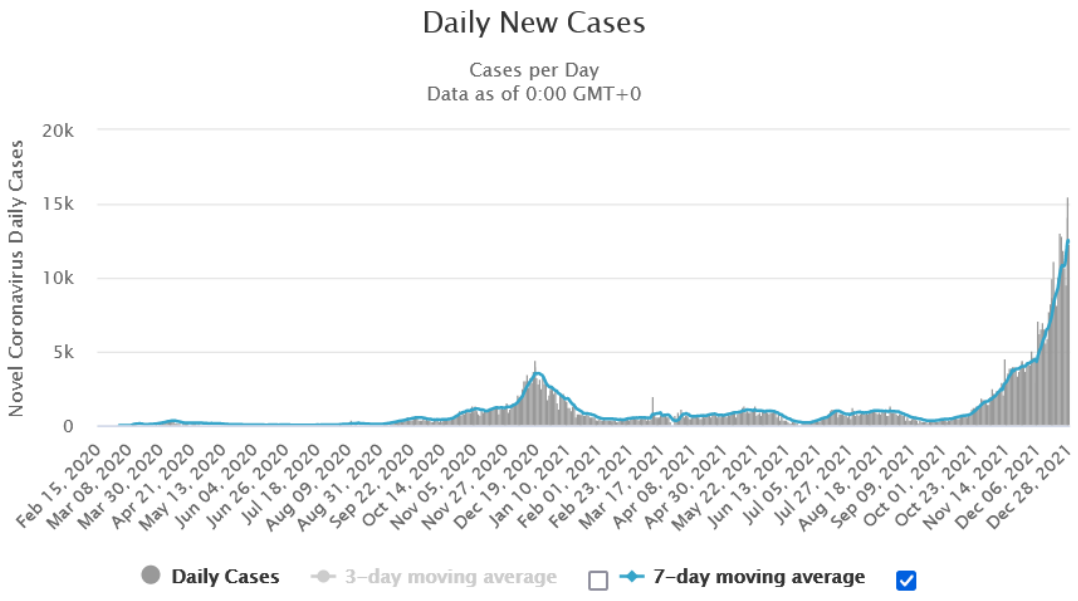
One important aspect of immunity not addressed by our work is cellular immunity contributed by cytotoxic lymphocytes, including T and natural killer (NK) cells. Even in the absence of neutralizing humoral immunity, previous studies have suggested that cellular immunity can mitigate severe or prolonged infection (Le Bert et al., 2020). In convalescent individuals, T cell immunity would not be restricted to spike-derived epitopes but also from other more abundant proteins such as nucleocapsid. As such, it would be reasonable to assume that T cell-mediated immunity elicited by infection would remain largely intact for circulating variants including B.1.351. Indeed, although recent studies by Johnson & Johnson have demonstrated reduced overall efficacy in South Africa, there was substantially more protection against severe or fatal disease than for mild-to-moderate disease (Herper and Branswell, 2021). However, with the exception of killed whole-virus vaccines, all currently available vaccine designs only provide spike protein as the target immunogen, thus limiting T cell immunity to spike epitopes….Given the global scale and magnitude of the ongoing pandemic, including case reports of reinfection, it is clear that viral evolution will continue.

https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC7953441/

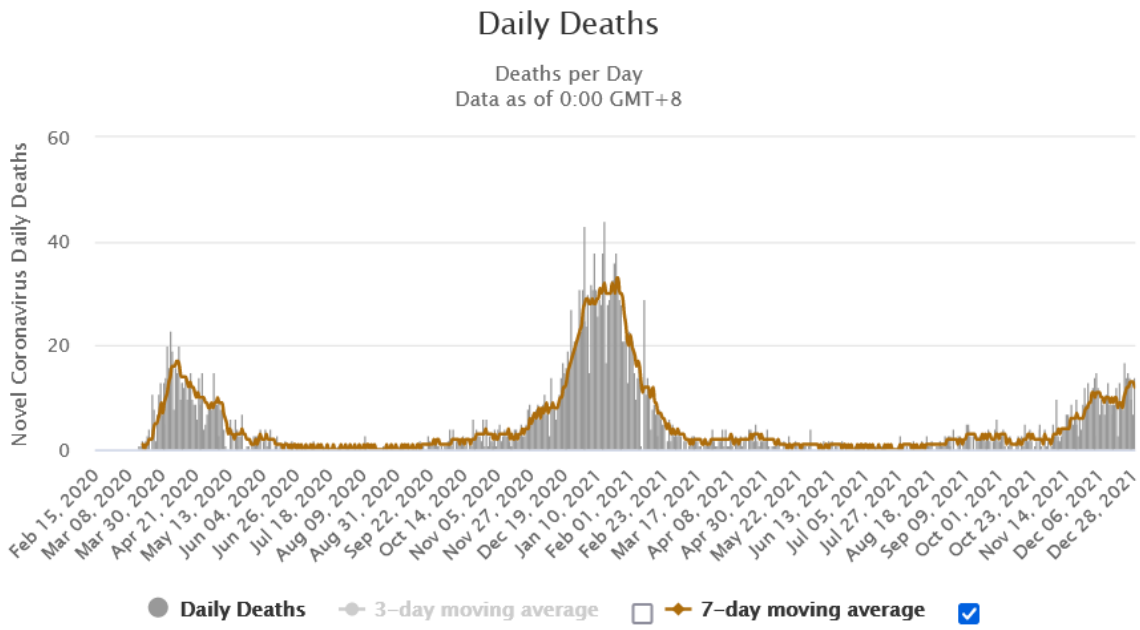
Denmark, a country that is over 80% vaccinated locking down amidst record high cases

Headline: **Denmark Proposes New Lockdown Measures Amid World Omicron Spread**
https://www.voanews.com/a/denmark-proposes-new-lockdown-measures-amid-world-omicron-spread-/6359300.html

Daily New Cases in Denmark

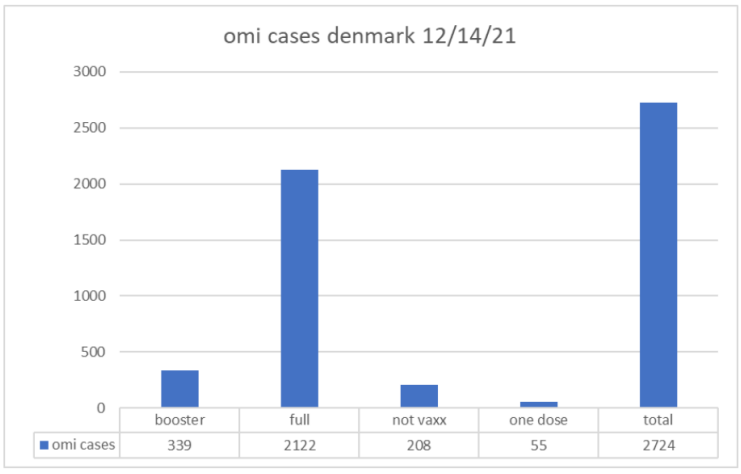


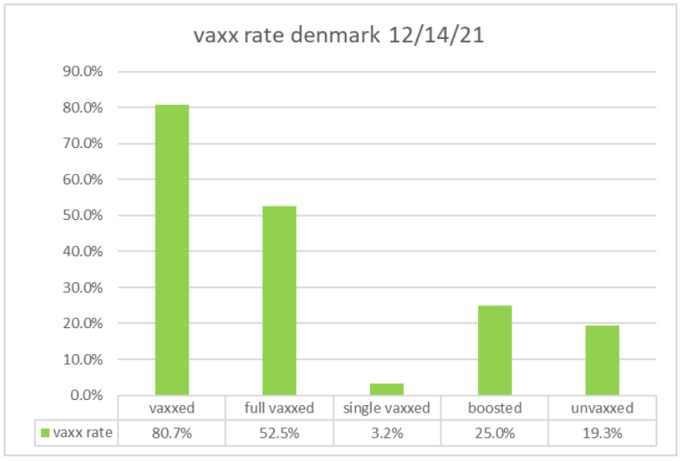
Daily New Deaths in Denmark

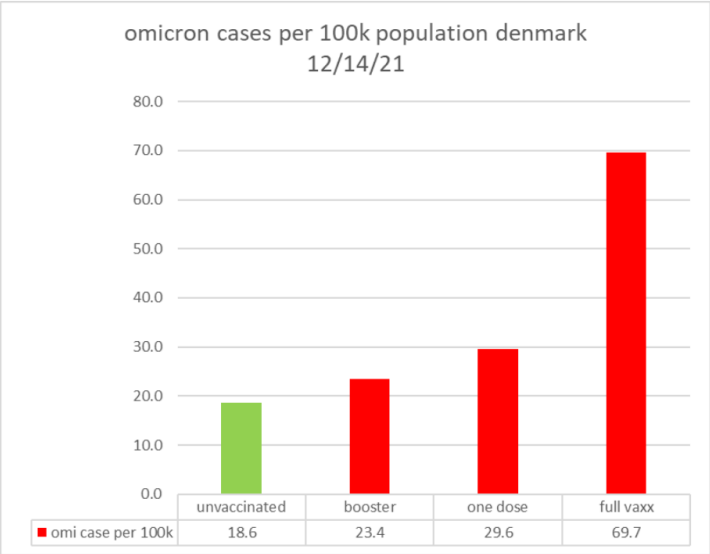


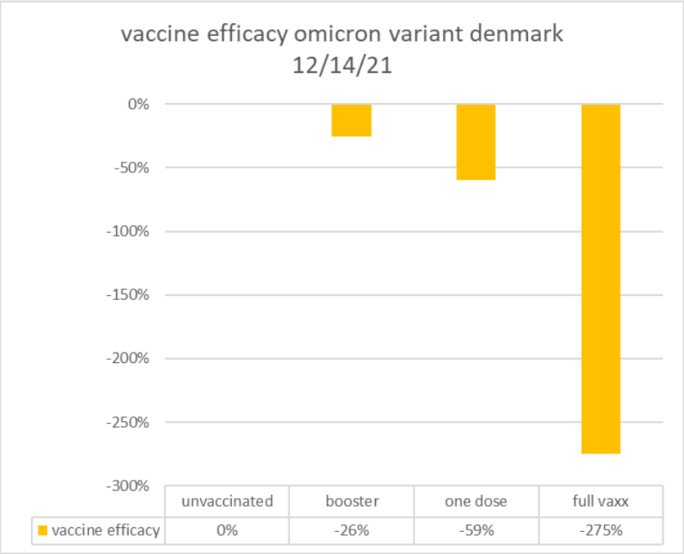
Omicron wreaking havoc among the vaccinated in Denmark with a vaccine efficacy of -275% among the fully vaccinated

A fantastic analysis of the data out of Denmark looking at the vaccine efficacy against the Omicron variant.









https://boriquagato.substack.com/p/addendumcorrection-to-danish-ve-data

This clearly shows that the vaccinated are far more likely to become infected with the virus than the unvaccinated. What does this suggest for the future of the vaccine program?

Another study, this time out of Germany shows that children are at extremely low risk from COVID-19

A medRxiv pre-print study published November 30th and titled, **Risk of Hospitalization, severe disease, and mortality due to COVID-19 and PIMS-TS in children with SARS-CoV-2-CoV-2 infection in Germany** verifies low risk for children, especially children aged 5-11.

The Abstract: (bold added by me)

Background: Although children and adolescents have a lower burden of SARS-CoV-2-CoV-2-associated disease as compared to adults, assessing absolute risk among children remains difficult due to a high rate of undetected cases. However, without more accurate case numbers, reliable risk analyses are impossible.

Methods:
We combine data from three sources – a national seroprevalence study (the SARSCoV-2 KIDS study), the German statutory notification system and a nationwide registry on children and adolescents hospitalized with either SARS-CoV-2-CoV-2 or Pediatric Inflammatory Multisystem Syndrome (PIMS-TS) – in order to provide reliable estimates on children's hospitalization, intensive care admission and death due to COVID-19 and PIMS-TS.

Results:
While the overall hospitalization rate associated with SARS-CoV-2-CoV-2 infection was 35.9 per 10,000 children, ICU admission rate was 1.7 per 10,000 **(My calc.: 1 ICU admission per 5,882 infections**) and case fatality was 0.09 per 10,000 **(My calc.:1 death in 111,111 cases).**

Children without comorbidities were found to be significantly less likely to suffer from a severe or fatal disease course. The lowest risk was observed in children aged 5-11 without comorbidities (My comment: Yet the CDC insists on vaccinating them). In this group, the ICU admission rate was 0.2 per 10,000 and case fatality could not be calculated, due to an absence of cases. The overall PIMS-TS rate was 1 per 4,000 SARS-CoV-2-CoV-2 infections, the majority being children without comorbidities.

Conclusion:
Overall, the SARS-CoV-2-CoV-2-associated burden of a severe disease course or death in children and adolescents is low. This seems particularly the case for 5-11-year-old children without comorbidities. By contrast, PIMS-TS plays a major role in overall disease burden among all pediatric age groups.

https://www.medrxiv.org/content/10.1101/2021.11.30.21267048v1

The article also mentioned that there were 13,743,944 children age 17 years and under in Germany. The national registry reported 14 deaths in that age group between March 2020 and May 2021 a total of approximately 14 months. That equates to one death in every 981,710 children in Germany. But this doesn't factor for is how many of those 14 deaths were in healthy children. As I've reported in a previous issue, Public Health England reported that there was only one death per 2 million healthy children over the course of the first year of the pandemic.

A molecular biologist/toxicologist warns of possible fertility issues from the COVID-19 shots

A Mercola article titled, **Toxicologist Warns Against COVID Jabs** contains quotes from an ***ACIP Committee*** comment by Dr. Janci Chunn Lindsay, Ph.D., a molecular biologist and toxicologist. Her expertise is analysis of pharmacological dose-responses, mechanistic biology and complex toxicity dynamics. In her ACIP comment, Lindsay described how she aided the development of a contraceptive vaccine in the 1990s that ended up causing unintended autoimmune destruction and sterility in animals which, despite careful pre-analysis, had not been predicted. She is extremely concerned that these mRNA shots may have adverse long-term effects on fertility.

Some key points from the article:

- April 23, 2021, Janci Chunn Lindsay, Ph.D., a molecular biologist and toxicologist, has called for an immediate halt to COVID-19 mRNA and DNA vaccines due to multiple safety concerns
- There's credible concern that the COVID jabs will cross-react with syncytin (a retroviral envelope protein) and reproductive genes in sperm, ova and placenta in ways that may impair fertility and reproductive outcomes
- In the case of the COVID shots, important animal studies that help ascertain toxic and systemic effects were not done. We're now seeing danger signals that are not being heeded. Preliminary safety results of mRNA COVID shots used in pregnant women, published in April 2021, revealed an 82% miscarriage rate when the jab was administered

during the first 20 weeks of pregnancy. *(I reported on this in a previous issue of my newsletter).*

- CDC data reveal more than 300 children between the ages of 12 and 18 have died from myocarditis, a now-recognized side effect of the COVID jab, yet the shot is now authorized for children as young as 5

- Since the COVID gene therapies do not prevent infection, but only lessen symptoms, they are actually a treatment, not a prevention. And there are far safer and more effective treatment available, including nebulized peroxide, ozone therapy, and hydroxychloroquine and ivermectin regimens

Janci Chunn Lindsay, Ph.D., is a molecular biologist and toxicologist and director of toxicology and molecular biology for Toxicology Support Services LLC. April 23, 2021, delivered a three-minute public comment to the ***U.S. Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP).***

She explains:

"We were developing what was meant to be a temporary contraceptive vaccine, which was very attractive because it prevented fertilization rather than preventing implantation — or it should have; that was the idea. Unfortunately, even though quite a bit of analysis was done in different animal models to make sure that it did not have an autoimmune action, it did end up having an autoimmune action and caused complete ovarian destruction.

Now it's used in that manner [for permanent sterilization] in dogs, cats and other animals. So, that's a cautionary tale of how animal studies can help us avoid mistakes in humans when they're used properly, and when proper animal studies are done."

Are COVID Jabs a Population-Wide Immunocontraceptive?

When asked what she thinks the motive behind this mass injection campaign might be, considering the clear danger signals, she replies:

*"I certainly think that to discount that it is a form of population-wide contraceptive would be naïve. There's a paper that came out in 2005. It's called '***Evaluation of Fusogenic Trophoblast Surface Epitopes as Targets for Immune Contraception***.' **See abstract below**

This paper tried to find *contraceptive peptides in persons that had infertility problems already that were isolated to placentation. So, it was taking a backwards approach, getting the sera from people who had fertility problems and trying to see what they had antibodies to that was causing the fertility problems … This work was sponsored by the WHO and the Rockefeller Foundation [and the National Institutes of Health]. No surprise there. It was then picked up by a company called AplaGen that took it to patent in 2007.*

These are 12-mer peptides, and there's a series of eight of them that can be used to induce sterility. When they patented it, they also said that it could be used to ameliorate sterility. Interestingly, it was also associated with all of the things that we know syncytin is associated with, — lupus, skeletal muscle disorders, bipolar depression [and] a number of other things.

Even though they don't name syncytin proteins as the proteins that are targeted, they worked backwards from these peptides, and then said they were a series of other proteins. Sometimes we know that proteins can be called the same thing in different discovery realms. So, that's going to take more research, but it was certainly interesting to me.

What it really points out is that there were efforts to use peptides or immune-contraceptive means at the placental trophoblast interface to cause sterilization … So, it would be naïve to think that this was not on the plate for future use."

Other comments she made in the interview with Dr. Mercola…

Dr. Mercola- Well, you've brought up some really good questions, and I definitely want to dive into them, but I want to tie up the loose end on the syncytin and the antibodies. If you could just briefly describe that, because you understand it really well. How can it contribute to long-term challenges, especially as related to fertility?

Dr. Lindsay- "Yeah, absolutely. So, there was a study that came out in Singapore, I think it was 15 women, two of which were pregnant. They did something that I had asked to be done a long time ago, which was to measure anti-syncytin antibodies in an ELISA (enzyme-linked immunosorbent assay) test. The syncytins are conformationally and genetically similar to the spike protein, this fusogenic spike protein."

"So, the thought by several was that you could have an autoimmune reaction to the syncytins by developing an immune reaction to the spike protein, and then that would prevent successful pregnancy. But the syncytins are also important in a number of psychological diseases, bipolar depression. They're important on autoimmune disease, lupus, and multiple sclerosis. They are present in skeletal muscle. There's some association with breast cancer. The really important ancient retroviral elements."

Unfortunately, Dr. Mercola doesn't archive his articles now because of the attacks he endured from our government as one of their "disinformation dozen."

The study Dr. Lindsay mentioned above was published in the journal ***Contraception*** in April 2005 and titled, **Evaluation of fusogenic trophoblast surface epitopes as targets for immune contraception**

The Abstract (red highlights are mine)

Syncytial trophoblast fusion is an essential step in the process of implantation. This project is aimed at the immunological inhibition of syncytial trophoblast fusion as a novel approach to contraception. Fusion-inhibiting recombinant antibodies were generated and used together with autoantibodies from patients with repetitive in vitro fertilization (IVF) failure that were shown to inhibit syncytial fusion and are expected to inhibit implantation, to generate anti-idiotypic peptides. These peptides mimic trophoblast epitopes essential for syncytial fusion and are, therefore, considered specific immunogens for the generation of antibodies that will inhibit implantation. To verify their physiological role in humans, 300 anti-idiotypic peptides were tested for their binding capacity to patient autoantibodies associated with repetitive IVF failure, habitual abortion and preeclampsia. Of these, only three peptides were found to selectively bind to autoantibodies of patients with repetitive IVF failure and were considered safe and efficient enough for evaluation in preclinical and clinical studies required for the development of immune contraceptives. **When used as immunogens, these**

peptides are expected to elicit an antibody response inhibiting syncytial fusion and thus implantation. Furthermore, the action of these antibodies needs to be restricted to the stage of syncytium formation at the time of implantation so as not to cause complications of pregnancy in those cases where they fail to have a contraceptive effect. To exclude potential side effects on other systems, toxicological experiments in animals are in progress.

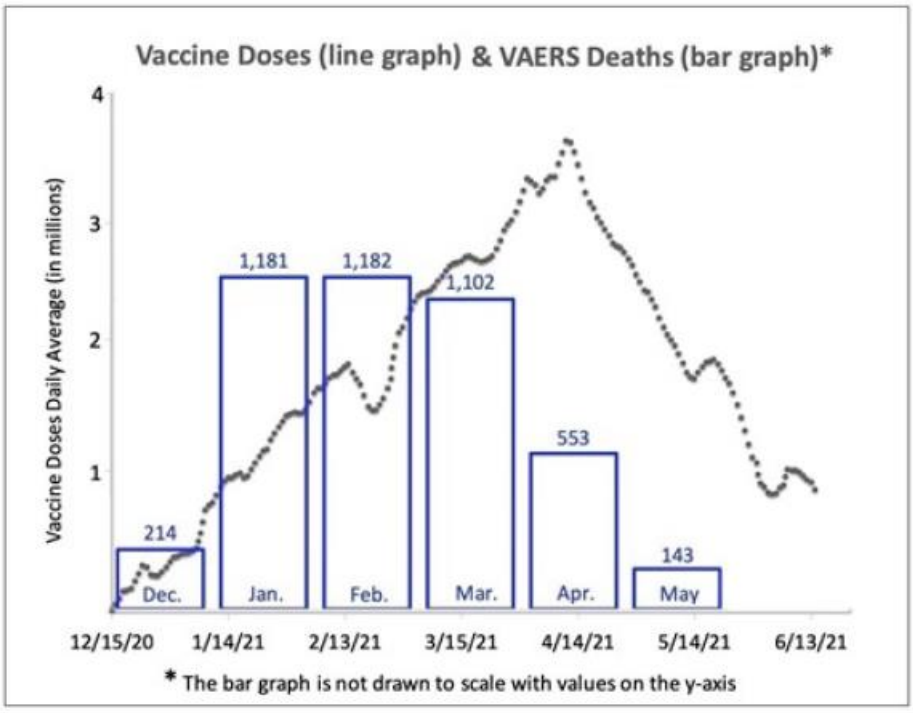
https://pubmed.ncbi.nlm.nih.gov/15792647/

As I have been reporting for over a year now, her concerns echo many other doctors and scientists that have been expressing their similar concerns since before the release of the experimental shots.

What is the true number of COVID vaccine related deaths? Is the CDC altering the figures?

That is the actual title of an article published on ***lifesitenews.com***. And the subtitle: **Is it possible that after February, the CDC started relocating massive number of vaccine-related adverse events to another database to ensure their vaccination drive proceeded without interruption?**

From the article
June 24, 2021 (American Thinker) – Based on official data from Open Vaccine Adverse Event Reporting System (VAERS) and the Centers for Disease Control and Prevention (CDC), 5,993 Americans have died out of 146,171,792 Americans who are fully vaccinated as of June 11. This corresponds to a ratio of about four deaths out of 100,000 who are fully vaccinated. When VAERS death rates are compared with COVID-19 vaccination rates from December to June, an odd pattern emerges: Vaccine-related deaths decline just as vaccination rates reach their peak in April (Graph 1). This implies that the VAERS death rate started at 18 per 100,000 on the1 of February, then dropped to around 3.1 per 100,000 on the 1 of June (Table). If this remarkable trend really took place, why didn't it make headlines?



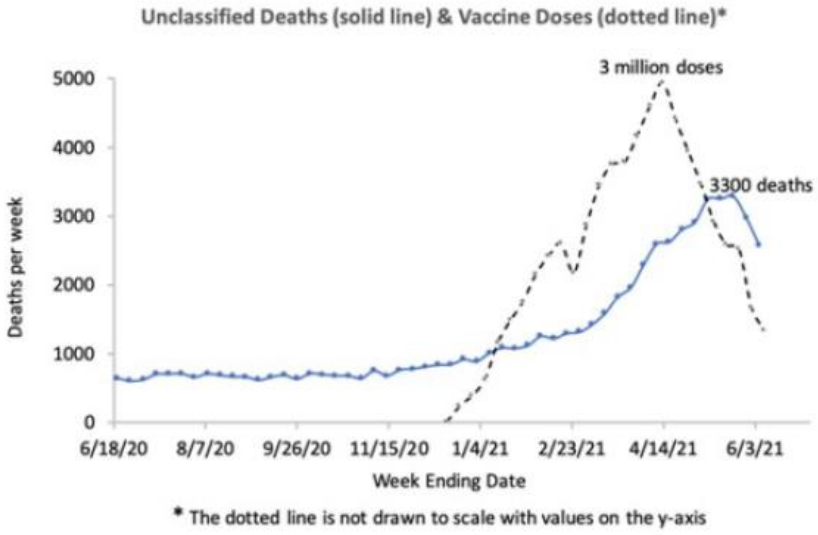
Graph 1: Comparing VAERS death rates by month with overall vaccination rates from December 2020 to June 2021. Vaccination rates were provided by the CDC's COVID Data Tracker. Death rates were provided by VAERS.

Date in 2021	Cumulative VAERS deaths	Cumulative Fully vaccinated	Calculated Deaths per 100K Fully Vaccinated
February 1	1,395	7,617,413	18
March 1	2,577	29,435,446	8.8
April 1	3,679	63,676,884	5.8
May 1	4,232	110,085,143	3.8
June 1	4,375	139,242,635	3.1

Table: Comparing VAERS death rates per 100K vaccinated over time. The vaccine death rate was calculated by dividing VAERS deaths per month by the total vaccinated. Cumulative total vaccinated was provided by the CDC's COVID Data Tracker.

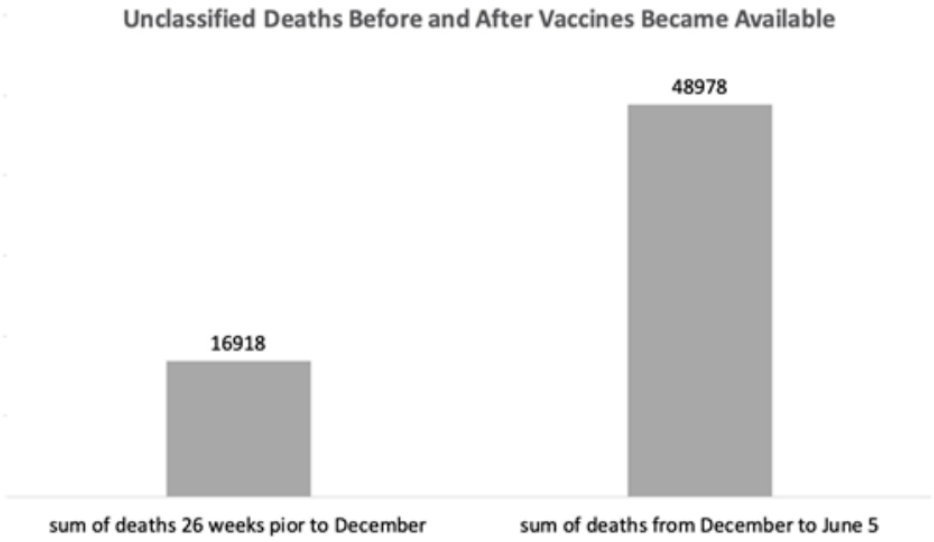
Silicon valley inventor/entrepreneur Steve Kirsch claims "inside sources" told him the true death count is 25,800 and that the CDC has been "reclassifying" most vaccine-related deaths. These are serious accusations and given the ubiquity of "anonymous sources" spreading fake news, it is unwise to relay this information unless it leads to citable evidence.

Fortunately, Kirsch did not only cite an anonymous source. He also provided instructions for accessing these "hidden" deaths from the CDC at the 20:20 time mark of this video. Following these instructions, I downloaded the CDC file and found that the "unclassified" death rate trend "coincidentally" follows the vaccination trend with remarkable consistency (Graph 2).



Graph 2: Comparing "unclassified" death rates by week with overall vaccination rates from December 2020 to June 2021. Vaccination rates were provided by the CDC's COVID Data Tracker. Death rates were provided by the CDC's "Weekly Provisional Counts of Deaths by State and Select Causes."

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).



Graph 3: 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."

A total of 32,060 vaccine-related deaths from December to June comes out to a death rate of 21 per 100,000 fully vaccinated. This is almost the same as the VAERS death rate recorded for the beginning of February (Table). Is this another "coincidence"?

For the sake of argument, let's suppose a massive number of people reporting these "unclassified" deaths were unsure if their loved one had died from the vaccine, so they avoided reporting to VAERS in fear of being prosecuted for the federal crime of "false reporting." How could the CDC have failed to notice this trend in "unclassified" death?

For the sake of argument, let's suppose that after February the CDC started relocating massive number of vaccine-related adverse events to another database to ensure their vaccination drive proceeded without interruption.

Occam's razor favors the second scenario, but either way, the CDC has a lot of explaining to do.

End of article

https://www.lifesitenews.com/opinion/what-is-the-true-number-of-covid-vaccine-related-deaths-is-the-cdc-altering-the-figures/

Circling back to the beginning of the article and taking the number of deaths through June 11th that were reported to the VAERS system (5,993) and comparing that number to the 32,060 deaths calculated here gives us a 5.35 X-Factor of under-reporting. As of December 17th, 2021, there were 20,622 reported deaths. Multiplying that number by the 5.35 X-factor and you get 110,328 deaths! That is in just the first year of the program. As we now know the "program" is designed to be an endless treadmill of shots. I say that because they knew early on that the shots did not provide sterilizing immunity, therefore infection or transmission.

And thus, they would not be able to stop the pandemic. Worse yet, vaccinated individuals are becoming more and more susceptible to infection from these variants that are driven to mutate by the vaccine pressure put on them.

Back to the under-reporting issue

And adding to that once again as discussed earlier in this newsletter, the VAERS system has been proven to be significantly underreported, to the tune of 100X in the CDC/Harvard Pilgrim Health Study.

I became aware of another reason that there may be such dramatic under-reporting. In an interview I watched this week, the individual who is familiar with filling out the VAERS reports said that it takes 30 to 45 minutes to complete one. She also said that if for some reason you have to step away from the computer before completion, rather than saving your data where you left off, the system kicks you out and forces you to start over. I don't know of too many physicians who may be able to find dedicated time to spend a straight 45 minutes filling out the forms or have the time to go back and start over again if they get interrupted and are kicked out of the system.

Former World Health Organization's European Advisory Group on Immunization vice president warns about wave of serious illness and deaths in vaccinated people over the winter

From America's Frontline Doctors…

"The World Health Organization's European Advisory Group on Immunization, former vice president Professor Christian Perronne, said yesterday that all vaccinated people must be quarantined through the winter months or risk severe illness.

Perronne specializes in tropical pathologies and emerging infectious diseases. He served as chair of the High Council of Public Health's Communicable Disease Technical Committee.

The infectious disease expert acknowledged the rapidly deteriorating situation in Israel and the United Kingdom, stating, "Vaccinated people should be quarantined and isolated from society."

He went on to say, "Unvaccinated people are not dangerous; vaccinated people are dangerous to others. It's proven now in Israel - I'm in contact with many doctors in Israel - they have big problems, severe cases in hospitals are among vaccinated people, and also in the UK there is the larger vaccination program and there are also problems."

The current working group on the COVID-19 pandemic in France is said to have "completely panicked" after receiving the news, fearing a pandemic if they follow the experts' instructions.

Israeli doctor Kobi Haviv told Channel 13 News, "95% of seriously ill patients are vaccinated. Fully vaccinated people account for 85-90% of hospitalizations. We are opening more and more COVID branches.
Vaccine effectiveness is declining or disappearing."

NB " Any booster jab will make this 10 X worse !!! Please pass on to as many people as possible.

Fully vaccinated Cruise ships are experiencing SARS-CoV-2-CoV-2 infection outbreaks

A December 23rd article published in the Epoch Times titled, **'95 Percent' Fully Vaccinated Royal Caribbean Cruise Ship Reports COVID-19 Outbreak**, Is just one of many examples of outbreaks recently on cruise ships. Cruise ships require 100% of the crew and passengers to be vaccinated. The reason this article says 95% is because there is a portion of the passengers that are young children not eligible for the shots yet.

From the article

Royal Caribbean's Odyssey of the Seas won't dock at the island nations of Aruba and Curacao this week following an onboard COVID-19 outbreak involving some 55 passengers and crew members, the firm said. All passengers aged 12 and older and crew members have to show proof they've been fully vaccinated for COVID-19 in order to board the ship, according to the cruise line's policy.

"The decision was made together with the islands out of an abundance of caution due to the current trend of COVID-19 cases in the destinations' communities as well as crew and guests testing positive on board," Royal Caribbean said in a statement Thursday to news outlets.

The cruise was slated to make stops in Aruba and Curacao. Now, the ship will stay at sea until its regular scheduled return on Dec. 26.

Aside from the Odyssey of the Seas, about 50 passengers aboard Royal Caribbean's Symphony of the Seas contracted COVID-19 earlier this month, said the company. The ship departed on Dec. 11.

Weeks before that, earlier in December, COVID-19 cases were reported on a Norwegian Cruise Lines ship, according to the Louisiana Department of Health. The Norwegian Breakaway cruise ship had left New Orleans on Nov. 28, making stops in Mexico, Honduras, and Belize.

Norwegian Cruise Lines confirmed at the time that it requires everyone on board to be fully vaccinated.

https://www.theepochtimes.com/95-percent-fully-vaccinated-royal-caribbean-cruise-ship-reports-covid-19-outbreak_4175154.html

International scientists and doctors convene in Rome Italy to declare the efficacy of early treatment options and other measures to return once again to a normal society

This story could have easily been categorized under either the natural immunity or use and suppression of off-label medication within this newsletter. However, they also certainly and very strongly address the issue of vaccination and especially when it comes to children, so I decided to include this under this section.

An international coalition of scientists and doctors from 19 countries met in Rome Italy to share the success of their experiences in effectively treating COVID-19 and their recommendations for a return to normal.

From their website

This cross-border initiative will take place on September 12 – September 14, 2021 in Rome, Italy and it will provide a safe space for these professionals to share experiences, research and studies. This crucial exchange of information will allow them to better care for Covid-19 patients worldwide.

Mission:

Covid 19 has affected everybody globally and the world has been working collectively and vigilantly to put an end to this pandemic.

The International Covid Summit was created for doctors, lawyers and professionals from all over the world to unite and discuss their experiences with Covid-19. They will be able to gather, share, discuss and analyze their findings in order to find a cure for this disease. These medical professionals have been working tirelessly on the front lines treating Covid patients and they have all documented their various experiences. This research will be instrumental in finding effective treatments for Covid-19 patients around the world and it will be pivotal in getting us all back together safely again.

Their efforts will be significant in finding effective treatments so that we can put this pandemic behind us and return to normal once again.

The world has endured the wrath of Covid-19 together, so let us now work towards the cure and let us start healing and moving forward united.

After eighteen months of frantic efforts to flatten the curve and save lives, the brave frontline medical professionals from all over the world will unite to discuss their scientific findings regarding Covid-19 research.

These respected and renowned medical professionals have treated Covid patients, first-hand, both at home and in the hospitals. By doing so, they have learned a great deal of critical information about this virus that they will discuss and compare, hopefully untangling fact from fiction.

Finally, the world can hear first-hand accounts of their herculean efforts and the research collected directly from the doctors who treated Covid-19 patients. It is time for the experts to join forces and put this pandemic behind us. We hope you join us for this significant event.

Declaration

Physicians Declaration II – Updated- **VIEW ORIGINAL DECLARATION**

Global Covid Summit- International Alliance of Physicians and Medical Scientists

October 29, 2021

WE, THE PHYSICIANS OF THE WORLD, united and loyal to the Hippocratic Oath, recognizing the imminent threat to humanity brought forth by current Covid-19 policies, are compelled to declare the following:

WHEREAS, after 20 months of research, millions of patients treated, hundreds of clinical trials performed and scientific data shared, we have demonstrated and documented our success and understanding in combating COVID-19;

WHEREAS, in considering the risks vs. benefits of major policy decisions, thousands of physicians and medical scientists worldwide have reached consensus on three foundational principles;

NOW THEREFORE, IT IS:

RESOLVED, THAT HEALTHY CHILDREN SHALL NOT BE SUBJECT TO FORCED VACCINATION (view supporting evidence)

- Negligible clinical risks from SARS-CoV-2-CoV-2 infection exist for healthy children under eighteen.
- Long term safety of the current COVID vaccines in children cannot be determined prior to instituting such policies. Without high-powered, reproducible, long term safety data, risks to the long-term health status of children remain too high to support use in healthy children.
- Children risk severe, adverse events from receiving the vaccine. Permanent physical damage to the brain, heart, immune and reproductive system associated with SARS-CoV-2-CoV-2 spike protein-based genetic vaccines has been demonstrated in children.
- Healthy, unvaccinated children are critical to achieving herd immunity. Natural immunity is proven to tolerate infection, benefiting community protection while there is insufficient data to assess whether Covid vaccines assist herd immunity.

RESOLVED, THAT NATURALLY IMMUNE PERSONS RECOVERED FROM SARS-CoV-2-CoV-2 SHALL NOT BE SUBJECT TO ANY RESTRICTIONS OR VACCINE MANDATES (view supporting evidence)

- Natural immunity is the most protective, and longest-lasting solution against the development of COVID-19 disease and its more serious outcomes.
- Naturally immune persons are at the lowest risk of transmission, thus should not be subject to travel, professional, medical or social restrictions.
- Natural immunity provides the best source of herd immunity, a condition necessary for eradicating the Covid virus.

RESOLVED, THAT ALL HEALTH AGENCIES AND INSTITUTIONS SHALL CEASE INTERFERING WITH PHYSICIANS TREATING INDIVIDUAL PATIENTS (view supporting evidence)

- Early intervention with numerous, available agents has proven to be safe and effective, and has saved hundreds of thousands of lives.
- No medicine already given regulatory approval shall be restricted from “off-label” use, particularly during this global humanitarian crisis caused by a rapidly mutating virus, which requires quick to adopt treatment strategies.
- Health agencies shall be prohibited from interfering with physicians prescribing evidence-based treatments they deem necessary, and insurance companies must cease blocking payments for life-saving medicine prescribed by doctors.

RECOMMENDED LEGISLATIVE OR EXECUTIVE ACTION:

We believe that violating any of these three principles unnecessarily and directly risks death to our citizens. We hereby recommend the leaders of states, provinces and nations legislate or take executive action to prohibit the three practices described above.

We'd like to thank each and every one of you for your support and your donations which helped make this event an unprecedented success, with over 100 million views per day.

https://globalcovidsummit.org/

An excellent paper on the problems with the development of, the ingredients contained and the many adverse consequences from the COVID-19 shots we are now seeing and may very well see in the future

A May 10, 2021 paper published in the ***International Journal of Vaccine Theory, Practice and Research*** titled, **Worse Than the Disease? Reviewing Some Possible Unintended Consequences of the mRNA Vaccines Against COVID-19**, goes into explicit detail about the many problems with the development of the "vaccines" including the ingredients and the numerous adverse consequences being realized now and potential ones in the future. Dr. Stephanie Seneff from M.I.T. is one of the authors. I have followed Dr. Seneff's work and research for many years. She is a brilliant and dedicated scientist whose work has previously focused on childhood neurodevelopmental diseases including autism.

ABSTRACT

Operation Warp Speed brought to market in the United States two mRNA vaccines, produced by Pfizer and Moderna. Interim data suggested high efficacy for both of these vaccines, which helped legitimize Emergency Use Authorization (EUA) by the FDA. However, the exceptionally rapid movement of these vaccines through controlled trials and into mass deployment raises multiple safety concerns. In this review we first describe the technology underlying these vaccines in detail. We then review both components of and the intended biological response to these vaccines, including production of the spike protein itself, and their potential relationship to a wide range of both acute and long-term induced pathologies, such as blood disorders, neurodegenerative diseases and autoimmune diseases. Among these potential induced pathologies, we discuss the relevance of prion-protein-related amino acid sequences within the spike protein. We also present a brief review of studies supporting the potential for spike protein "shedding", transmission of the protein from a vaccinated to an unvaccinated person, resulting in symptoms induced in the latter. We finish by addressing a common point of debate, namely, whether or not these vaccines could modify the DNA of those receiving the vaccination. While there are no studies demonstrating definitively that this is happening, we provide a plausible scenario, supported by previously established pathways for transformation and transport of genetic material, whereby injected mRNA could ultimately be incorporated into germ cell DNA for transgenerational transmission. We conclude with our recommendations regarding surveillance that will help to clarify the long-term effects of these experimental drugs and allow us to better assess the true risk/benefit ratio of these novel technologies.

A prophetic prediction

This paper was published in May of 2021, prior to the realization of the extent of the failure of the vaccines and the growing emergence of vaccine resistant mutations of the virus, yet the authors describe very accurately what we are seeing happening today.

Emergence of Novel Variants of SARS-CoV-2-CoV-2

An interesting hypothesis has been proposed in a paper published in Nature, which described a case of serious COVID-19 disease in a cancer patient who was taking immune-suppressing cancer chemotherapy drugs (Kemp et al., 2021). The patient survived for 101 days after admission to the hospital, finally succumbing in the battle against the virus. The patient constantly shed viruses over the entire 101 days, and therefore he was moved to a negative-pressure high air-change infectious disease isolation room, to prevent contagious spread.

During the course of the hospital stay, the patient was treated with Remdesivir and subsequently with two rounds of antibody-containing plasma taken from individuals who had recovered from COVID-19 (convalescent plasma). It was only after the plasma treatments that the virus began to rapidly mutate, and a dominant new strain eventually emerged, verified from samples taken from the nose and throat of the patient. An immune-compromised patient offers little support from cytotoxic T cells to clear the virus.

An in vitro experiment demonstrated that this mutant strain had reduced sensitivity to multiple units of convalescent plasma taken from several recovered patients. The authors proposed that the administered antibodies had actually accelerated the mutation rate in the virus, because the patient was unable to fully clear the virus due to their weak immune response. This allowed a "survival of the fittest" program to set in, ultimately populating the patient's body with a novel antibody-resistant strain. Prolonged viral replication in this patient led to "viral immune escape," and similar resistant strains could potentially spread very quickly within an exposed population (Kemp et al., 2021).
Indeed, a similar process might plausibly be at work to produce the highly contagious new strains that are now appearing in the United Kingdom, South Africa and Brazil.

There are at least two concerns that we have regarding this experiment, in relation to the mRNA vaccines. The first is that, via continued infection of immune-compromised patients, we can expect continued emergence of more novel strains that are resistant to the antibodies induced by the vaccine, such that the vaccine may quickly become obsolete, and there may well be demands for the population to undergo another mass vaccination campaign. Already a published study by researchers from Pfizer has shown that vaccine effectiveness is reduced for many of these variant strains. The vaccine was only 2/3 as effective against the South African strain as against the original strain (Liu et al., 2021).

The second more ominous consideration is to ponder what will happen with an immune-compromised patient following vaccination. It is conceivable that they will respond to the vaccine by producing antibodies, but those antibodies will be unable to contain the disease following exposure to COVID-19 due to impaired function of cytotoxic T cells. This scenario is not much different from the administration of convalescent plasma to immune-compromised patients, and so it might engender the evolution of antibody-resistant strains in the same way, only on a much grander scale. This possibility will surely be used to argue for repeated rounds of vaccines every few months, with increasing numbers of viral variants coded into the vaccines. This is an arms race that we will probably lose. **End of excerpts**

That is a haunting warning, similar to what Dr. Geert Vanden Bossche and Dr. Robert Malone, the inventor of the mRNA technology used in the vaccines have been warning us about.

https://ijvtpr.com/index.php/IJVTPR/article/view/23/51

Study identifies mechanisms for delayed chronic adverse responses related to autoimmunity after COVID-19 infection or shots

A study published in ***PLOS One*** September 2021 titled, **Development of ACE2 autoantibodies after SARS-CoV-2 infection** looks at specific mechanisms discovered that could help explain the chronic symptoms that some people experience either from the infection itself or from the COVID-19 shots.

From the abstract

Background
Activation of the immune system is implicated in the Post-Acute Sequelae after SARS-CoV- 2 infection (PASC) but the mechanisms remain unknown. Angiotensin-converting enzyme 2 (ACE2) cleaves angiotensin II (Ang II) resulting in decreased activation of the AT1 receptor and decreased immune system activation. We hypothesized that autoantibodies against ACE2 may develop after SARS-CoV-2 infection, as anti-idiotypic antibodies to anti-spike protein antibodies.

Conclusions
Many patients with a history of SARS-CoV-2 infection have antibodies specific for ACE2. Patients with ACE2 antibodies have lower activity of soluble ACE2 in plasma. Plasma from these patients also inhibits exogenous ACE2 activity. These findings are consistent with the hypothesis that ACE2 antibodies develop after SARS-CoV-2 infection and decrease ACE2 activity. This could lead to an increase in the abundance of Ang II, which causes a proinflammatory state that triggers symptoms of PASC.

From the Discussion
We found that ACE2-specific antibodies are present in patients after SARS-CoV-2 infection. These antibodies may develop early in the disease process since they were detected in 93% of the patients hospitalized for COVID-19. Interestingly, only one of the twenty outpatients with a known SARS-CoV-2 infection had ACE2 antibodies. It is possible that these patients had not yet had time to develop ACE2 antibodies, However, because we used residual samples that had been deidentified, we do not know the timing of infection relative to sample collection. This is the first demonstration of anti-ACE2 antibodies in patients with SARS-CoV-2 infection. It is likely that the early antibodies are IgM, and the later ones are IgG, although our assay did not differentiate between these subtypes. Since anti-ACE2 antibodies were detected almost exclusively in patients that have formed antibodies against the RBD of SARS-CoV-2, it is likely that these are anti-idiotypic antibodies. The difference in the percent of subjects with ACE2 antibodies could be due to timing of sample collection relative to the infection, but it could also be due to severity of illness. Wang et al. demonstrated that COVID-19 patients exhibit increases in autoantibodies compared to healthy controls and that patients with more severe disease develop higher levels of autoantibodies.

Anti-idiotypic antibodies are antibodies that are specific to the antigen-binding region of a host antibody that recognizes a foreign protein. In this case, antibody 1 is the host antibody that recognizes the viral RBD protein. Antibody 2 is a host anti-idiotypic antibody that recognizes the binding domain of antibody 1. Some of these

antibodies also recognize the binding partner of the original viral protein. In this case, the binding partner is the host ACE2 protein. This subset of anti-idiotypic antibodies are called internal image or homobodies. Thus, after developing an antibody that recognizes the RBD of SARS-CoV-2, the host can develop an antibody that recognizes and potentially inhibits its own ACE2 enzyme. This is one mechanism by which viruses trigger autoantibodies that cause autoimmune diseases. We speculate that the autoantibodies seen in these patients may be anti-idiotypic antibodies. In SARS-CoV-2 infection, they may be relatively common since an antibody against ACE2 was present in 93% of the Inpatient+ and 81% of Convalescent+ patients in our cohort.
Three unresolved issues regarding the response to SARS-CoV-2 can potentially be explained using Jerne's Network Theory of the Immune System. First, as we have discussed, the formation of anti-idiotypic antibodies to the SARS-CoV-2 spike protein could result in anti-ACE2 antibodies, as part of the normal homeostasis of immune system function. Second, there are anecdotal data suggesting that patients experiencing PASC, who become vaccinated with a SARS-CoV-2 vaccine may have improvement. This is also aligned with Jerne's Network Theory, as the vaccine may induce the immune system to balance the idiotypic and anti-idiotypic antibodies for homeostatic control. Third, from early in the COVID-19 disease process there are reports that anti-SARS-CoV-2 antibodies last for only a few months. This again is consistent with **Jerne's Theory**, in that immunologic control mechanisms should typically limit production of an autoimmune antibody, which could result in disease. Thus, the idiotype/ anti-idiotype interactions, with the anti-idiotype having autoimmune potential, could result in down-regulation of the idiotypic antibody (homeostatic balancing). Since the half-life of IgG is 21–28 days, significant loss of anti-SARS-CoV-2 antibody responses over 6–9 months is plausible.

Possible treatment
These studies show for the first time that ACE2 antibodies are present after SARS-CoV-2 infection. This finding is consistent with a hypothesis that ACE2 antibodies may be involved in a process that leads to immune activation. While we do not have data about the association of ACE2 antibodies and PASC in this cohort, we hypothesize that antibodies could initiate a cascade of effects that lead to the symptoms of PASC. If these antibodies are responsible for symptoms of PASC, several treatments are possible. Angiotensin receptor blockers are safe and widely used. These drugs would mitigate the effects of increased Ang II caused by inhibition of ACE2. An association between protection from sequelae of SARS-CoV-2 infection and treatment with angiotensin receptor blockers or ACE inhibitors has not yet been examined but should be a high priority for ongoing research into PASC. Treatment with these RAS blockers may not be possible however in patients with low blood pressure. More targeted therapy of the mechanism of ACE2 inhibition is possible. Recombinant soluble ACE2 protein is proposed as a treatment during acute phases of infection but may also be useful for PASC. Small molecule activators of ACE2 are available and have been proposed for treatment of hypertension and may be useful for the treatment of PASC. Thus if the relationship between ACE2 antibodies and PASC is confirmed, several treatments will be available.

https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC8415618/

While this study discusses specific phenomenon related to post-infection with COVID, many experts are looking at this mechanism and realizing that it could also play a role in post-vaccination toxicity which is a relatively new term being used in the scientific literature.

An excellent British Medical Journal Rapid Response lays out very good reasons against mandatory COVID-19 shots

The opinion was published December 3rd, 2021, and titled, **Evidence is insufficient to back mandatory NHS staff vaccination, says House of Lords committee.**

I am including the entire piece along with the references. I have also highlighted (in red) some key points, especially relating to the flawed Pfizer trial.

Evidence does not justify mandatory vaccines – everyone should have the right to informed choice

Dear Editor,

As doctors and health professionals, many of whom work in the NHS, we would like to express our opposition to anti-SARS-CoV-2-CoV-2 vaccination being mandated for any group of people, including health and care workers. We agree with the House of Lords committee that the evidence is insufficient to justify this measure, but the government and Parliament do not appear to be listening and mandatory vaccines for NHS staff looks likely to be passed into law this week.

We do not dispute that covid-19 can be and has been a dangerous infection, and we agree that vaccines are effective in many situations. However, there is considerable uncertainty about the effectiveness of the covid vaccines, some serious short-term complications and a lack of data on long-term harms. In this situation, it is imperative that people are able to make a fully-informed choice about whether to have the vaccine or not.
It is widely accepted that 546andomized controlled trials are the only means of providing robust data on the efficacy of medical interventions because observational data is subject to uncontrolled biases. Yet the 546andomized trials of the covid vaccines lasted for a very short time and were only powered to provide definitive statistical evidence on preventing 'symptomatic infections', not on preventing infection per se, 546andomized546tion or death. The trials also provided no data on whether the vaccines reduce transmission or not—things we have had to learn the hard way, through real world evidence like the rapid spread of the Delta and now Omicron variants.

Results from the 546andomized vaccine trials published so far suggested the vaccines were effective in reducing symptomatic infections for a few weeks. The average duration of follow-up for people in the first report from the Pfizer trial, on which licensing was based, was only 46 days, for example. [1] The recent report on data from people who had been in the trial for up to 6 months revealed that the mean total duration of follow-up for the primary outcome of the double-blind trial was 3.6 months for those who received the vaccine and 3.5 months for those allocated to placebo. [2] Moreover, only 7% of participants actually remained in the double blind trial for 6 months. [3] Real-world data are not consistent with the trial results, with high case numbers in doubly vaccinated individuals reported from the UK [4] and Israel [5], for example. This suggests either that effects of vaccines wear off quickly, and/or that some bias crept into original trial procedures, possibly due to unblinding caused by vaccine reactions [6] or other procedural irregularities. [7] The same observational data suggests the vaccines may reduce hospital admission and death due to covid infection, but, in the absence of data from 546andomized trials it is difficult to be certain, since unknown factors may bias the data in either direction.

More alarmingly, third and fourth 'booster' shots have not been tested in any 546andomized trials, and other data on the efficacy and safety of administering further doses are scanty.

In other words, data on the only outcome properly tested in 546andomized trials, the prevention of cases by two vaccinations, appear unreliable, possibly due to rapidly waning effects or other factors, and other outcomes and procedures have not been investigated in 546andomized trials, meaning there is no secure evidence either way.

As far as the safety of the vaccines is concerned, it is clear that rare but serious, and potentially fatal adverse effects occur, such as thrombosis and myocarditis, [8] and that these took months to identify. Long-term harms will be difficult to detect due to the short duration of the 547andomized trials, and will only become apparent in coming years.

There are also no data on groups who might be particularly adversely affected by the vaccine, such as those with, or at risk of autoimmune disorders, and there is little data on adverse effects of booster shots, which is significant since there have long been safety concerns about repeated exposure to mRNA technology. [9] Repeated booster vaccines therefore represent cumulative risk for untested benefit.

For young age groups, in whom covid-related morbidity and mortality is low, and for those who have had covid 19 infection already, and appear to have longstanding immunological memory, [10] the harms of taking a vaccine are almost certain to outweigh the benefits to the individual, and the goal of reducing transmission to other people at higher risk has not been demonstrated securely. [11]

Respecting people's autonomy and bodily integrity is at the heart of human rights and medical ethics and the data currently available on the vaccines by no means justify over-riding these important principles. More good quality research and access to existing data from the vaccine trials are required for people to make fully informed decisions about whether to take these vaccines or not. [12] Coercing people to have a covid vaccine, either through the threat of legal sanctions or, in the case of mandates for occupational groups, by depriving people of their livelihoods and careers, is not justified due to the prevailing uncertainty about the overall benefits of the vaccines, the unfavourable risk-benefit ratio for many groups, and, not least, the lack of data on long-term harms.

1. Polack FP, Thomas SJ, Kitchin N, et al. Safety and Efficacy of the BNT162b2 mRNA Covid-19 Vaccine. N Engl J Med 2020;383(27):2603-15. Doi: 10.1056/NEJMoa2034577 [published Online First: 2020/12/11]
2. Thomas SJ, Moreira ED, Jr., Kitchin N, et al. Safety and Efficacy of the BNT162b2 mRNA Covid-19 Vaccine through 6 Months. N Engl J Med 2021;385(19):1761-73. Doi: 10.1056/NEJMoa2110345 [published Online First: 2021/09/16]
3. Doshi P. Does the FDA think these data justify the first full approval of a covid-19 vaccine? British Medical Journal 2021 23rd Aug 2021. https://blogs.bmj.com/bmj/2021/08/23/does-the-fda-think-these-data-justi...
4. UK Health Security Agemcy. COVID-19 vaccine surveillance report: Week 48. 2021
5. Goldberg Y, Mandel M, Bar-On YM, et al. Waning Immunity after the BNT162b2 Vaccine in Israel. New England Journal of Medicine 2021;385:e85. Doi: DOI: 10.1056/NEJMoa2114228
6. Doshi P. Pfizer and Moderna's "95% effective" vaccines—we need more details and the raw data. British Medical Journal 2021 4th Jan 2021. https://blogs.bmj.com/bmj/2021/01/04/peter-doshi-pfizer-and-modernas-95-... (accessed 10th Dec 2021).
7. Thacker PD. Covid-19: Researcher blows the whistle on data integrity issues in Pfizer's vaccine trial. British Medical Journal 2021;375:n2635. Doi: doi.org/10.1136/bmj.n2635
8. Mevorach D, Anis E, Cedar N, et al. Myocarditis after BNT162b2 mRNA Vaccine against Covid-19 in Israel. New England Journal of Medicine 2021;385:2140-49. Doi: 10.1056/NEJMoa2109730
9. Garde D. Lavishly funded Moderna hits safety problems in bold bid to revolutionize medicine. STAT News 2017 10th Jan 2017. https://www.statnews.com/2017/01/10/moderna-trouble-mrna/ (accessed 12th Dec 2021).

10. Dan JM, Mateus J, Cato Y, et al. Immunological memory to SARS-CoV-2-CoV-2 assessed for up to 8 months after infection. Science 2021;371☹6529):eabf4063. Doi: 10.1126/science.abf4063
11. Singanayagam A, Hakki S, Dunning J, et al. Community transmission and viral load kinetics of the SARS-CoV-2-CoV-2 delta (B.1.617.2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study. Lancet Infect Dis 2021 doi: 10.1016/S1473-3099(21)00648-4 [published Online First: 2021/11/11]
12. Tanveer S, Rowhani-Farid A, Hong K, et al. Transparency of COVID-19 vaccine trials: decisions without data. BMJ Evid Based Med 2021 doi: 10.1136/bmjebm-2021-111735 [published Online First: 2021/08/11]

https://www.bmj.com/content/375/bmj.n2957/rr-1

On the heels of that story, comes more detail on the shortened duration of the clinical trial…

A review of the Pfizer Clinical Trial database revels that a high percentage of the trial participants did NOT continue beyond 4 months of the trial. The question is why?

The population for the updated vaccine efficacy analysis per protocol included participants 16 years of age and older who had been enrolled from July 27, 2020, and followed for the development of COVID-19 during blinded placebo-controlled follow-up through March 13, 2021, representing up to ~6 months of follow-up after Dose 2. **Overall, 60.8% of participants in the COMIRNATY group and 58.7% of participants in the placebo group had ≥4 months of follow-up time after Dose 2 in the blinded placebo-controlled follow-up period.** The overall VE against COVID-19 in participants without evidence of prior SARS-CoV-2-CoV-2 infection was 91.1% (95% CI: 88.8 to 93.1). The overall VE against COVID-19 in participants with or without evidence of prior SARS-CoV-2-CoV-2 infection was 90.9% (95% CI: 88.5 to 92.8).

That means that approximately 40% of participants did not continue. Is that because they were dropped? Is that because they dropped out? This seems like a disproportionate number compared to other trials. How that affects the efficacy outcomes they determined, would depend on why these people were not longer involved. If they were dropped from the trial because Pfizer did not like their outcomes, then that would skew the results to make them look much better than they really were. If you think that is far-fetched, Pfizer has paid settlements for doing this very thing in the past.

Pfizer for example, 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. https://violationtracker.goodjobsfirst.org/parent/pfizer .

The way pharma behaves, it would appear as though they consider fines as a cost of doing business. If your profits are multiples of the costs, they may decide that in their cost-benefit analysis.

The FDA has petitioned a judge to allow 75 years for the release of the Pfizer clinical trial data. What could they possibly be trying to hide?

The following are from excerpts from Aaron Siri's ***Injecting Freedom*** Sub stack article dated December 8th 2021 titled, **FDA Doubles Down: Asks Federal Judge to Grant it Until at Least the Year 2096 to Fully Release Pfizer's COVID-19 Vaccine Data**.

Excerpts

A prior post explained that the FDA has asked a federal judge to make the public wait until the year 2076 to disclose all of the data and information it relied upon to license Pfizer's COVID-19 vaccine. Literally, a 55-year delay. My firm, on behalf of PHMPT, asked that this information be disclosed in 108 days – the same amount of time it took for the FDA to review and license Pfizer's vaccine.

The Court ordered the parties to submit briefs in support of their respective positions by December 6, 2021. The FDA's brief, incredibly, doubles down. It now effectively asks to have until at least 2096 to produce the Pfizer documents. Not a typo. **A total of at least 75 years**.

Other than producing an initial ~12,000 pages in around two months, the FDA thereafter only wants to commit to producing 500 pages per month. The FDA also disclosed that it actually has approximately at least 451,000 pages to produce.*

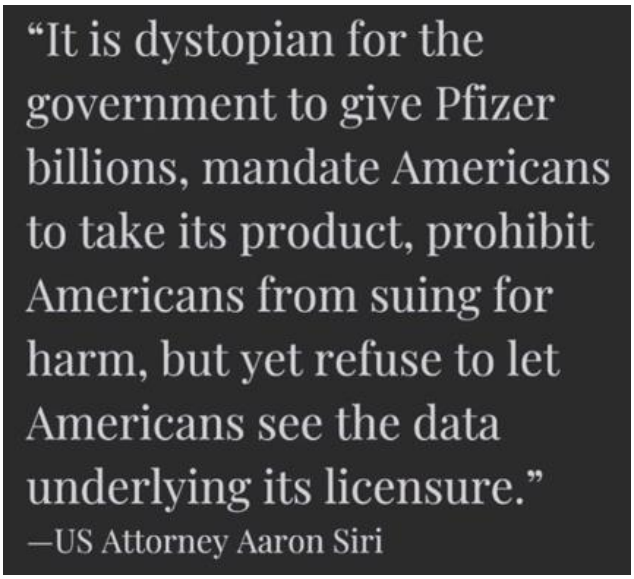
Each side gets to file response briefs on December 13, 2021, and then there is oral argument on December 14, 2021 before the Judge. If you want to read the response to the FDA's position, a copy of the introduction in the brief my firm filed is below. And below that, a downloadable copy of each side's full briefing is available. Enjoy. And if you find what you are reading difficult to believe – that is because it is dystopian for the government to give Pfizer billions, mandate Americans to take its product, prohibit Americans from suing for harms, but yet refuse to let Americans see the data underlying its licensure. **The lesson yet again is that civil and individual rights should never be contingent upon a medical procedure.**

A minimum of 20,010 days (54 years and 10 months). That is how long the FDA proposes to take, at a rate of 500 pages per month, to produce only a portion of the documents in its file for the COVID-19 Pfizer vaccine that PHMPT requested pursuant to the Freedom of Information Act (the "**FOIA Request**") and 21 C.F.R. § 601.51(e). But when it came to reviewing those same documents to license this product so that Pfizer could freely sell it to the public, the FDA took **just 108 days**. It took the FDA's parent department even less time to grant Pfizer complete immunity to liability for injuries from this product, and it took a stroke of the President's pen to mandate this product for federal employees, the private sector and military personnel.

Other sections omitted here:

The FDA does not dispute that it should produce these documents. Rather, it proposes doing so at a rate so slow that the documents will not be fully produced until almost all of the scientists, attorneys, and most of the Americans that received Pfizer's product, will have died of old age. The FDA's excuse? It cries it does not have the resources. Considering how many taxpayer dollars this administration has spent on its COVID-19 response, the FDA cannot now claim it lacks the money to timely conduct its review. This excuse is a red herring that just adds insult to the liberty-crushing approach the FDA and administration have taken with this product.

The Executive Branch gave Pfizer $1.95 billion in taxpayer funds to promote development of its vaccine through an advance-purchase agreement. It then paid Pfizer more than $15.7 billion collected from the American people to purchase that product. Thereafter, it spent $18.75 billion more of the American people's money promoting that product. Yet, when it comes to being transparent with those same American people, the FDA claims it cannot muster the resources to timely produce the same documents it reviewed for licensure in 108 days. Just as the government found the resources for Operation Warp Speed, it must now do the same to produce these critical documents with the same warp speed. How about the federal government spend just 0.1% of the taxpayer money it has given Pfizer – that would be at least $17.6 million – a pittance compared to the billions given to Pfizer and more than sufficient to hire enough reviewers to timely produce the documents. Companies in private litigation produce hundreds of thousands of pages per month in discovery, reviewing each document for privilege, etc. But yet the vast federal government, on an issue this important, claims it cannot find the resources. A product the administration says everyone must take under penalty of exclusion from American life and for which they cannot even sue Pfizer if injured! Whose interests is the executive branch protecting, the American people or its own?



You can subscribe to Mr. Siri's excellent newsletter here https://aaronsiri.substack.com/

Small wins pile up as Governor Hochul of New York drops the vaccine mandate for New York transportation workers

On Monday December 27th, 2021, the unelected governor acknowledged that suspending or firing workers who are refusing to comply with vaccine requirements would be detrimental to the Big Apple's transportation infrastructure, which is already implementing reduced service schedules.

"Our concern, as you mention shortages of crews, is the individuals who will not want to participate in a mandatory vaccination program will be individuals who would exacerbate that problem," Hochul said during a press conference addressing the Omicron variant Monday.

https://www.newswars.com/ny-gov-drops-covid-vax-requirement-for-transportation-workers-citing-crew-shortages/

An important warning for seniors by an expert on vaccine injuries

Wayne Rhode has been involved with helping injured persons navigate the Vaccine Injury Compensation Program for more than two decades. He wrote a December 4th, Substack article that I feel deserves to be highlighted here as a warning for seniors about the potentially dangerous recommendation of combining the COVID shots with a high-dose flu shot.

The article

With all the focus currently about the COVID-19 vaccines and their boosters, the CDC is quietly building another vaccine campaign for our seniors. This time it is the influenza vaccine in combination with a COVID vaccine.

Sanofi's FluZone HD (high dose) influenza vaccine for administration to anyone above the age of 65 has been approved for several years. The trivalent (3 strains) HD vaccine was approved in 2013. The quadrivalent (4 strains) was approved in late 2019.

But to inject someone with the COVID vaccines and the flu vaccine during the same office visit was not approved until ACIP gave the go-ahead in May of 2021. Prior to this approval, the waiting time was 14 days between COVID vaccines and the others.

The FluZone HD vaccine is designed to deliver 4 times the antigen as compared to the regular flu shot. The idea according to CDC, FDA and Sanofi, by delivering a higher dose of influenza antigens, seniors with lower immune systems will benefit greatly with this vaccine.

Its a theory that has delivered some very devastating results, not only in the real world but also in the clinical trials conducted by the manufacturer Sanofi.

There is a higher risk of adverse reactions and serious medical conditions by administer a flu shot to those above the age of 65 or those with compromised immune systems.

Most common injuries are shoulder injuries (injected in wrong location) and Guillain-Barré Syndrome (GBS). It is the GBS injuries that rise to become a greater concern.

In the National Vaccine Injury Compensation program (NVICP), there is an increase in the severity of GBS from the FluZone HD as compared to other similar aged persons who received a non HD flu shot.
And the severity often times leads to death.

We have to be careful about conclusions because of selection bias. Was a petition filed in the NVICP because of the severity GBS leading to death versus no petition filed because the GBS was not as severe and the injured person recovered?

Another problem comparing HD petitions to regular flu shot petitions. Will there be any mention of the specific vaccine administered. A couple of Special Masters in the NVICP will not mention any brand names or specific types of vaccines other than influenza or MMR or Tdap, etc.

But just a cursory review of petitions, there is an increase in the severity of GBS leading to death for those who receive the FluZone HD vaccine.

VAERS has nearly 12,000 reports for the FluZone HD vaccine. With many more serious events than the traditional influenza vaccines. With all the criticisms of VAERS regarding underreporting, there is definitely a safety signal with bells and whistles ringing. Yet the CDC refuses to investigate.

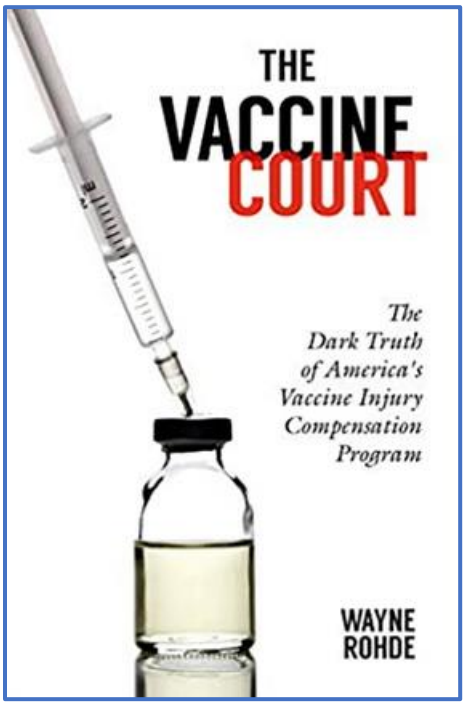
Once again, CDC refuses to examine adverse event reporting. In their mind, if we do not examine, there are not issues, thus the vaccines are safe and effective.
Pathetic.

Keep learning, keep challenging yourself and always, always question authority.

Have a good day.

You can follow Wayne Rhode on his Substack at thevaccinecourt@substack.com

Also, his excellent book is available on Amazon.



The Vaccine Court looks at the mysterious and often unknown world of the National Vaccine Injury Compensation Program (NVICP), the only recourse for seeking compensation for those who have been injured by a vaccine. The NVICP, better known as the "Vaccine Court," however, is not without controversy.

Established by Congress as a direct result of the passage of the National Childhood Vaccine Injury Act of 1986, the NVICP was supposed to offer a no-fault alternative to the traditional injury claims filed in state or federal courts and was to provide quick, efficient, and fair compensation for those who have been injured by vaccines. The reality, however, is that many cases take several years or longer to complete and require tremendous commitment from families already pushed to the brink of bankruptcy caring for the vaccine-injured family member, only to discover that the end result is manipulated by the government in defense of the US vaccine policy.

Excellent resource for building your case for legal exemptions from the experimental shots

https://patienttoolbox.cchfreedom.org/pmh.php/44

Updates February 1st, 2022

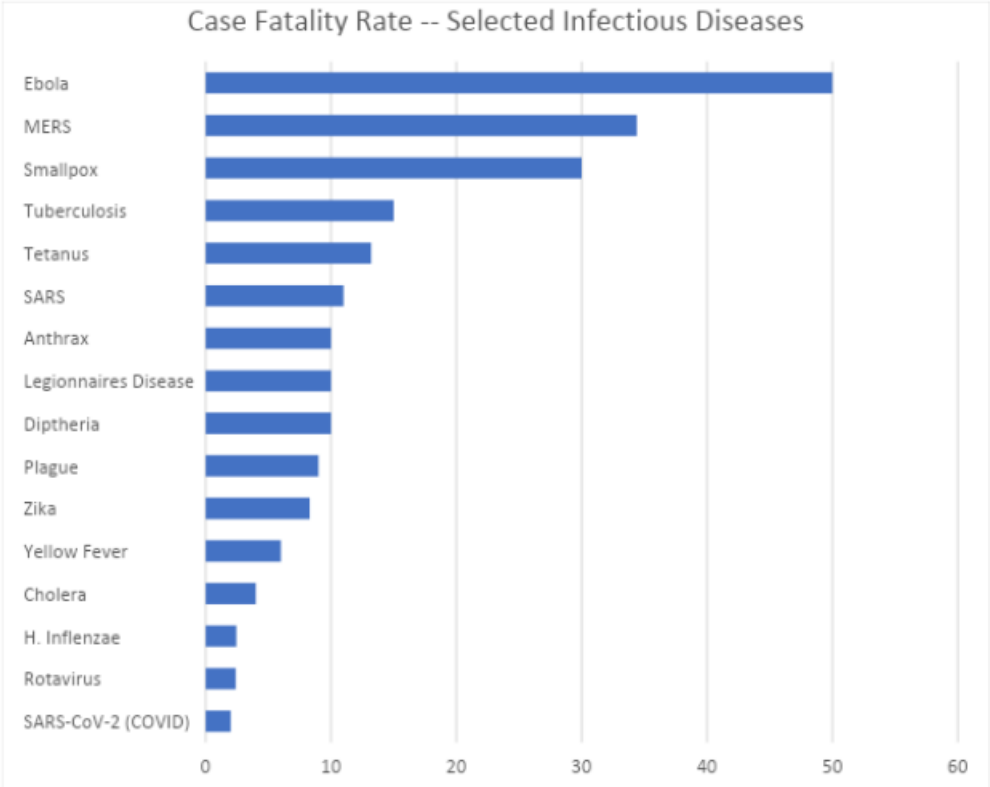
To start this section, I would like to look at some of the data coming out related to the risks from the Omicron Variant versus previous variants.

This information comes from an Amicus Brief to the ***Supreme Court of the United States*** by ***America's Frontline Doctors*** as it pertains to ***OSHA's*** Vaccine Mandates.

What does the data say regarding the Omicron Variant?

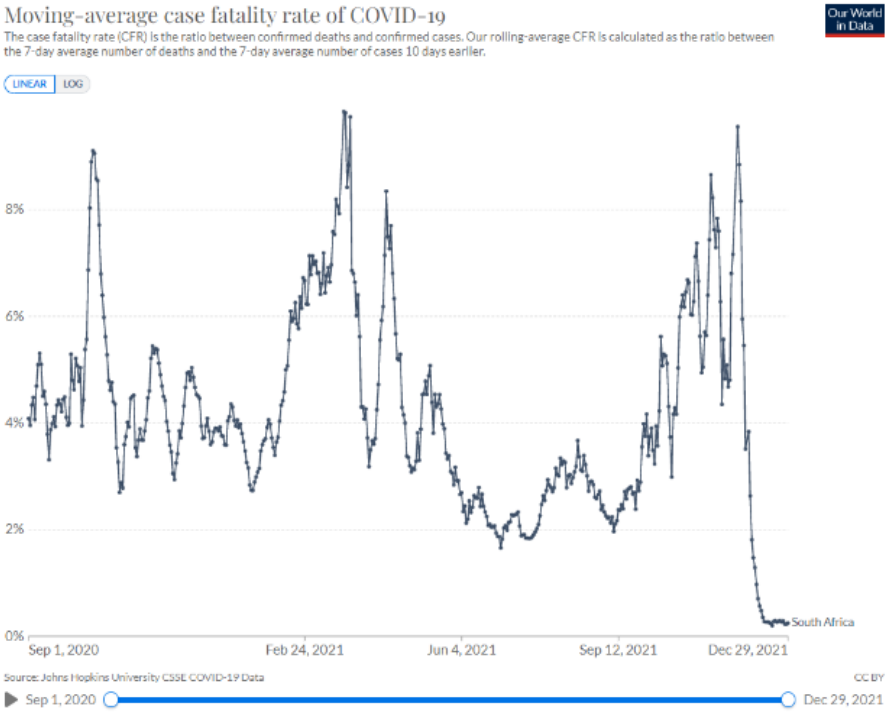
Here are some of the highlights presenting data as it relates to the new variant.

Case fatality rates might be an even better way to conceptualize the risk than other common measures. As Dr. Jay Bhattacharya of Stanford notes: It is helpful to provide some context for how large the mortality risk is posed by COVID infection relative to the risk posed by other infectious diseases. Since seroprevalence- based mortality estimates are not readily available for every disease, in the figure im- mediately below, I plot case fatality rates, defined as the number of deaths due to the disease divided by the number of identified or diagnosed cases of that disease. The case fatality rate for SARS-CoV-2 is ~2% (though that number has decreased with the availability of vaccines and effective treatments). By contrast, the case fatality rate for SARS is over five times higher than that, and for MERS, it is 16 times higher than that.



But the case fatality rate appears to be falling even more sharply than that. In South Africa, the case fatality rate plunged dramatically when Omicron be- came dominant. Pieter Streicher of the University of Johannesburg projects that for Gauteng Province: "C- 19 deaths are expected to total 640 for this wave, 25x lower compared to Delta (15,400)."14 The graph below tracks a 7-day moving average of the case fatality rate

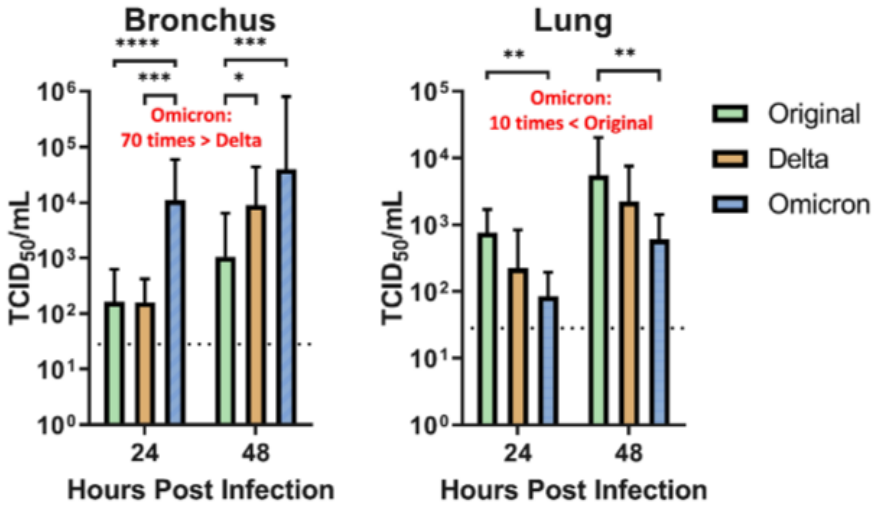
of COVID infection from September 1, 2020 to January 1, 2022 in South Africa with data from a well -known COVID data provider, Our World in Data. 15 It confirms the collapse in the case fatality rate of COVID in South Africa as Omicron be- came the dominant strain.



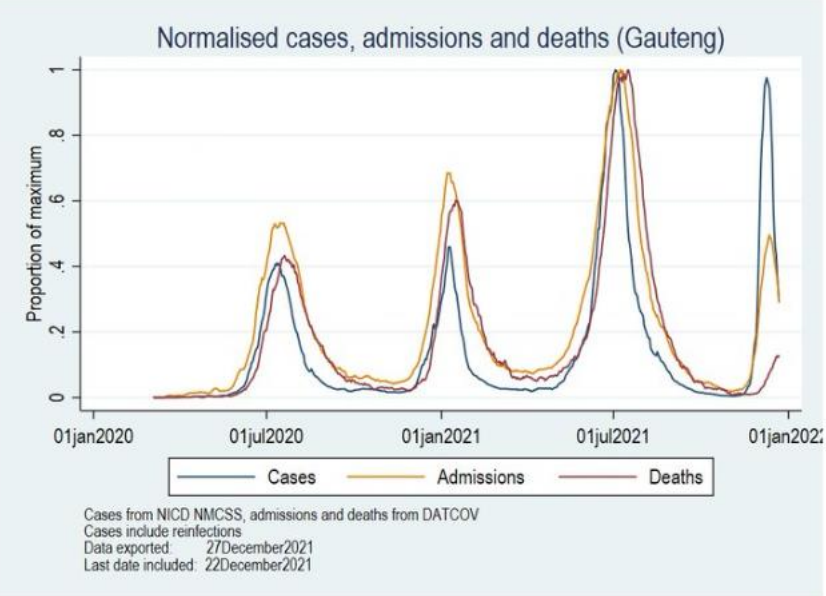
Source: Our World in Data

Other graphics from the brief

Hong Kong University researchers pointed to the likely reason, or mechanism, for Omicron's increased infectiousness but reduced virulence: it replicates far more efficiently in the bronchus and upper respiratory tract than Delta, but less efficiently in the lungs:[9]



South Africa, particularly the Gauteng province (population 18 million) where the first recognized Omicron wave occurred. According to Dr. Harry Moultrie of the South African government's National Institute for Communicable Diseases, Gauteng cases peaked on December 9 at 97 percent of the delta wave. Even more reassuringly, deaths were only 13 percent of the delta peak:[10]

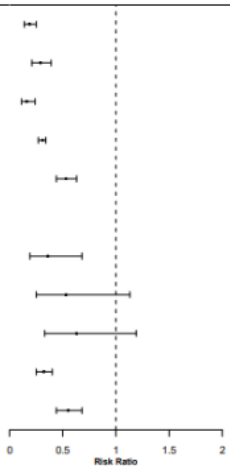


Continued on the next page…

Early U.S. data is available in a preprint from a team at Case Western Reserve University, which used propensity matched-cohort analysis to find markedly reduced disease severity during the period from December 14 to December 24, 2021. On an age and risk-matched basis, they found ER visits were 70% lower than earlier cohorts, hospitalizations were 56% lower, ICU admissions were 67% lower, and ventilation were 84% lower.

Age–stratified comparison of 3–day acute outcomes in matched patients with SARS–CoV–2 infections Emergent Omicron cohort (12/15–12/24) vs. Delta cohort (9/1–11/15)

Age group	Outcome	Emergent Omicron cohort	Delta cohort	RR (95% CI)
0–4 (n=1,361)	ED visit	3.89% (53)	21.01% (286)	0.19 (0.14–0.25)
5–11 (n=1,307)	ED visit	3.60% (47)	12.62% (165)	0.29 (0.21–0.39)
12–17 (n=1,244)	ED visit	2.09% (26)	13.10% (163)	0.16 (0.11–0.24)
18–64 (n=7,761)	ED visit	4.55% (353)	14.91% (1,157)	0.32 (0.27–0.34)
>=65 (n=2,173)	ED visit	7.36% (160)	13.94% (303)	0.53 (0.44–0.63)
0–4 (n=1,361)	Hospitalization	0.96% (13)	2.65% (36)	0.36 (0.19–0.68)
5–11 (n=1,307)	Hospitalization	0.77% (10)	1.45% (19)	0.53 (0.25–1.13)
12–17 (n=1,244)	Hospitalization	1.21% (15)	1.93% (24)	0.63 (0.33–1.19)
18–64 (n=7,761)	Hospitalization	1.20% (93)	3.78% (293)	0.32 (0.25–0.40)
>=65 (n=2,173)	Hospitalization	5.29% (115)	9.67% (210)	0.55 (0.44–0.68)



This substantial reduction of severe disease risk must be applied to a contextualized understanding of the already low-risk to working-age individuals.

Since the start of the pandemic, there have been 206,156 COVID-associated deaths among the working age 18 to 64 population – overwhelmingly in those above age 50 with pre-existing health conditions – according to the preliminary death count at the CDC's National Center for Health Statistics:[13]

	Deaths With COVID	Total Deaths	Deaths Without COVID	Deaths With COVID as % of Age Group Deaths	Population	Deaths With COVID Per 100,000 Population	Deaths Without COVID Per 100,000 Population	Age Group % of U.S. Population	Age Group % of all Deaths with COVID	Age Group % of all Deaths Without COVID
0-17 years	678	66,234	65,556	1.0%	74,128,216	0.91	88.44	22.2%	0.1%	1.1%
18-29 years	4,956	126,217	121,261	3.9%	54,277,315	9.13	223.41	16.2%	0.6%	2.1%
30-39 years	14,614	184,876	170,262	7.9%	45,227,543	32.31	376.46	13.5%	1.8%	2.9%
40-49 years	35,190	276,337	241,147	12.7%	40,772,122	86.31	591.45	12.2%	4.3%	4.2%
50-64 years	151,396	1,121,577	970,181	13.5%	63,657,235	237.83	1524.07	19.0%	18.6%	16.7%
65 years and over	607,972	4,845,695	4,237,723	12.5%	56,441,027	1077.18	7508.23	16.9%	74.6%	73.0%
All Ages	814,806	6,620,936	5,806,130	12.3%	334,503,458	243.59	1735.75	100.0%	100.0%	100.0%

CDC NVSS Deaths, Wonder Population Estimates. From January 1, 2020 to December 25, 2021 as of December 29, 2021.

Given substantial improvements in treatments, including therapeutics that can reduce the risk of hospitalization of death by more than 50 percent, we would expect that even if the virus had not attenuated deaths in this age group, and even in the absence of vaccination, deaths would be 50,000 or less per year going forward.

With Omicron's observed decline in severity, expected working-age deaths fall into a range comparable to — or even lower than — the CDC's modeled 8,000 influenza deaths in 2017- 18.[16] Quite simply, the Omicron variant is now a normal respiratory virus, not an unusual, extraordinary, or grave danger. There is no evidence in the record specific to Omicron to support a grave danger finding.

III. VACCINES ARE INEFFECTIVE AT PREVENTING OMICRON INFECTIONS

Pfizer and BioNTech are the manufacturers of the current leading vaccine. They recently admitted that the existing vaccine does not provide robust protection against Omicron, saying: Sera from individuals who received two doses of the current COVID -19 vaccine did exhibit, on average, more than a 25- fold reduction in neutralization titers against the Omicron variant compared to wild- type, indicating that two doses of BNT162b2 may not be sufficient to protect against infection with the Omicron variant.[17]

Moderna, the second-leading manufacturer, similarly admitted that its vaccine does not provide acceptable efficacy against Omicron, stating: All groups had low neutralizing antibody levels in the Omicron PsVNT assay prior to boosting.[18] Similarly, NIH-funded researchers at Duke university found in vitro that: "neutralizing titers to Omicron are 49-84 times lower than neutralization titers to D614G [wild-type SARS-CoV2] after 2 doses of mRNA-1273 [Moderna], which could lead to an in- creased risk of symptomatic breakthrough infections."[19] Real-world evidence from at least four countries with significant experience with Omicron — Den- mark, the United Kingdom, Germany, and Canada, all of which provide more detailed and transparent data than has been made available in the United States — evidences that these vaccines have substantially zero efficacy at preventing Omicron transmission, undermining the central rationale for mandating them in the workplace.

The Statens Serum Institut in Copenhagen, Denmark analyzed Danish data and found vaccine efficacy turned negative after 91 days following the second dose was administered. In other words, vaccinated Danes were even more likely than unvaccinated Danes to be infected with Omicron after 3 months:[20]

This may be because unvaccinated, COVID- recovered patients have better protection versus Omicron than vaccinated patients who never previously had COVID.[21]

In Germany, the most recent detailed report from the Robert Koch Institute (the German equivalent of the CDC) found that 78.6 percent (4,020 of 5,117) of sequenced Omicron cases were in vaccinated Ger- mans,[22] despite a population vaccination rate of just 70 percent.[23] In the United Kingdom, the UK Health Security Agency calculated preliminary vaccine effectiveness estimates remarkably like the Danish findings, with near-zero vaccine efficacy for both Pfizer-BioNTech and Moderna vaccines after 20 weeks following the second dose:[24]

16 https://www.cdc.gov/flu/about/burden/2017-2018.htm

17 https://www.pfizer.com/news/press-release/press-release-detail/pfizer-and-biontech-provide-update-omicron-variant

18 https://investors.modernatx.com/news/news-de- tails/2021/Moderna-Announces-Preliminary-Booster-Data-and- Updates-Strategy-to-Address-Omicron-Variant/default.aspx

19 https://www.medrxiv.org/content/10.1101/2021.12.15.21267805v1.full-text

20 https://www.medrxiv.org/con- tent/10.1101/2021.12.20.21267966v2.full.pdf

21 Sivan Gazit, Roei Shlezinger, Galit Perez, Roni Lotan, Asaf Peretz, Amir Ben-Tov, Dani Cohen, Khitam Muhsen, Gabriel Chodick, Tal Patalon (2021) Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections, medRxiv (Aug. 25, 2021) https://doi.org/10.1101/2021.08.24.21262415

22 https://www.rki.de/DE/Content/InfAZ/N/Neuartiges_Coronaviru s/Situationsberichte/Wochenbericht/Wochenbericht_2021-12-30.pdf

23 https://ourworldindata.org/covid-vaccinations

24 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1043807/technical-briefing-33.pdf

Read the entire filing document here…
https://aflds.org/news/press-releases/aflds-files-an-amicus-brief-to-the-us-supreme-court-to-appeal-the-sixth-circuits-decision-dissolving-the-stay-of-the-osha-mandate/

New Lancet paper confirms that Omicron escapes the 2-dose and booster regimen

The ***Lancet*** paper was published online January 18th, 2022, and is titled, **Breakthrough infections with SARS-CoV-2 omicron despite mRNA vaccine booster dose**. It studied the original seven Omicron vaccine breakthrough cases in South Africa.

From the study

The most recent SARS-CoV-2 variant of concern to emerge has been named omicron. Its immune evasion potential was predicted by genomic data and has been preliminarily confirmed by observations of an increased incidence of reinfections and breakthrough infections.

A group of German visitors who had received three doses of SARS-CoV-2 vaccines, including at least two doses of an mRNA vaccine, experienced breakthrough infections with omicron between late November and early December, 2021, while in Cape Town, South Africa. The group consisted of five White women and two White men) with an average age of 27·7 years (range 25–39) and a mean body-mass index of 22·2 kg/m2 (range 17·9–29·4), with no relevant medical history. Four of the individuals were participating in clinical elective training at different hospitals in Cape Town, whereas the others were on vacation.

Six individuals were fully vaccinated with BNT162b2 (Comirnaty, Pfizer–BioNTech, Mainz, Germany), five of whom received a third (booster) dose of BNT162b2 in October or early November, 2021.

One individual had received a full dose of CX-024414 (Spikevax, Moderna, Cambridge, MA, USA) in early October, 2021; this was not in line with the European Medicines Agency recommendations at that time, which suggested a half dose to boost healthy individuals. The seventh individual received an initial dose of ChAdOx1-S (Vaxzevria, AstraZeneca, Cambridge, UK), followed by a dose of BNT162b2 for completion of primary immunisation, and a booster dose of the same vaccine. Except for the CX-024414 booster, all vaccinations were in accordance with European recommendations. The early timepoints of some individuals' primary and booster vaccinations were due to their occupation in the medical field. Nobody reported a history of SARS-CoV-2 infection.

We obtained swab and serum samples 2–4 days after onset of symptoms. Further details of how samples were processed are provided in the appendix (p 2). All patients were placed in domestic isolation and used a daily symptom diary to document the course of disease during the observation period of 21 days. Illness was classified as mild (n=4) or moderate (n=3; shortness of breath) according to National Institutes of Health COVID-19 Treatment Guidelines. Two individuals were asymptomatic by the end of the observation period (day 21). Blood oxygenation levels (SPO 2) remained in the normal range (>94%) without exception and none of the patients required hospitalisation. Prevalence of symptoms over time is provided in the appendix (p 4). All seven individuals were infected with omicron (PANGO lineage B.1.1.529, Nextstrain clade 21K).

…These were the first documented breakthrough infections with the omicron variant in fully vaccinated individuals after receipt of booster vaccine doses.

… Booster doses were administered 21 –37 weeks after the second vaccine doses, and breakthrough infections occurred 22–59 days thereafter.

… Viral RNA loads in omicron variant infections have yet to be reported. It remains unknown whether the viral loads observed in our group are different from those in unvaccinated, or differently vaccinated, individuals. During wild-type SARS-CoV-2 infection, an average viral RNA load of 5·83 log10 viral RNA copies per swab was found in samples taken up to day after onset of symptoms, with a maximum of 8·85 log10 viral RNA copies per swab. In this group of individuals, an average of 6·38 log 10 viral RNA copies per mL of eluted swab was detected, with the highest viral load (8·22 log 10) detected on day 4 after onset of symptoms. This suggests that the individuals were infectious, in keeping with the occurrence of infection clusters sparing none of the members of the two groups.

Specific T-cell responses were detected in all participants tested at least 2 weeks after symptom onset, in the range reported after vaccination, 9 with additional T-cell responses to the viral nucleocapsid and membrane proteins.

This case series adds further evidence that, as predicted, omicron is able to evade immunity induced by mRNA vaccines in vivo.

In-vitro data suggest lower titres of neutralising antibodies against omicron compared to other SARS-CoV-2 lineages following BNT162b2 vaccination but increased titres after a third dose, supporting calls for booster doses while the omicron variant appears to be spreading globally. Our study, however, demonstrates insufficient prevention of symptomatic infection in otherwise healthy individuals who had received three doses of COVID-19 mRNA vaccines.

End of excerpts

https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)00090-3/fulltext#sec1

My comment: The authors try to make the case that the cases were mild because of the fact that they were vaccinated…. "The mild to moderate course of illness suggests that full vaccination followed by a booster dose still provides good protection against severe disease caused by omicron." What is so disingenuous about that statement is that with this paper being released January 18th, 2022, and tens of millions of cases of Omicron world-wide in the 6 weeks prior to the release of this article that has been shown to be no more serious than a common cold for the vast number of infected people. The other thing is that these 7 people were relatively young and healthy (which they did acknowledge in the paper).

We have seen the "I'm sure their illness was less severe because of being vaccinated" as a fallback narrative with the media when they have to report on breakthrough cases. And we hear people we talk to who are true believers in the jabs, parroting the same talking points. If they were ever effective at all (and we'll see after the Pfizer data the FDA was trying to hide for 75 years), it would have only been the first 90 days or so after the original shots, designed and administered for the original strain. At the 60-90 day point, antibody levels dropped quickly (the efficacy waned), and the vaccines started driving multiple mutations around the globe, causing variants that escaped the shot-induced immune response. The bottom line is that the holy grail is a failure and likely to cause a weakening of a person's immune system, See more on that in this issue.

Another study confirms that both vaccinated and boosted individuals are more likely to be infected with Omicron

In a *medRxiv* pre-print study posted December 21st, 2021 titled, **SARS-CoV-2 Omicron VOC transmission in Danish households reveals the increased susceptibility of vaccinated and boosted individuals**, authors describe early evidence that the shots and boosters are becoming increasingly ineffective.

The Abstract

The Omicron variant of concern (VOC) is a rapidly spreading variant of SARS-CoV-2 that is likely to overtake the previously dominant Delta VOC in many countries by the end of 2021.

We estimated the transmission dynamics following the spread of Omicron VOC within Danish households during December 2021. We used data from Danish registers to estimate the household secondary attack rate (SAR).

Among 11,937 households (2,225 with the Omicron VOC), we identified 6,397 secondary infections during a 1-7 day follow-up period. The SAR was 31% and 21% in households with the Omicron and Delta VOC, respectively. We found an increased transmission for unvaccinated individuals, and a reduced transmission for booster-vaccinated individuals, compared to fully vaccinated individuals. Comparing households infected with the Omicron to Delta VOC, **we found a 1.17 (95%-CI: 0.99-1.38) times higher SAR for unvaccinated, 2.61 times (95%-CI: 2.34-2.90) higher for fully vaccinated and 3.66 (95%-CI: 2.65-5.05) times higher for booster-vaccinated individuals, demonstrating strong evidence of immune evasiveness of the Omicron VOC.** Our findings confirm that the rapid spread of the Omicron VOC primarily can be ascribed to the immune evasiveness rather than an inherent increase in the basic transmissibility.

Excerpts from the study

The Omicron VOC has been reported to be three to six times as infectious as previous variants (4), with a short doubling time (11), including early estimates from countries with a high vaccination coverage indicating doubling times of 1.8 days (UK), 1.6 days (Denmark), 2.4 days (Scotland) and 2.0 days (United States) (26).

These results are supported by laboratory studies establishing a markedly reduced elimination of the Omicron VOC by neutralizing antibodies, indicating that the vaccination effectiveness with Pfizer-Biontech against infection is only at 35% for the Omicron VOC (5). This was corroborated by another in vitro study reporting an

8.4-fold reduction in neutralization for the Omicron VOC vs. the PV-D614G reference strain, whereas there was only a 1.6-fold reduction in neutralization for the Delta VOC (27). Therefore, the advantage of the Omicron VOC seems to be a combination of high transmissibility and increased immune evading abilities.

… We therefore started the study period on 9th December 2021 when cases of both variants were treated approximately equally, thus reducing bias from intensified contact tracing and active case finding of the Omicron VOC that was implemented shortly after it's discovery in Denmark (24). The end of the inclusion period for primary cases was set at 12th December to balance the inclusion of enough cases for proper estimation and early dissemination of the results. Potential secondary cases were followed up to 7 days after, i.e., until 19th December 2021 to allow for test results to be obtained. We obtained the last test results on 21st December.

We defined a primary case as the first individual within a household to test positive with an RT-PCR test within the study period. We followed all tests of other household members in the study period. A positive secondary case was defined by either a positive RT-PCR test or a positive antigen test (10). Almost all samples that tested positive with RT-PCR were tested with Variant PCR to determine the VOC (21) (see Appendix section 6.2).

A total of 2,225 primary cases with the Omicron VOC and 9,712 primary cases with the Delta VOC were included (Table 1). The SAR was 31% in households with the Omicron VOC and 21% in households with the Delta VOC. Generally, the estimated SAR was higher for the Omicron VOC than for the Delta VOC, for all age groups. Unvaccinated potential secondary cases experienced similar attack rates in households with the Omicron VOC and the Delta VOC (29% and 28%, respectively), while fully vaccinated individuals experienced secondary attack rates of 32% in household with the Omicron VOC and 19% in households with the Delta VOC. For booster-vaccinated individuals, Omicron was associated with a SAR of 25%, while the corresponding estimate for Delta was only 11%.

…Surprisingly, we observed no significant difference between the SAR of Omicron versus Delta among unvaccinated individuals (Table 3).

…Our data indicate that the non-pharmaceutical interventions that were used to control the previous variants of SARS-CoV-2 are also likely to be effective against the Omicron VOC.

…Similarly, there are likely underlying behavioural drivers for an individual being unvaccinated, which are likely to confound with other risky behaviours that might be expected to increase both transmission and susceptibility to infection (e.g. poor use of face masks, reduced attention to hygiene).

End of excerpts

https://www.medrxiv.org/content/10.1101/2021.12.27.21268278v1

My comment: The last comment shows blatant ignorance of the authors about the intelligence and behaviors of unvaccinated individuals. My experience is that unvaccinated individuals are some of the most educated on all aspects of this virus including infection control, hygienic behavior and alternative forms of taking care of themselves. Most understand the data on paper and cloth face masks and understand the fallacy of their use. And to state that unvaccinated individuals subscribe to risky behavior and in particular "reduced attention to hygiene" shows unsupported biased and complete ignorance.

Not only are the shots incapable of preventing infection or transmission, but are making people MORE susceptible to becoming infected

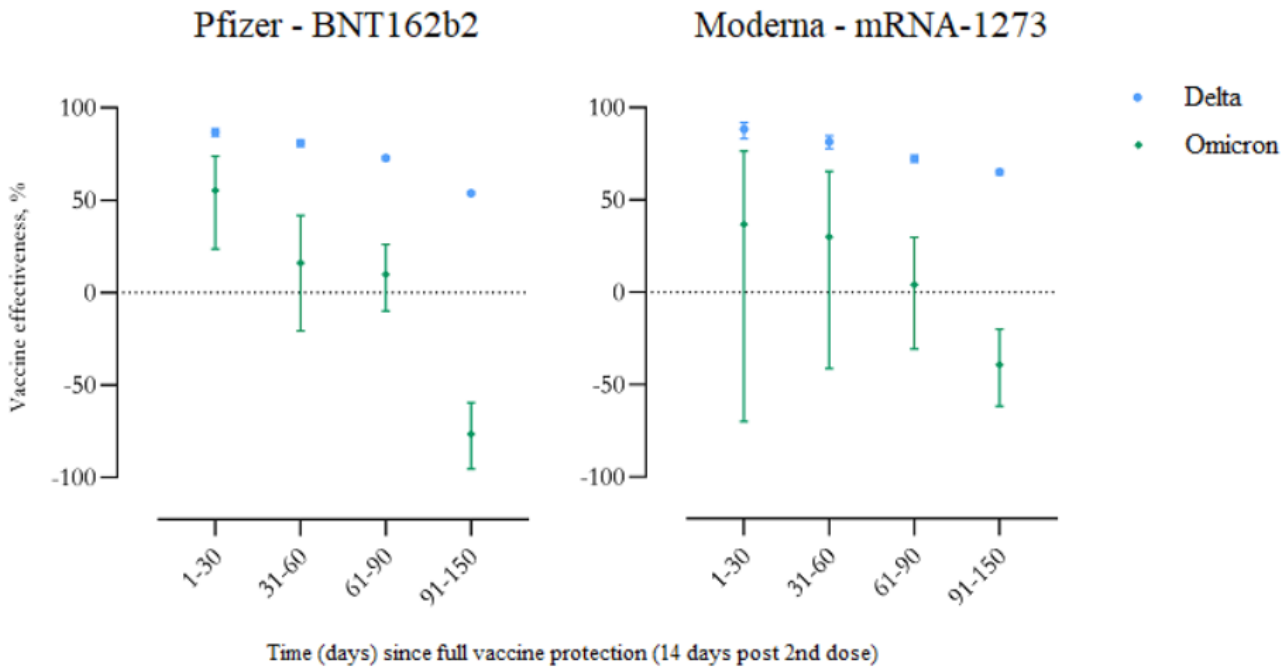


Figure Vaccine effectiveness against SARS-CoV-2 infection with the Delta and Omicron variants, shown separately for the BNT162b2 and mRNA-1273 vaccines. Vertical bars indicate 95% confidence intervals.

Table Estimated vaccine effectiveness for BNT162b2 and mRNA-1273 against infection with the SARS-CoV-2 Omicron and Delta variants during November 20 – December 12, 2021, Denmark.

	Pfizer – BNT162b2				Moderna - mRNA-1273			
	Omicron		Delta		Omicron		Delta	
Time since vaccine protection	Cases	VE, % (95% CI)	Cases	VE, % (95% CI)	Cases	VE, % (95% CI)	Cases	VE, % (95% CI)
1-30 days	14	55.2 (23.5; 73.7)	171	86.7 (84.6; 88.6)	4	36.7 (-69.9; 76.4)	29	88.2 (83.1; 91.8)
31-60 days	32	16.1 (-20.8; 41.7)	454	80.9 (79.0; 82.6)	8	30.0 (-41.3; 65.4)	116	81.5 (77.7; 84.6)
61-90 days	145	9.8 (-10.0; 26.1)	3,177	72.8 (71.7; 73.8)	48	4.2 (-30.8; 29.8)	1,037	72.2 (70.4; 74.0)
91-150 days	2,851	-76.5 (-95.3;-59.5)	34,947	53.8 (52.9; 54.6)	393	-39.3 (-61.6;-20.0)	3,459	65.0 (63.6; 66.3)
1-30 days after booster vaccination protection	29	54.6 (30.4; 70.4)	453	81.2 (79.2; 82.9)	-	-	5	82.8 (58.8; 92.9)

CI = confidence intervals; VE = vaccine effectiveness. VE estimates adjusted for 10-year age groups, sex and region (five geographical regions). Vaccine protection was assumed 14 days post 2nd dose. Insufficient data to estimate mRNA-1273 booster VE against Omicron.

And hospitalizations are rising faster in vaccinated and even vaxxed-and-boosted than in the unvaccinated with Omicron

A publication titled, **Status of the SARS-CoV-2 variant Omicron in Denmark**- 3rd January 2022, shows that only 24 percent of the people hospitalized with Omicron during late November and December were unvaccinated - while 76 percent were vaccinated, including 18 percent who were boosted. During the same period, unvaccinated people made up 45 percent of those hospitalized with earlier variants - yet more proof the vaccines simply do not work as well against Omicron as earlier variants.

Hospitalizations

Table 7. Vaccination status for individuals infected with Omicron compared to other variants, from 21st of November to 28th of December 2021. The table only includes samples with a known variant.

Tabel 7. Vaccinationsstatus for personer med omikron-infektion sammenlignet med andre varianter i perioden fra 21. november 2021 til 28. december 2021. Tabellen indeholder kun data på prøver med en kendt variant.

Vaccination status among individals tested positive prior or within 48 hrs after admisson	Other variants (No. of cases)	Other variants (%)	Omicron (No. of cases)	Omicron (%)
Not vaccinated	641	45.4	109	24
Received first dose	39	2.8	24	5.3
Completed primary vaccination schedule	617	43.7	239	52.6
Revaccinated	116	8.2	82	18.1
Total	1,413	100.1	454	100

Deaths

Table 9. Number and proportion of Omicron related deaths compared to other variants, data included in the table are from 21st of November to 28th of December 2021. The table only includes samples with a known variant.

Tabel 9. Antal og andel omikron-relaterede dødsfald sammenlignet med andre varianter i perioden fra 21. november 2021 til 28. december 2021. Tabellen indeholder kun data på prøver med en kendt variant.

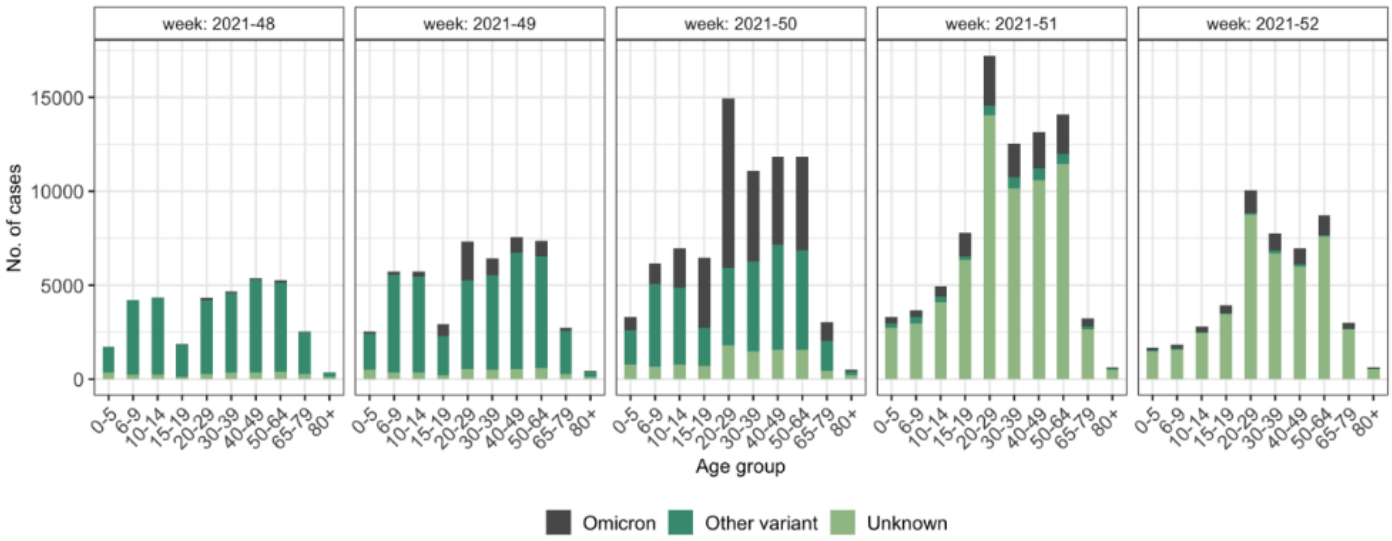
Dead within 30 days after a positive test	Other variants (No. of cases)	Other variants (%)	Omicron (No. of cases)	Omicron (%)
No	127,146	99.9	55,673	100
Yes	100	0.1	18	0
Total	127,246	100	55,691	100

The Case Fatality Rate (CFR) for other variants calculates to 0.0786%. The Case Fatality Rate (CFR) for other Omicron calculates to 0.0323% or about 60% less than with other variants.

Number of cases of various variants vs. Omicron

Figure 1. Number of cases with Omicron, other SARS-CoV-2 variants and unknown variant Omicron by age group and week. The figure includes data from 29th of November to 28th of December 2021, thus week 52 is not yet complete.

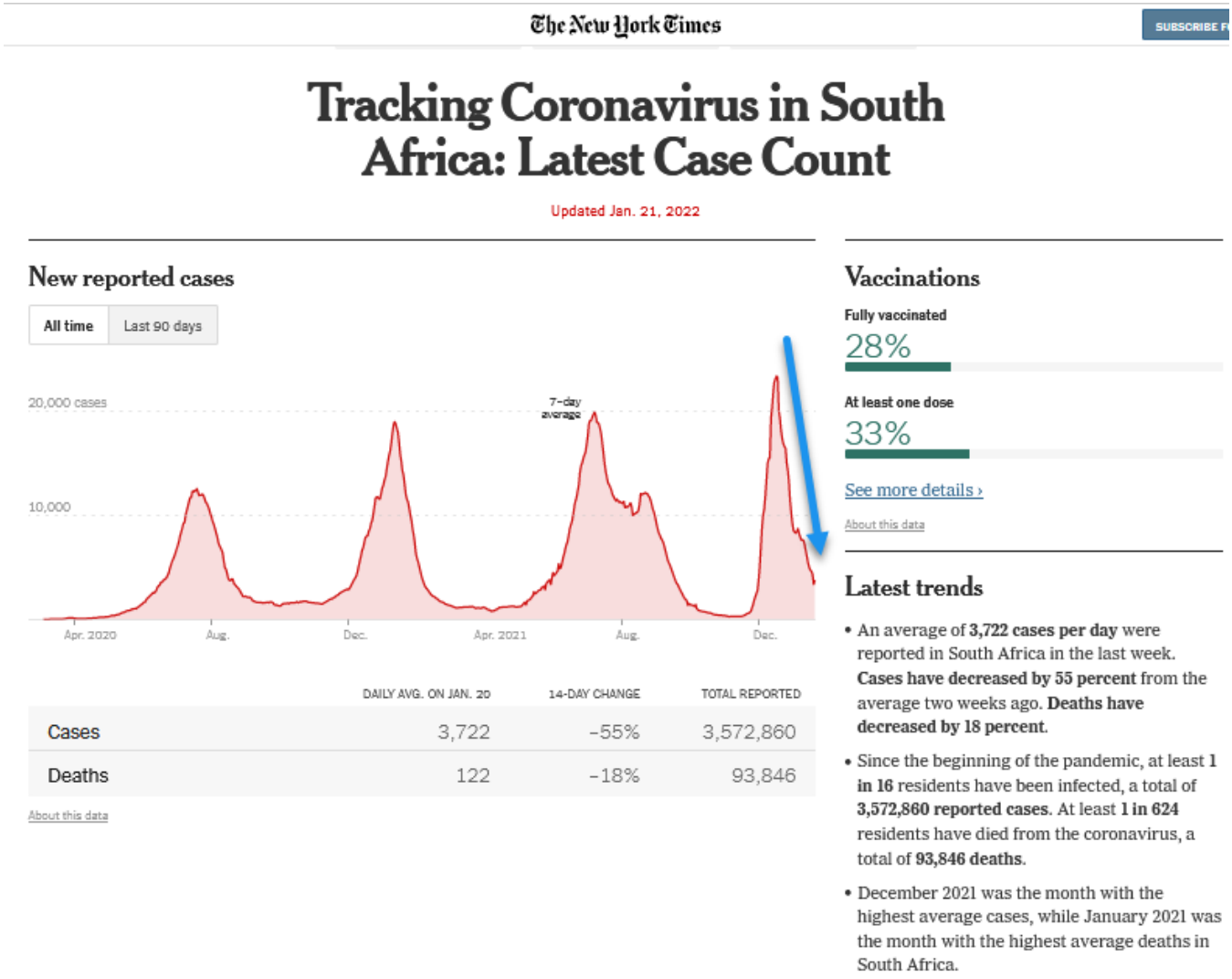
Figur 1. Antal tilfælde med omikron, andre SARS-CoV-2 varianter og ukendt variant, pr. aldersgruppe og uge. Figuren er opgjort i perioden fra 29. november 2021 til 28. december 2021, hvorfor uge 52 endnu ikke er komplet.



https://files.ssi.dk/covid19/omikron/statusrapport/rapport-omikronvarianten-03012022-9gj3

It's interesting to note that the percentage of Omicron cases (black lines) seemed to peak in the second week of December. In the third week the percentage of "unknowns" seems to dominate. The caption above it says that week 52 data was incomplete but doesn't indicate that week 51 was. So, either the level of testing intensity had dropped dramatically during week 51, or the percentage of Omicron cases dropped precipitously.

Interestingly, that is exactly what happened in South Africa. It seems that Omicron tends to run through the susceptible population very quickly (Omicron label and blue arrow added by me).



The New York Times

SUBSCRIBE F

Tracking Coronavirus in South Africa: Latest Case Count

Updated Jan. 21, 2022

New reported cases

All time | Last 90 days

	DAILY AVG. ON JAN. 20	14-DAY CHANGE	TOTAL REPORTED
Cases	3,722	-55%	3,572,860
Deaths	122	-18%	93,846

About this data

Vaccinations

Fully vaccinated
28%

At least one dose
33%

See more details ›

About this data

Latest trends

- An average of **3,722 cases per day** were reported in South Africa in the last week. **Cases have decreased by 55 percent** from the average two weeks ago. **Deaths have decreased by 18 percent.**
- Since the beginning of the pandemic, at least **1 in 16** residents have been infected, a total of **3,572,860 reported cases.** At least **1 in 624** residents have died from the coronavirus, a total of **93,846 deaths.**
- December 2021 was the month with the highest average cases, while January 2021 was the month with the highest average deaths in South Africa.

https://www.nytimes.com/interactive/2021/world/south-africa-covid-cases.html

Nobel Prize winning scientist blows up the current effectiveness of the vaccines and the irrationality of the mandates

A January 9th, 2022 ***Wall Street Journal*** opinion piece written by Luc Montagnier and Jed Rubenfeld and titled, **Omicron Makes Biden's Vaccine Mandates Obsolete - There is no evidence so far that vaccines are reducing infections from the fast-spreading variant**, blows up the notion that mandates of the failing vaccine program should continue.

Authors: *Dr. Montagnier was a winner of the 2008 Nobel Prize in Physiology or Medicine for discovering the human immunodeficiency virus. Mr. Rubenfeld is a constitutional scholar.*

Excerpts from the opinion piece

Federal courts considering the Biden administration's vaccination mandates—including the Supreme Court at Friday's oral argument—have focused on administrative-law issues. The decrees raise constitutional issues as well. But there's a simpler reason the justices should stay these mandates: the rise of the Omicron variant.

It would be irrational, legally indefensible and contrary to the public interest for government to mandate vaccines absent any evidence that the vaccines are effective in stopping the spread of the pathogen they target. Yet that's exactly what's happening here.

Both mandates—from the Health and Human Services Department for healthcare workers and the Occupational Safety and Health Administration for large employers in many other industries—were issued Nov. 5. At that time, the Delta variant represented almost all U.S. Covid-19 cases, and both agencies appropriately considered Delta at length and in detail, finding that the vaccines remained effective against it. Those findings are now obsolete. As of Jan. 1, Omicron represented more than 95% of U.S. Covid cases, according to estimates from the Centers for Disease Control and Prevention. Because some of Omicron's 50 mutations are known to evade antibody protection, because more than 30 of those mutations are to the spike protein used as an immunogen by the existing vaccines, and because there have been mass Omicron outbreaks in heavily vaccinated populations, scientists are highly uncertain the existing vaccines can stop it from spreading. As the CDC put it on Dec. 20, "we don't yet know . . . how well available vaccines and medications work against it."

… As the World Health Organization puts it, "if mandatory vaccination is considered necessary to interrupt transmission chains and prevent harm to others, there should be sufficient evidence that the vaccine is efficacious in preventing serious infection and/or transmission." For Omicron, there is as yet no such evidence.

The little data we have suggest the opposite. One preprint study found that after 30 days the Moderna and Pfizer vaccines no longer had any statistically significant positive effect against Omicron infection, and after 90 days, their effect went negative—i.e., vaccinated people were *more* susceptible to Omicron infection. Confirming this negative efficacy finding, data from Denmark and the Canadian province of Ontario indicate that vaccinated people have higher rates of Omicron infection than unvaccinated people.

Meantime, it has long been known that vaccinated people with breakthrough infections are highly contagious, and preliminary data from all over the world indicate that this is true of Omicron as well. As CDC Director Rochelle Walensky put it last summer, the viral load in the noses and throats of vaccinated people infected with Delta is "indistinguishable" from that of unvaccinated people, and "what [the vaccines] can't do anymore is prevent transmission."

There is some early evidence that boosters may reduce Omicron infections, but the effect appears to wane quickly, and we don't know if repeated boosters would be an effective response to the surge of Omicron. That depends among other things on the severity of disease Omicron causes, another great unknown. According to the CDC, the overwhelming majority of symptomatic U.S. Omicron cases have been mild. The best policy might be to let Omicron run its course while protecting the most vulnerable, naturally immunizing the vast majority against Covid through infection by a relatively benign strain. As Sir Andrew Pollard, head of the U.K.'s Committee on Vaccination and Immunisation, said in a recent interview, "We can't vaccinate the planet every four or six months. It's not sustainable or affordable."

… Omicron was mentioned sparsely at Friday's oral argument, but the justices—particularly those most favorable to the mandates—appeared to labor under drastically false assumptions. Justice Stephen Breyer suggested that if mandatory vaccination went forward, that would prevent all new Covid infections—750,000 new cases every day, he said. This is wildly false. So is Justice Sonia Sotomayor's assertion that "we have over 100,000 children . . . in serious condition, many on ventilators." According to Health and Human Services Department data, there are currently fewer than 3,500 confirmed pediatric Covid hospitalizations, and that includes patients who tested positive and were hospitalized for other reasons.

It is axiomatic in U.S. law that courts don't uphold agency directives when the agency has entirely failed to consider facts crucial to the problem. In many contexts courts send regulations back to the agency for reconsideration in light of dramatically changed circumstances. If the agency's action "is not sustainable on the record itself, the proper judicial approach has been to vacate the action and to remand the matter back to the agency for further consideration," as the U.S. Circuit Court of Appeals for the District of Columbia put it.

Neither HHS nor OSHA ever considered Omicron or said a word about vaccine efficacy against it, for the simple reason that it hadn't yet been discovered. In these circumstances, longstanding legal principles require the justices to stay the mandates and send them back to the agencies for a fresh look.

https://www.wsj.com/articles/omicron-makes-bidens-vaccine-mandates-obsolete-covid-healthcare-osha-evidence-supreme-court-11641760009

I just love this picture from the article! Make up your own caption.

ILLUSTRATION: DAVID GOTHARD

The data shows the cases, hospitalizations and death per 100K are MUCH higher in the vaccinated than the unvaccinated

Godspeed to the Vaccinated- by James Lyons-Weiler

The Vaccinated are Getting COVID. The Vaccinated are Being Hospitalized. The Vaccinated are Dying from COVID.

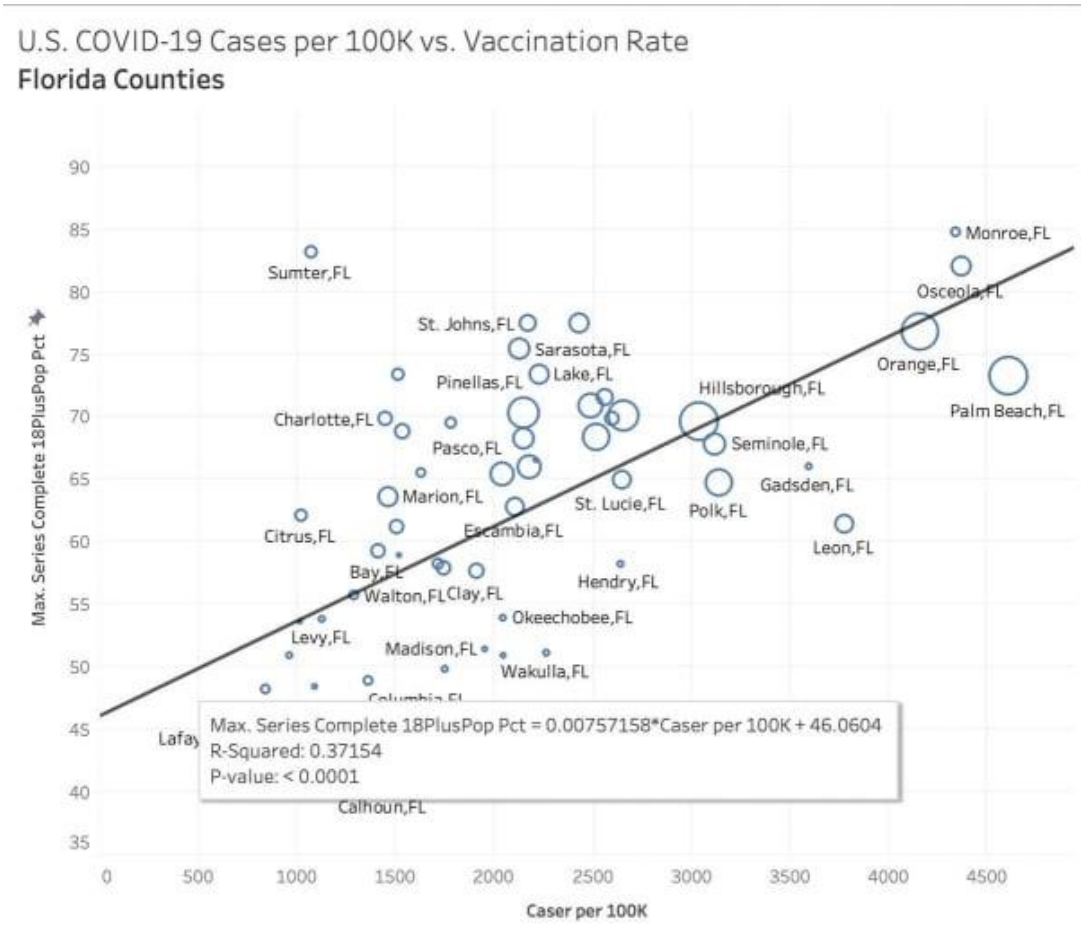
The data are in, and they are stark.

This analysis by Justin Hart, while it confuses X and Y axis (X = independent variable (cause, vaccination - uptake), Y = response variable (new cases), matches my, and others', whole-country and all-50-state analyses.

Tweet by Justin Hart @justin_hart

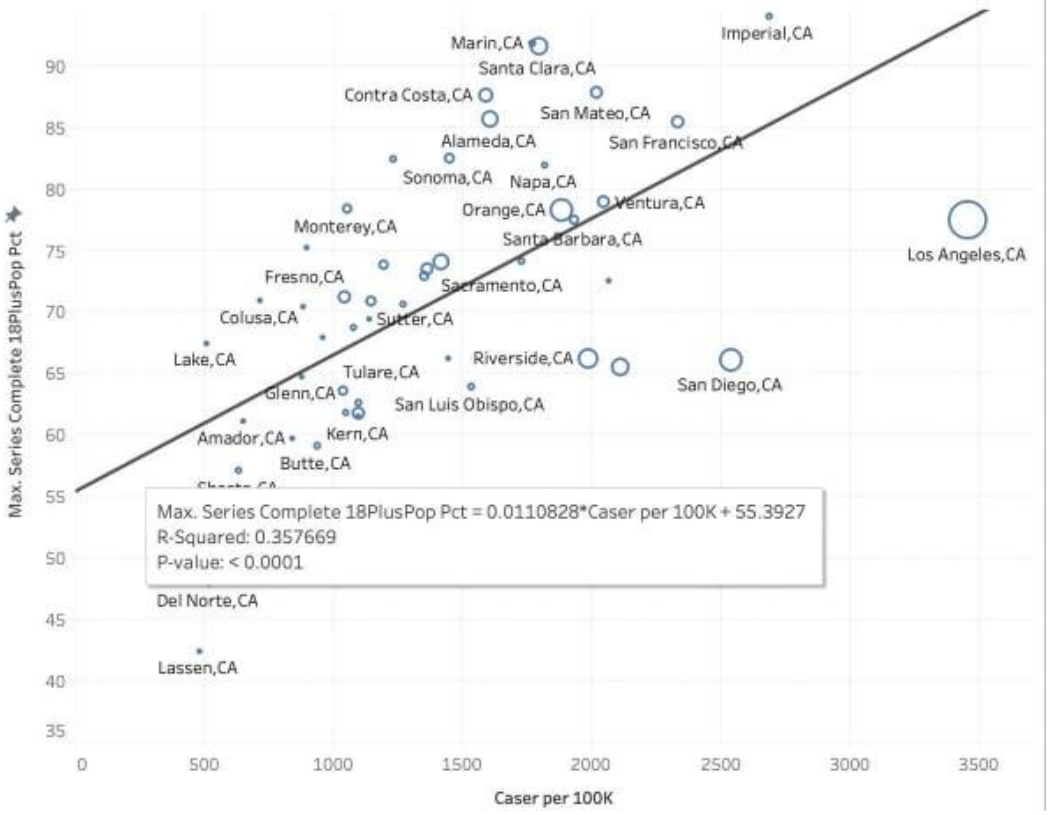
I mean. When you compare case rates and vax rates for the past 3 weeks you'd think that the line wouldn't look like this. But it does. That trend line should be going in the other direction.

My comment: Look at the P Values on these 3 scatter graphs. They are highly statistically significant (anything less than 0.05 is considered statistically significant).



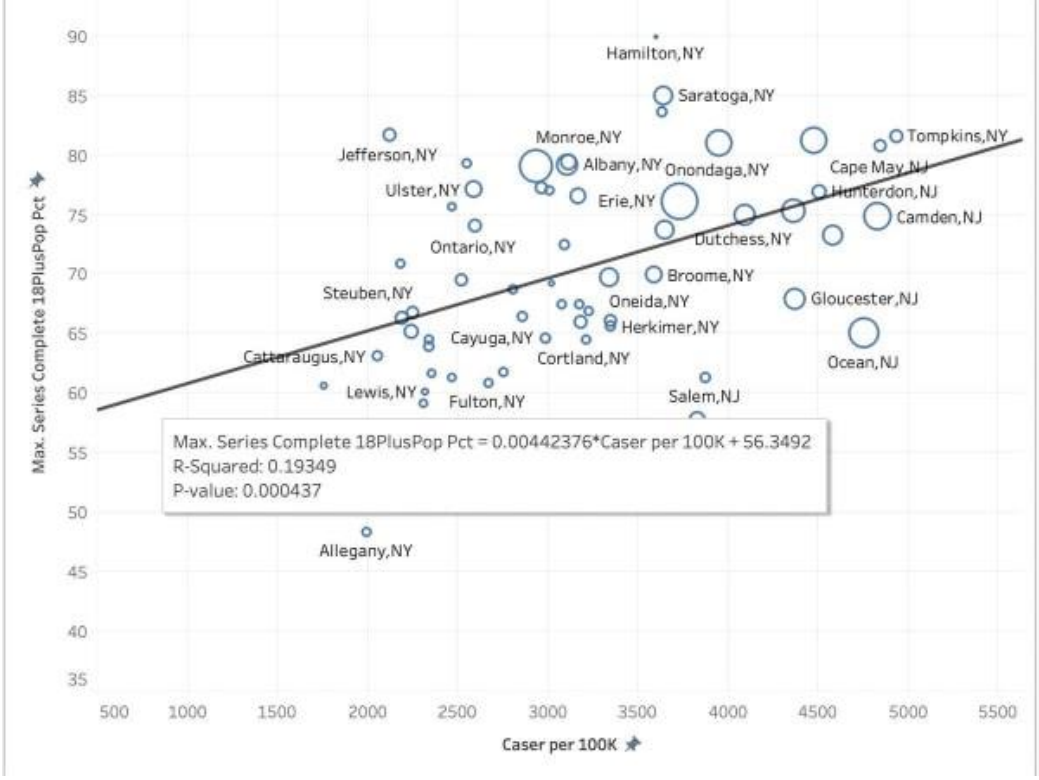
U.S. COVID-19 Cases per 100K vs. Vaccination Rate

California Counties

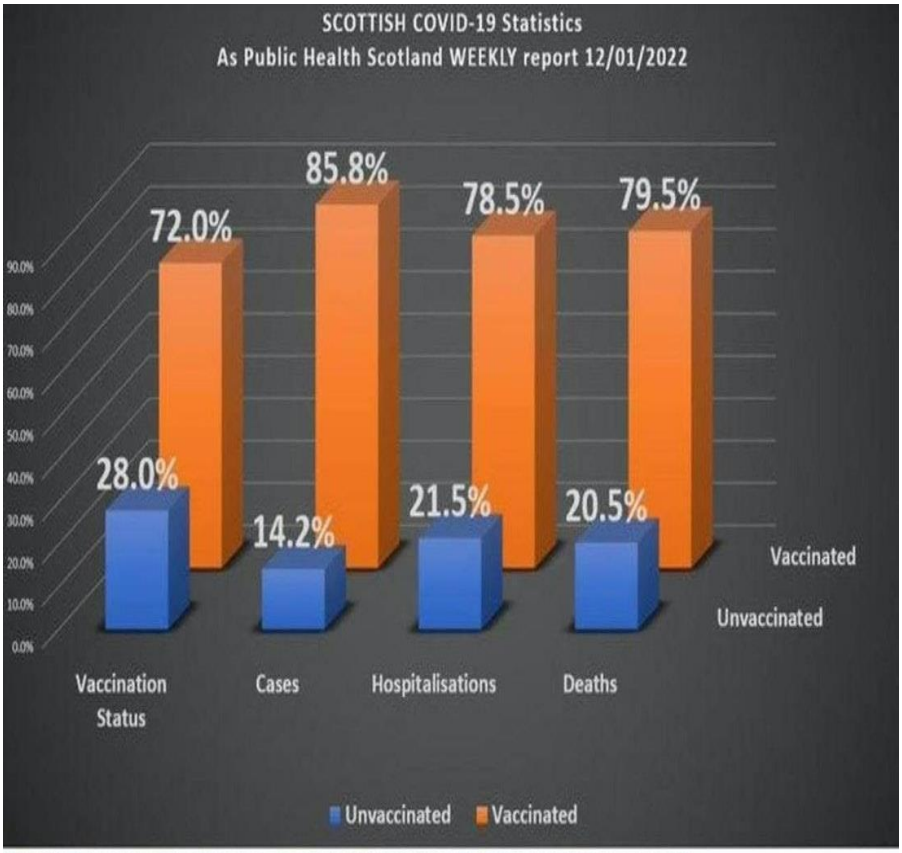


U.S. COVID-19 Cases per 100K vs. Vaccination Rate

New Jersey & New York Counties

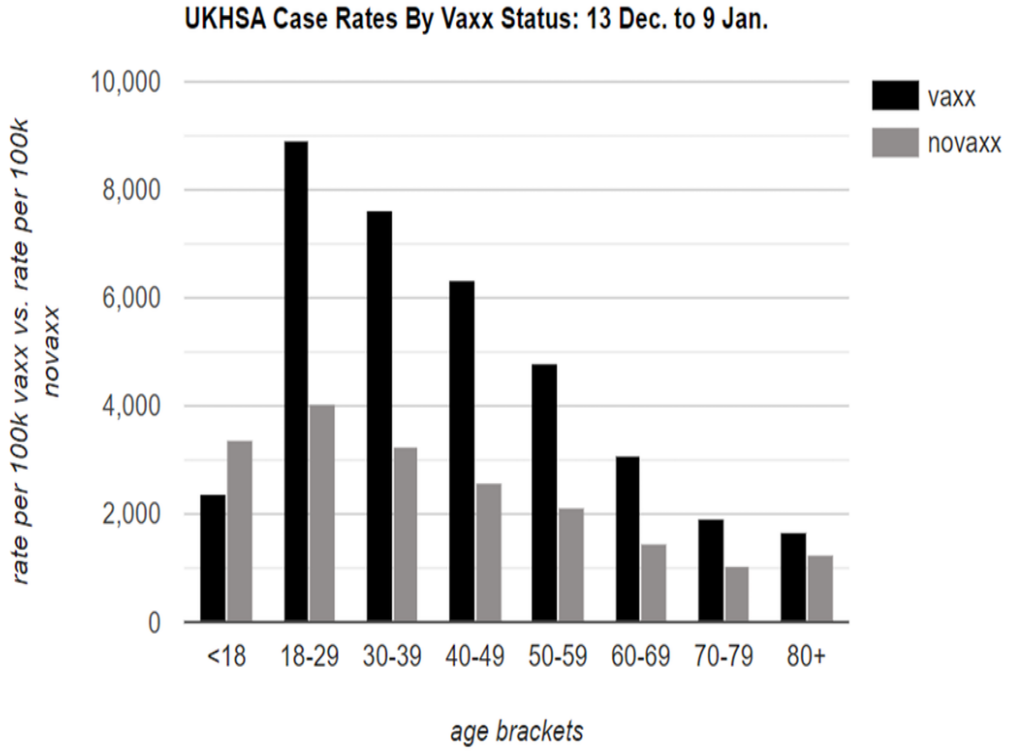


And the data from Scotland are clear:



https://www.publichealthscotland.scot/media/11076/22-01-12-covid19-winter_publication_report.pdf

And from the UKHSA



Your loved ones who are vaccinated are turning into high-risk candidates.

The Vaccinated are getting COVID. The Vaccinated are being hospitalized. The Vaccinated are dying from COVID.

It's Pathogenic Priming, specifically Antibody-dependent enhancement:

Subscribe to Dr. Lyons-Weiler's Substack here: https://popularrationalism.substack.com/subscribe

Third shot added to children aged birth-4 years old in Pfizer study, because two shots didn't produce sufficient antibody response. Here's another compelling reason for parents to say H _ _ _ NO!

There are so many things that parents must consider before making the decision to inject these are experimental biologicals into their children, far too many for the scope of this monthly newsletter. But I do have a document on my website that is a free download covering many of the various aspects of the risk versus reward ratios for subjecting children to so many known risks and many more unknowns. That can be found here… https://www.wellnessdoc.com/the-risk-vs-reward-of-the-covid-19-vaccines-for-children/

- Another very compelling reason that wasn't mentioned in my document but is certainly important is the fact that most likely 75% or so of children in the US have already had COVID-19. CDC data in the summer of 2020 estimated that approximately 40% of COVID-19 infections were asymptomatic. This may be even higher with the omicron variant since for most adults and especially younger people it is so mild.

- **A major complaint I have is why hasn't the CDC done a large study looking at antibody and T cell levels in children?** That would allow us to determine how many are even "at risk" (theoretically speaking). I think we all know the answer to that.

- Not only is the virus quite benign especially for healthy children, once infected and recovered, children should be bulletproof. It's quite possible that 75% or more children have had the infection and thus have no reason to receive the vaccines, especially these antiquated vaccines that are not even working well now in adults with the omicron variant.

- On top of that, it's insane to be injecting young children two or three times with this product that contains the spike protein which is a toxin and forces the body to make billions of copies of it when it has been shown that healthy children are at a statistical risk of zero of dying from COVID-19. I do have that data in my free document.

Watch the ***Chief Medical Officer*** of the ***Moderna*** mRNA vaccine Tal Zaks, explain how their vaccine is "hacking the software of life" and forcing your cells to make this genetically engineered spike protein with such a cavalier and nonchalant attitude. https://www.youtube.com/watch?v=r3UboxYLHcM

"Hacking the software of life?" What could possibly go wrong?!

- In adults it has been shown that people who have had the infection and recovered are at a greater risk for

adverse effects from the vaccines. What are going to be the short and long term and I'm emphasizing the long-term effects on children from giving them three of these experimental agents?

The CDC was asked what the magic number of deaths or disabled people that will signal the stopping point for the jabs is? You may or may not be surprised at the answer.

A January 7th, 2022 Substack article by Steve Kirsch explains that there literally may be no stopping point or casualty count that will cause the CDC to pull the plug on their "vaccine" program.

CDC: There is no stopping condition

I asked the CDC for the stopping condition for the COVID vaccines: you know, like how many kids have to die before they pull the plug, etc. Do you want to know what they said?

Remember Jacob Clynick, the 13-year old from Minnesota who died of **cardiac arrest** on June 20, 2021, **just 3 days after his second Pfizer shot**? Here's the story.

I sent an email to everyone at the CDC who was involved in the investigation of his death asking them what the stopping condition was for these vaccines. How many kids have to die? How many adults have to die? How many previously healthy Americans have to be permanently disabled?

I received no reply. They didn't even acknowledge the email.

That's pretty much what I expected.

If you don't believe me, you are welcome to ask them yourself. You can find their emails here. If you do ask and get a response, please post their response in the comments.

But this tells you everything you need to know, doesn't it?

The false comparison

Some people, including many doctors, believe that as long as the death rate from the vaccine is less than the death rate from COVID that we shouldn't stop the vaccine since it produces a net savings in lives.

This is totally false. It is not the # killed by the virus that matters. It is the estimated # of lives saved by the vaccine.

Net lives saved = (# saved by the vax) - (# killed by the vax)

Let's look at that. The Pfizer Phase 3 trial proved they could save 1 COVID life for every 22,000 vaccinated.

So with 220M fully vaccinated, we'll save 10,000 lives according to Pfizer's own study. There is no better data than this. This is the gold-standard, double-blind randomized trial result. Nobody can argue with it.

But the calculation of deaths due to the vaccine is at least 150,000, and I have 13 different ways to show that.

So we've killed over 150,000 people to maybe save 10,000 lives.

Any rational person would stop the vaccines immediately.

But this isn't about science or rational thinking. This is about a belief. The belief is that the only thing that matters is saving people from COVID, no matter how many people we have to kill to do it.

Ask your blue pill friends what the stopping condition is

If you are trying to convince your blue pill friends that there really is something very seriously wrong, simply ask them to tell you the stopping condition. If they don't find it troubling that they can't answer your question, then they are unreachable and you are wasting your time.

You don't need to be much of a critical thinker to figure this out:

Your safety is not their priority

Their priority is vaccinating everyone in America. Period.

There is no stopping condition. There never was one. Nobody in Congress will set a stopping condition either. Once everyone is vaccinated, then they do it again with a booster. And another booster. Each one makes you sicker and sicker.

The vaccines hurt your immune system after a very short "honeymoon period"

By giving you a vaccine that **compromises your immune system and makes you more susceptible to getting Omicron**, they can keep the "emergency" alive so that the EUA can be renewed so that they can keep vaccinating you again and again.

See my earlier articles on negative vaccine efficacy for details. All of these studies show the more you vaccinate with these vaccines, the more you compromise people's immune systems:

1. The Lyons-Weiler paper
2. The Harvard study
3. The German study
4. The Denmark study
5. German government data (this is from The Expose)
6. 80% of the COVID deaths in the UK are vaccinated

A note to the so-called "fact checkers" of the world

PLEASE fact check this!!! I'd love to be wrong. Prove me wrong. Tell us all what the stopping condition is and when it was created. Show us the documents.

If you would like to subscribe to Steve Kirsch's Substack newsletter you can do that here: https://stevekirsch.substack.com/

Reports surface about the large unreported numbers of injuries to U.S. military personnel from the shots

An article posted January 28th, 2022, on the ***Children's Health Defense*** website titled, **Nearly 35,000 Reports of COVID Vaccine Injuries Among 5- to 17-Year-Olds, CDC Data Show**, reveals many interesting and disturbing statistics from the CDC. But it may be the statistics that are not being reported that may be equally disturbing.

From the article

COVID vaccines causing miscarriages, cancer, neurological disorders among Military

In a hearing organized this week by Sen. Ron Johnson (R-Wis.), attorney Thomas Renz told a panel of experts data provided to him by three whistleblowers show COVID vaccines are causing catastrophic harm to members of the U.S. military while not preventing them from getting the virus.

Renz summarized data obtained from the Defense Medical Epidemiology Database — the military's longstanding epidemiological database of service members.

The data show miscarriages and cancer increased 300% in 2021 over the previous five-year average. Neurological disorders increased 1000% in 2021 over the past five-year average, increasing from 82,000 to 863,000 in one year.

"Our soldiers are being experimented on, injured and sometimes possibly killed," Renz said.

Following Renz's presentation, attorney Leigh Dundas reported evidence of the DOD doctoring data in DMED to conceal cases of myocarditis in service members vaccinated for COVID.

End of excerpts

https://childrenshealthdefense.org/defender/vaers-cdc-covid-vaccine-injuries-children/

Also, From The Blaze:

"In a declaration under penalty of perjury that Renz plans to use in federal court, Drs. Samuel Sigoloff, Peter Chambers, and Theresa Long — three military doctors — revealed that there has been a 300% increase in DMED codes registered for miscarriages in the military in 2021 over the five-year average.
The five-year average was 1,499 codes for miscarriages per year. During the first 10 months of 2021, it was 4,182.

https://www.theblaze.com/op-ed/horowitz-whistleblowers-share-dod-medical-data-that-blows-vaccine-safety-debate-wide-open

Since males in the ages most at-risk from myocarditis represent the majority of U.S. personnel, this next article really exposes the gravity of the situation. If true, this poses a significant national security risk.

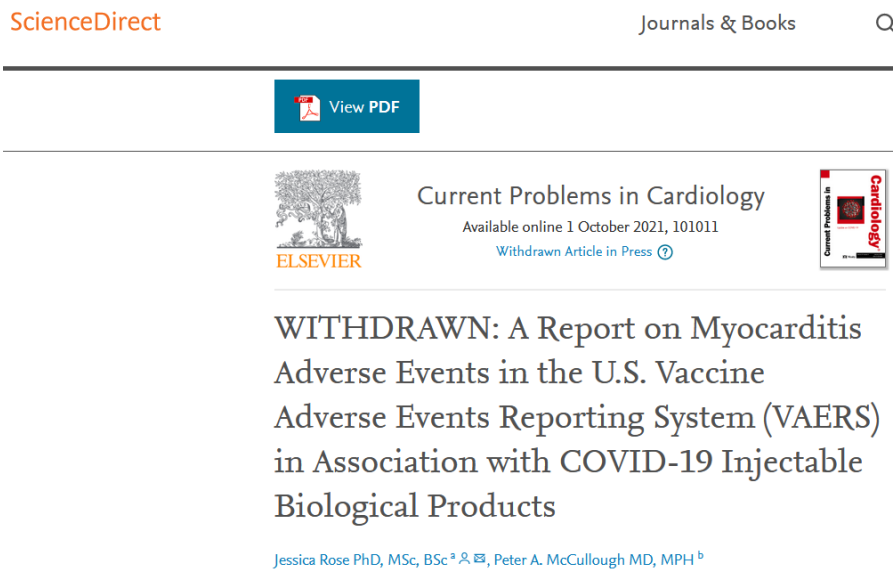
One interesting point made by Senator Johnson in the hearing discussed above, was the vaccine injuries and deaths from CDC and FDA data as it relates to some of the early treatment medications as compared to other meds and the flu and COVID vaccines. It shows the astronomical numbers from the COVID vaccines as compared to all the others. And, it shows how Ivermectin and Hydroxychloroquine are so much safer than Tylenol and Remdesivir.

This was a chart that Senator Johnson showed during the discussion.

A bombshell study from the journal Cardiology exposes the real risks of myocarditis from the shots

An October 2021 study pre-print from the journal ***Current Problems in Cardiology*** titled, **A Report on Myocarditis Adverse Events in the U.S. Vaccine Adverse Events Reporting System (VAERS) in Association with COVID-19 Injectable Biological Products**, reveals some startling data and mechanisms for one of the more serious adverse events from the spike protein containing injectables. Authors: Jessica Rose PhD, MSc, BSc , Peter A. McCullough MD, MPH.

When I went to Elsevier site to access the article, this is what it now states…. "This article has been withdrawn at the request of the author(s) and/or editor. The Publisher apologizes for any inconvenience this may cause."



I don't know for sure, but this appears to be another case of cancel culture that has infected medical and scientific journals. I don't believe that Dr. McCullough or Jessica Rose would have retracted it, so that would only leave one to conclude that it was done by the editors. If so, this study uncovering inconvenient truths about data that goes against narrative that the powers that be want out there has become another casualty of the suppression of truth. I have reported on many such instances over the years in my eBook ***1200 Studies-Truth Will Prevail*** available at https://www.wellnessdoc.com/1200studies .

From the paper

The abstract

Following the global rollout and administration of the Pfizer Inc./BioNTech BNT162b2 and Moderna mRNA-1273 vaccines on December 17, 2020, in the United States, and of the Janssen Ad26.COV2.S product on April 1st, 2021, in an unprecedented manner, hundreds of thousands of individuals have reported adverse events (AEs) using the Vaccine Adverse Events Reports System (VAERS). We used VAERS data to examine cardiac AEs, primarily myocarditis, reported following injection of the first or second dose of the COVID-19 injectable products. Myocarditis rates reported in VAERS were significantly higher in youths between the ages of 13 to 23 ($p<0.0001$) with ~80% occurring in males. Within 8 weeks of the public offering of COVID-19 products to the 12-15-year-old age group, we found 19 times the expected number of myocarditis cases in the vaccination

volunteers over background myocarditis rates for this age group. In addition, a 5-fold increase in myocarditis rate was observed subsequent to dose 2 as opposed to dose 1 in 15-year-old males. A total of 67% of all cases occurred with BNT162b2. Of the total myocarditis AE reports, 6 individuals died (1.1%) and of these, 2 were under 20 years of age - 1 was 13. These findings suggest a markedly higher risk for myocarditis subsequent to COVID-19 injectable product use than for other known vaccines, and this is well above known background rates for myocarditis. COVID-19 injectable products are novel and have a genetic, pathogenic mechanism of action causing uncontrolled expression of SARS-CoV-2 spike protein within human cells. When you combine this fact with the temporal relationship of AE occurrence and reporting, biological plausibility of cause and effect, and the fact that these data are internally and externally consistent with emerging sources of clinical data, it supports a conclusion that the COVID-19 biological products are deterministic for the myocarditis cases observed after injection.

There was so much noteworthy material in this study that it made it hard to pick the highlights. I have selected some of the best, but for those that want to read more there is a link at the end to the full PDF.

From the study

3. Discussion

In the context of COVID-19, and according to Dr. Leslie Cooper, there are a significant number of patients who present clinically as healthy who are experiencing heart-related complications, including myocarditis. 7 [2,17,18,19] There is a high risk of cardiac involvement both from COVID-19 infection and from COVID-19 injectable products and the risks of the latter must be further assessed and evaluated. Because of the spontaneous reporting of events to VAERS, we can assume that the cases reported thus far are not rare, but rather, just the tip of the iceberg. Again, under-reporting is a known and serious disadvantage of the VAERS system. *28,29,30+ The only way to understand how common myocarditis is after COVID-19 vaccination, is to perform a prospective cohort study where all vaccinated individuals undergo clinical assessment, ECG, and troponin measurement at regular intervals post-administration.

The fact that the VAERS reporting of myocarditis is 6X higher in 15-year-olds following dose 2 may be indicative of a cause-effect relationship. If we assume that following dose 1, a certain percentage of healthy young males who lack co-morbidities or co-factors experience cardiac-related AEs mild enough so as not to dissuade them from receiving dose 2 (ie: pallor, chest pain and shortness of breath, for example), then it is not difficult to imagine that they may have been experiencing symptoms of myocarditis. If a percentage of young males had experienced primary damage to the heart as a result of inflammation following dose 1, then dose 2 may have induced a much more noticeable clinical impact, or cardiac ‘insult’. In other words, these young males may receive a definitive diagnosis of myocarditis only following dose 2. What this implies, based on these assumptions, is that if there is a causal relationship then it might manifest with overlooked/unreported AEs following dose 1 and a diagnosis of myocarditis following dose 2. It is noteworthy that ‘Vaccine-induced myocarditis’ was in fact used as the descriptor by medical professionals as the reason for the myocarditis in the VAERS database.

…mRNA platforms have never before been implemented for use in human subjects on a global scale in the context of viruses and it has recently been shown that the spike protein itself systemically traffics inducing damage within cells, at the cell surface, and through circulation with endothelial damage and thrombosis. [44,45] It is unknown which cells and organs are seeded with mRNA, the cellular half-life of the products, duration of spike protein production, reverse transcription, future regulation, and ultimate disposal of mRNA technology. [51,52] Safety is always a point of relevance with regards to new biological agents and given these

new findings, it would be prudent to pay particular attention to the AEs being reported to the VAERS system in the context of these experimental products with known dangerous mechanisms of action. When evidence of harm appears, we need to follow the evidence and immediately take steps to mitigate risks.

Based on this study, the risk of suffering myocarditis subsequent to injection with the mRNA based products is low with an average of 4 individuals suffering myocarditis per million fully injected. However, the Israeli Ministry of Health recently announced that approximately 1 in 4,500 men ages 16 to 24 who received BNT162b2 developed myocarditis. *46+ This rate is much higher than the rate estimated based on VAERS data and could reflect variation in reporting. Nonetheless, the risk is higher for the young with an average of 28 12-15-year-olds succumbing to myocarditis per million fully immunized.

As a general rule, the ICU cardiac injury described in COVID-19 illness is subclinical and largely reflected by a minor elevation of cardiac troponin, whereas CIRM is characterized by a clinical syndrome often warranting hospitalization, dramatic ECG changes, and very large elevations of cardiac troponin that are sustained over time. [53,54,55,56,57,58,87].

It is vital to recall that children have a negligible risk for COVID-19 respiratory illness, and yet they are a high-risk group for myocarditis with vaccination. Newly-published evidence of Vaccine- Induced Autoimmune Myocarditis, *58+ demonstrates the risks of myocarditis associated with vaccination. [87,88,89,92,93,94,95] Despite this, a recent CDC report (May 31, 2021) claimed no danger signal was detectable from the VAERS AE data in the context of myocarditis and as such, they continue to support administration of these products into children 12 years of age and older despite reports of myocarditis and pericarditis in youth in temporal proximity to dose administration. [94].

It possible that vaccine-induced myocarditis is amplified by prior infection and pathogenic priming. Higher uptake of genetic material in some younger individuals who have been previously recovered from COVID-19 and were vaccinated, may partially explain why some individuals suffer from CIRM and others do not. Nevertheless, the background rate for children aged 12-15 has been established outside of the COVID-19 context and the rates in the context of CIRM are 19 times higher than the expected value.

A recent study shows increased myocardial ACE-2 expression in individuals with ‘basic heart failure disease’ indicating an intrinsic susceptibility of the heart to SARS-CoV-2 infection and worse prognosis. [55] Another study in *Hypertension* from 2008 claims that cardiac over-expression of ACE-2 exerts protective influence on the heart during myocardial infarction by preserving left ventricular wall motion and contractility, and by attenuating LV wall thinning. [56] However, we postulate the pathogenesis of CIRM must be much different with isolated production of spike protein over a sustained period of time and expression of the cell surface of cardiomyocytes, which would be considerably different than virion replication. The implications are the ACE-2 expression probably plays a smaller role in vaccine-induced myocardial injury and it has been noted by the co-author that the latter is more highly-associated with maintained elevated troponin levels. *[unpublished clinical findings].

Additional information may be gleaned from routine EKG readings and cardiac troponin measurement in volunteers post-injection. It is unknown if in-situ production or perfusion with blood carrying spike protein are the major mechanisms by which CIRM is initiated. Once, damaged, inflammation in the myocardium may last for weeks or months after the original insult is removed.

The exact mechanisms of action for induction and progression of CIRM needs to be elucidated to ensure improved and safer products for the future.

The clinical implications of acute myocarditis in younger individuals as a result of uncontrolled production of the SARS-CoV-2 spike protein within cardiac myocytes and cardiac support cells is unknown. If myocarditis has developed after the first injection, then second administrations and boosters should be avoided. Sustained elevations of cardiac troponin, reduction in left and right ventricular function, large areas of inflammation or scar on imaging, and cardiac arrhythmias all portend a poor prognosis for the development of heart failure and cardiac death. Because the duration of action of genetic material coding for spike protein is unknown, follow-up with cardiology consultation is advised in all cases and repeat imaging and biomarkers is wise. Empiric treatment with renin-angiotensin system inhibitors and evidence-based beta-blockers is advised for those at risk for or with manifest left ventricular dysfunction.

4. Conclusions

These data are derived from a rushed, non-FDA-approved, ongoing investigational product rollout, and our conclusions are thus limited by the information at hand. In addition to the 12-15-year-old age group data being *very* early, it is vital to acknowledge that these reports represent a fraction of the actual total. Thus, due to both the problems of under-reporting and the known lag in report processing, this analysis reveals a strong signal from the VAERS data that the risk of suffering CIRM – especially males is unacceptably high. Again, children are not a high-risk group for COVID-19 respiratory illness, and yet they are the high-risk group for CIRM.

Efficacy of these products needs to be assessed by immunological assays and long-term studies are required, while safety needs to be evaluated by rigorous clinical, laboratory and imaging assessments of severe reported adverse events such as CIRM. Autopsies should be done in cases of cardiovascular-related deaths temporally associated with COVID-19 injectables. It is reasonable to use the precautionary principle in this particular setting since an alarming number of reports are coming from young males between the ages of 12 and 15. Boys of these ages should be carefully monitored for warning signs of myocarditis which many may pass off such as pallor, chest pain, shortness of breath or lethargy, following dose 1 with the aim of seeking prompt evaluation and avoiding dose 2. Effective multidrug therapy is available for rare case of serious COVID-19 respiratory illness in the forms of antivirals, immunomodulators, and anthrombotics. *59,60,61,62,63,64,65,66,67,68,69,70,71,72].

The combination of a low IFR in children indicating effective and robust immune responses [73,74,75,76,77,78,79,80,81,82,83+, and the ability to treat with medical therapy, should the need arise, bodes well for clinical outcomes in children [69,70,71,72].

As part of any risk/benefit analysis which must be completed in the context of experimental products, the points herein must be considered before a decision can be made pertaining to agreeing to 2-dose injections of these experimental COVID-19 products, especially into children and by no means, should parental consent be waived under any circumstances to avoid children volunteering for injections with products that do not have proven safety or efficacy.

Future work may include on-site clinical observations of Troponin, BNP, galectin-3, ST2, IL-6 and D-dimer levels to corroborate temporal effects of onset of myocarditis following injections with particular COVID-19 products. Delineation between COVID-19 respiratory infection with mild ICU-related cardiac injury and true CIRM using these and other clinical diagnostic markers would be incredibly useful for clinicians and should become the standard for differential diagnosis of suspected CIRM. Correcting the inherent limitations of the VAERS dataset must be a priority as part of future studies. Incomplete VAERS dataset field entries describing prior COVID-19 infection and diagnostic tests such as cardiac MRIs in individuals diagnosed with myocarditis,

for example, would make this particular study even more potent. However, despite these limitations, and the limitation of using the VAERS dataset for studies like this one, the usable sample sizes have good statistical power. Ultimately, it remains vital to share the results herein to allow true pharmacovigilance to take place.

Figures from the study

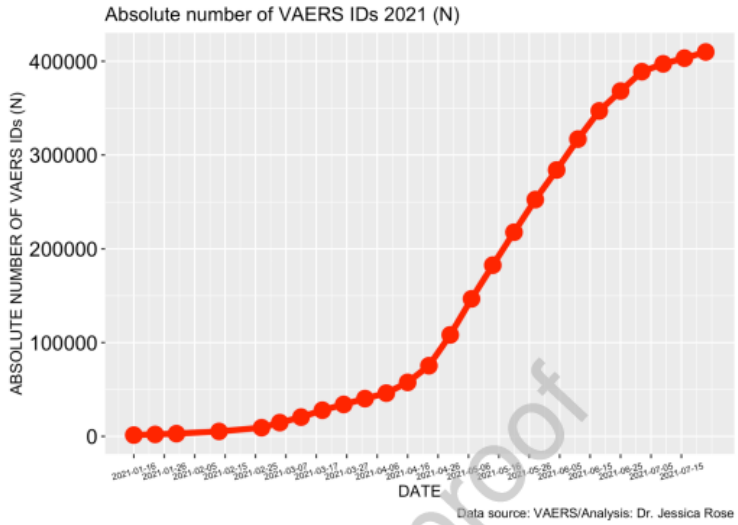


Figure 1. Time series plots – all VAERS reports in association with all vaccines administered to the U.S. population by year (left) and VAERS reports in association with COVID-19 products for 2021 (right).

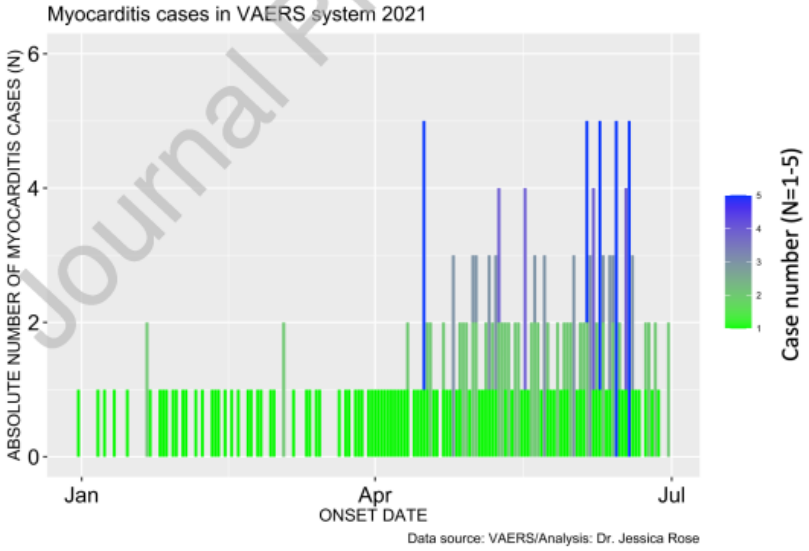


Figure 2. Bar plot showing the number myocarditis cases reported from January 1st to July 9th, 2021.

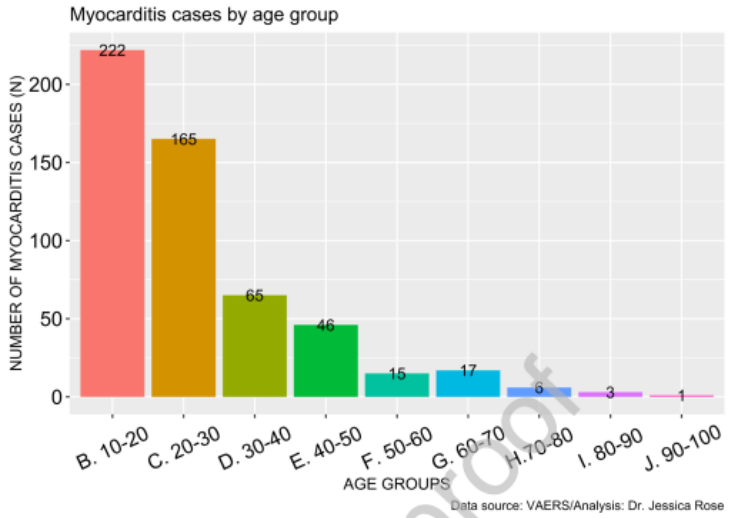


Figure 3. Histogram showing the number of reported VAERS cases of myocarditis by age group.

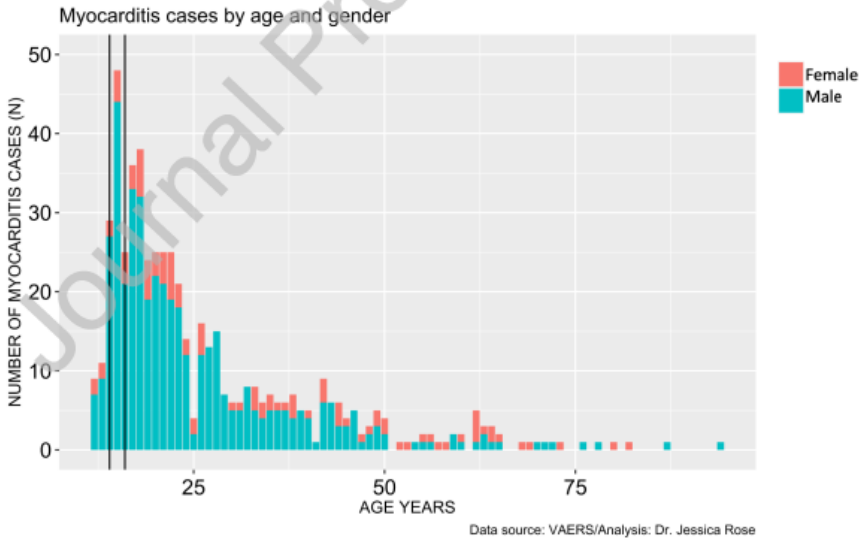


Figure 4. Histogram showing Myocarditis cases reported in VAERS following injection with COVID-19 products according to age and gender.

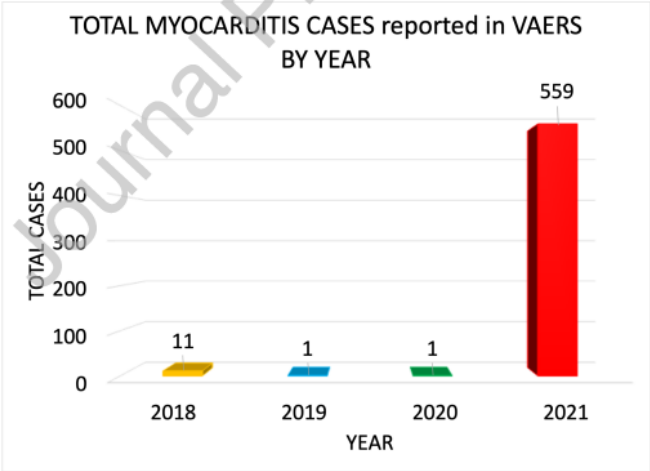


Figure 6. Bar plot showing Myocarditis cases reported in VAERS by year. *2021: up to and including July 9th, 2021.

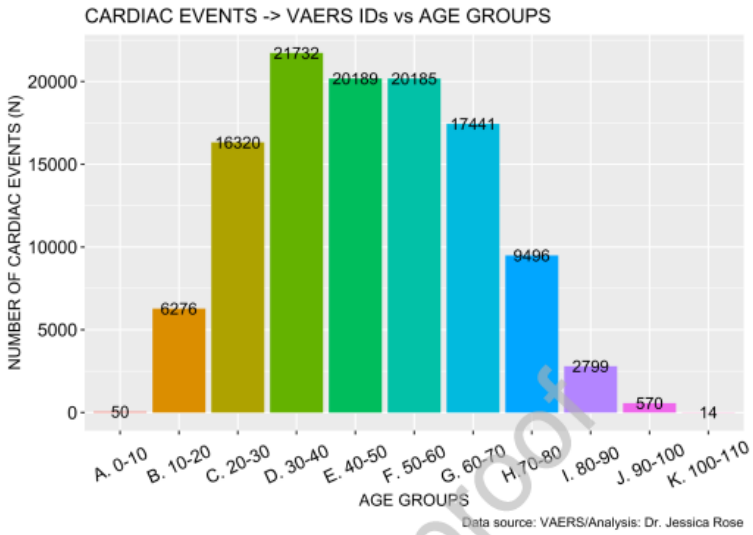


Figure 7. Histogram showing Cardiac cases reported in VAERS by year.

Table 1. Case rates of myocarditis per year based on estimated number of doses per year with respect to the population size for the season normalized to the number of doses administered per vaccine. *Population data extracted from Worldometer[9] and vaccine data extracted from Our World in Data[10] and CDC database[11]. [45,46,48]

Year	Rate/million doses
2018	0.067
2019	0.006
2020	0.024
2021	3.092

This study has 100 references.

End of excerpts

I found a link that still has the full study… https://www.peakprosperity.com/wp-content/uploads/2021/10/A-Report-on-Myocarditis-Adverse-Events-in-the-U.S.-Vaccine-Adverse-Events-Reporting-System-VAERS.pdf

Check out this shocking list of 291 recorded athlete heart attacks and heart related deaths in 2021

Sadly, the list and the summary details is too long to include in this newsletter. But you can see it here on Steve Kirsch's December 22nd, 2021 Substack.

https://stevekirsch.substack.com/p/athlete-collapsesdeaths-following

Wow! And, listen to the reporting on this from concerned journalists and the media…….Crickets……

In any given year, there may be 1 or 2 elite athlete heart attacks. But 291 in less than a year? And that was ones that were reported through local news outlets in their own towns or regions. No doubt, there were many others involving lesser-known athletes that went unreported. Yet, no one has put all of these together and reported on that in the major networks. And, of course suggesting that any of these massive numbers of deaths in healthy athletes might be related to the jabs, is completely taboo. After all, who wants to called an **ANTI-VAXXER?** (sarcasm). Oh, the shame!!!

UChicago students write one of the best and most well-referenced letters against vaccine mandates I have ever read. This can be a model template for other student and employment appeal letters

The letter in its entirety

Per the University of Chicago's newly announced booster mandate, all students and employees must obtain a booster shot by January 24. Those who do not comply will be barred from campus and restricted from attending in-person classes, among other activities.

This booster mandate is demonstrably unsafe, ineffective, unnecessary, inconsistent, and unethical. We've struggled beneath UChicago's draconian COVID decrees for years, but the university's booster mandate reaches a new height of absurdity.

UChicago Demands We Submit to Experimental ShotsUChicago claims to rely upon "expert" opinion in structuring its COVID regime. Yet, even advisory committees at the FDA and CDC initially declined to recommend the COVID booster for those under the age of 65.

The FDA's Vaccines and Related Biological Products Advisory Committee made an official recommendation to approve Pfizer's application for boosters *only* for those 65 and older and certain high-risk populations after rejecting, in a 16-2 vote, Pfizer's application for broader approval for the general population. The committee cited a lack of data on potential adverse effects, particularly the risks of developing myocarditis and pericarditis.

However, the FDA chose to cast aside this concern and granted "approval" anyways. ??But even this "approval" is itself questionable. The FDA only granted approval to *Comirnaty*, a legally distinct version of the Pfizer-BioNtech vaccine that *isn't actually* available in the United States. The version of the vaccine currently available in the US remains under Emergency Use Authorization, not formal approval.

Similarly, the CDC's initial recommendation that Americans under the age of 65 receive boosters was made *against* the counsel of its own Advisory Committee on Immunization Practices, which voted to recommend boosters *only* for those over the age of 65 or who have underlying conditions. Director Rochelle Walensky overruled this vote in an unusual departure from agency protocol. The committee later reversed course, recommending a booster for 12-17 year olds. But the calculus behind its sudden 180-degree turn remains unclear, given that the initial concerns regarding myocarditis and pericarditis remain unresolved.

Vaccine-induced heart issues merit legitimate concern, especially for young males. A recent Danish study found that "??pharmacovigilance reports, health system surveillance studies, and case series suggest an association between SARS-CoV-2 vaccination and myocarditis and myopericarditis. This association is thought

to occur particularly after the second booster dose of mRNA vaccines BNT162b2 (Pfizer-BioNTech) and mRNA-1273 (Moderna)." An analysis published in the *New England Journal of Medicine* reached similar conclusions, particularly in males between the ages of 12 and 29.

Meanwhile, a new study published in the journal *Obstetrics & Gynecology* found a positive association between COVID vaccination and increased menstrual cycle length.

According to Diana Bianchi, director of the National Institute of Child Health and Human Development, "Nobody expected [the COVID vaccine] to affect the menstrual system, because the information wasn't being collected in the early vaccine studies." The study's authors note that "questions remain about other possible changes in menstrual cycles, such as menstrual symptoms, unscheduled bleeding, and changes in the quality and quantity of menstrual bleeding."

Ironically, despite the speed with which the vaccine and booster have been infallibly declared "safe and effective" in disregard for potential long-term risks, the FDA is in no such rush to release its data on the vaccine.

According to the FDA's statement on expanding eligibility for boosters to individuals 18 years of age and older, "Both Pfizer and Moderna are conducting post-authorization/post-marketing studies to assess known serious risks of myocarditis and pericarditis." However, a post-authorization study is useless if everyone has already been boosted 50 times by the time the study is complete.

The Public Health and Medical Professionals for Transparency (PHMPT) filed a formal request to the FDA for the expedited release of all data on the Pfizer vaccine under the Freedom of Information Act. Members of PHMPT include well-established professors in the relevant fields from Yale, Brown, University of Maryland, UCLA, and other universities. The FDA denied this request, arguing the absence of a "compelling need."

In fact, the FDA requested that a federal judge grant it until the year 2076 to release Pfizer's data on the COVID vaccine, before it was recently ordered to release it all in eight months.

Despite the lack of transparency, and the booster's observed and potential adverse health effects, UChicago forces its students and employees to accept its cost-benefit analysis: that the booster is "preferable" to the risk of contracting COVID while unboosted. In so doing, our anti-science university unsafely denies us the right to evaluate the cost-benefit analysis for ourselves.

Don't Be Fooled! It's Not Just One More Jab If being "boosted" becomes a prerequisite for participation in normal life, the vaccine's diminishing efficacy means the booster campaign will never end.

Comprehensive evidence suggests that the level of vaccination does not have a positive influence on lowering COVID cases. On these very lines, CDC Director Rochelle Walensky contended in August that vaccines *no longer* prevent transmission, despite confident promises she and many of her fellow "experts" previously made to the contrary.

Moreover, the original vaccine regime has proven ineffective over time, with another Israeli study showing that effectiveness declined from 95% in January to a mere 39% in June.

When first introduced, the boosters were posited as a way to rebuild the vaccine's effectiveness. Yet, the COVID booster contains the same formula as the original, ineffective vaccinations, which means it, too, loses efficacy.

To this point, Cornell, which currently has both a mask and vaccine requirement, and a 97% on-campus vaccination rate, recently experienced a surge of COVID cases. In response, the administration declared an "Alert Level Red" zone, moved exams online, and shut down the campus. Out of the 930 confirmed cases, "Virtually every case of the Omicron variant to date has been found in fully vaccinated students, a portion of whom had also received a booster shot," Vice President for University Relations Joel Malina stated.

If UChicago is planning to mandate recurring boosters (which is the only logical conclusion of its present decrees), then it should just own up and admit it immediately, rather than continue to deceive students with the false impression that these measures are temporary.

We Will Not Play Pretend—COVID Is Not the PlagueMandates for the COVID vaccine and booster are unnecessary to protect the health of the UChicago community.

COVID has a survival rate of over 99.87% for individuals under the age of 65.

According to the CDC, only 5% of "COVID deaths" are solely attributable to COVID as the cause. The other 95% of "COVID deaths" involve, on average, almost 4 additional conditions (comorbidities) or causes per death.

We will not play pretend by accepting our university's gross exaggerations of the public health risks of catching and transmitting COVID. We will not live in fear.

UChicago Ignores Natural ImmunityIf slowing the spread of this glorified flu were the goal, UChicago would recognize natural immunity as a robust protection against reinfection—but it doesn't.

As it stands, UChicago's vaccine requirement cannot be satisfied with proof of T-cell immunity or a positive antibody or antigen test. This is unreasonable, as those who have been vaccinated not only have *increased* risk for infection, but an increased risk for symptomatic infection, in comparison to those possessing natural immunity.

This is made clear by a recent Israeli study, which "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."

UChicago's continued refusal to acknowledge natural immunity leads to only one conclusion: our university does not care about science, but only uses "science" as a guise for mandating recurring injections.

No, You Didn't Misread: Doctors and Scientists Are Exempt (Read the Fine Print)The *Chicago Thinker* recently confirmed that the university exempts University of Chicago Medical Center (UCMC) employees from the booster mandate, precisely because a significant number of *doctors* will resign if forced to get the jab. The university admitted to the *Thinker* that its UCMC exemption is an attempt to maintain medical staff, since presumably a significant number of UCMC's 9,000-plus employees will resign if beholden to a booster mandate.

UChicago also exempts clinically active faculty and staff within its Biological Sciences Division (BSD) from its booster mandate, presumably for the same reason.

The lessons here are manifold.

First, UChicago is much less immune to protest than it pretends. If we speak out loudly now, we might just accomplish something.

Second, "the science" isn't what the university claims and it's actually bad business to pretend otherwise.

Consider that the UCMC's total staff is larger than the total undergraduate population at UChicago. If our university truly believes the COVID booster is necessary to save lives, why are UCMC staff—who are arguably most at risk for catching and spreading the coronavirus—exempt from the booster mandate? The answer is clear: even the university itself *doesn't believe* "the risks" posed by un-boostered employees outweigh the costs of losing crucial personnel.

Rather than allow all UChicago community members to engage in a cost-benefit analysis of our own, the university deceptively exploits tuition payers, in addition to countless employees, by forcing us to get the booster. Meanwhile, UChicago's world-renowned medical health professionals and scientists get to live quietly by a different set of rules.

Moreover, the UCMC and BSD include some of the country's top doctors and scientists, including experts in immunology. Take that in: Those who know *the most* about the booster are refusing to get it. What do these experts know about the booster that we don't? And if they're refusing to inject themselves with the booster, how is it remotely ethical to force us to inject ourselves? It's not.

UChicago's COVID caste system prioritizes the health and freedoms of a chosen few, while trampling on the rest. University instructors and tenured faculty members, University of Chicago police officers, dining hall workers, and twenty-something-year-old college students are all being coerced into getting the booster, but not doctors and select, "special" scientists.

Obviously, we need instructors in order to learn. Three UChicago community members were shot to death in Chicago *in 2021 alone*, so, clearly, we also need police officers to defend our community. Yet, by imposing such a discriminatory mandate, our university wrongly suggests some lives are more valuable than others. Or, at the very least, it shows it cares more about maintaining doctors and select scientists than professors and police officers, among others.

To be clear, we're not calling for the UCMC and BSD to implement a booster requirement, but we *do* condemn UChicago for unethically discriminating against its employees and students. We'd expect such behavior from a Soviet committee, not a prestigious university purportedly dedicated to the production of knowledge in a free country.

This Isn't Just Bad Science—It's Also Wildly UnethicalUChicago directly violates established medical ethics by coercing its community members into experimental vaccination.

Free and informed consent is a precondition for *all* medical treatments and procedures, including vaccination. For consent to be truly informed, the potential recipient must be proactively informed of all the observable and potential risks, side-effects, and dangers. And for consent to be truly free, the potential recipient must be made aware of all options, including the option to freely decline. Most importantly, this decision must be free of coercion, pressure, or threat of punishment.

For the first time in history, universities like our own are requiring experimental vaccination as a condition of attendance and employment.

The university's threat of expulsion constitutes unjustifiable pressure, especially considering the vaccine's experimental nature; this absolutely qualifies as an element of "duress," "overreaching," and "coercion."

To make matters worse, we find ourselves in a position where those who wish to infringe upon our bodily autonomy have relieved themselves of the responsibility of even having to prove their scientific assertions. Instead, they've shifted the burden of proof onto us; we must conclusively demonstrate why their hypochondriacal impositions do *not* make sense, which is a total inversion of the normal process of scientific inquiry.

Rather than allow us to engage in the intimately *personal* and inherently subjective process of making our own risk-assessments concerning these novel injections, UChicago refuses to allow us to *freely* consent or decline. Instead, it treats us like lab rats.

The yes-men will try to interject that we can all apply for exemptions and disenroll from UChicago if denied, but this counterargument is as immoral as it is lousy.

First, universities across the country, including UChicago, have consistently announced their new COVID policies on a whim—not even leaving students the time or ability to create contingency plans. Second, choosing a college isn't a game of plug-and-play. It's a process that entails a significant investment of hard work, time, financial resources, and effort to find the right match.

To tell a student who has invested two or three years of hard work and over $100,000 in tuition to attend UChicago that he must suddenly find a way to transfer to a school in a different state—a school that might not even be able to properly accommodate his specific academic interests and career track—in the middle of his winter quarter is ludicrous.

UChicago's Booster Mandate Doesn't End the Hysteria—It Enshrines It For the past two academic years, we've endured mandatory weekly invasive COVID testing; a laundry list of restrictions on movement and socialization enforced by a suffocating surveillance-and-reporting apparatus; needless quarantines in dorm rooms, even after testing negative; lackluster online classes; barred access to countless campus amenities and resources, including libraries and gyms; and, now, vaccine and booster requirements with limited exemptions, all while footing the same $60,000+ in annual tuition.

We went along with these initial edicts for convenience's sake, perhaps contending that compliance in the short term would mean a long-term return to normalcy.

We rationalized that after bearing one year of Zoom classes to "slow the spread," we'd finally be able to enjoy the state-of-the-art research facilities, nerdy camaraderie, and beautiful campus we were attracted to when we first applied to UChicago.

If we got the vaccine, we thought we'd finally be able to take off our masks and breathe, sit in a classroom with our friends, hang out in our dorms, and go to parties.

Those who thought we'd be free to enjoy the normal college experience we so desperately wanted *if* we just got the first two vaccine doses were completely wrong. This isn't over. It's only just begun.

We've become lab rats in a perpetual war against a glorified flu—and there's no end in sight. UChicago continues to defy scientific and moral standards, dehumanizing us in the process.

Clearly, this is not about saving lives. It's about control. We will not be controlled.

Our demands are as follows:

1. We demand that the University of Chicago withdraw its unsafe, ineffective, unnecessary, inconsistent, and unethical vaccine and booster mandates.

2. We demand that the university name those responsible for creating and implementing its COVID decrees, especially with regards to vaccination. We also demand it name those responsible for reviewing and approving *both* medical and religious exemptions to vaccine and booster mandates.

3. We demand that the university make a public statement to all community members explaining *why* UCMC staff and BSD personnel are not required to receive boosters, but students and other university employees are.

4. Lastly, we call on all members of our university community to fight back. This mandate is wrong. Do not allow University President Paul Alivisatos's administration to pretend otherwise.

Signed,

The 2021-2022 Editorial Board of the *Chicago Thinker*:

Audrey Unverferth (Publisher & Editor-in-Chief, '22)

Evita Duffy (Managing Editor, '22)

Declan Hurley (Vice President, '24)

Matthew Heck (Chief Newsletter Author and Senior Editor, '22)

Chad Berkich (Senior Editor, '24)

Sonni Fitzsimonds (Senior Editor, '22)

Aidan Griffin (Senior Editor, '23)

Eden Negussie (Senior Editor, '24)

Mitchell Robson (Senior Editor, '24)

Primary Author: Eden Negussie (Senior Editor, '24)

Published January 11, 2022

What about the rationale for vaccinating children? A World-renowned vaccine developer/expert weighs in

Geert Vanden Bossche is an expert on vaccines, microbiology, immunology and virology. That is indisputable when you look at his resume. You can hear first-hand what he has to say about giving children these experimental gene therapy shots.

https://www.voiceforscienceandsolidarity.org/videos-and-interviews/part-1-children-vaccination-english

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

Here is a promotional piece from a conference that Dr. Vanden Bossche spoke at in the summer of 2019, about 7-months before the outbreak of SARS-CoV-2. I am showing this because I believe that many people don't appreciate two things about Dr. Vanden Bossche, his level of expertise and involvement with speaking about and promoting vaccines, but also how **he is putting his whole career on the line to tell the truth**. And, in the scientific community telling the truth is becoming a rarity these days. Researchers and scientists, most of who receive their funding from pharma are being cancelled and ostracized if they dare to speak against the pharma profit-driven narrative.

36th Euro Global Summit and Expo on Vaccines & Vaccination- June 03-04, 2019 London, UK

Geert Vanden Bossche

Biography

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 GH Discovery team as SPO and later on to work with GAVI as Senior Ebola Program Manager; he subsequently joined the German Center for Infection Research as Head of the Vaccine Development Office. Geert is now primarily serving as a Biotech/ Vaccine consultant while also conducting his own research on NK cell-based vaccines. His work is driven by a relentless passion to translate scientific breakthrough findings into competitive vaccine products. As a creative thinker, innovator, entrepreneur and visionary, Geert has been invited to speak at multiple international congresses.

https://europe.vaccineconferences.com/speaker/2019/geert-vanden-bossche-vareco-belgium

Understand how vaccine induced pressure drives more infectious variants

Listen to one of the best explanations of how it is the vaccinated rather than the unvaccinated that are driving the development of high levels of mutation and more infectious variants. Dr. Vanden Bossche also explains how boosters can cause immune tolerance (also can cause immune fatigue).

https://www.voiceforscienceandsolidarity.org/scientific-blog/in-reply-to-the-facebook-factcheck-on-my-dana-loesch-interview

A fact checker disputed some of what Dr. Vanden Bossche said in this interview. This is his response to that "fact-checker".

December 27, 2021

Facebook wrote that my predictions of an ever-evolving virus, pressured by an ever-expanding population-level immune pressure caused by mass vaccination are wrong. I have always said that mass vaccination would cause more infectious variants to expand in prevalence and become dominant. Making it impossible for mass vaccination fanatics to 'stay ahead of the virus' as they always claim. The consecutive dominance of alpha, beta, gamma, delta and, more recently, the omicron variant is merely proof that my predictions have come true.

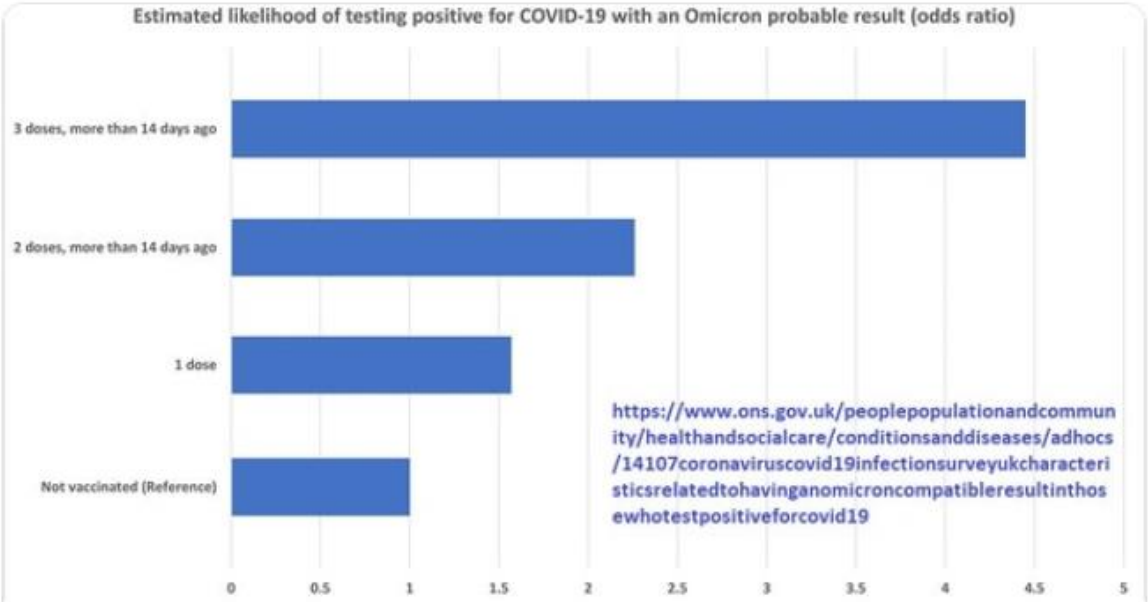
Even though the highly infectious Omicron does not seem to be highly virulent, there can be no doubt that continued mass vaccination campaigns that will soon use updated boosters against Omicron are at high risk of provoking ADE (antibody-dependent enhancement of disease) and will thereby dramatically enhance the incidence of severe disease in vaccinees. I have explained this in my most recent video message to the WHO, urging them not to allow vaccination against Omicron (Second call to WHO: Please, don't vaccinate against Omicron). Damania's comments on my scientific analysis and predictions have already been proven void. Furthermore, arguments he's been trying to tease out from experts, like Paul Offit, have been seamlessly refuted in my interview with Del Bigtree (Geert Vanden Bossche Warns of Covid-19 Vaccination Catastrophe). Damania obviously has a big mouth, but has never been responsive to engaging in an open scientific debate, while being heavily paid to spout misinformation and misinterpretations on the evolutionary dynamics of this pandemic. Of which he clearly doesn't understand due to his limited knowledge of virology, immunology and vaccinology. "Separating the wheat from the chaff" (Some guidance to separating the wheat from the chaff) is, therefore, a 'must read' for all those who are trying to find credible information enabling them to make informed decisions about their own health and that of their children. In that regard, cheap and hollow one-liners like those uttered by Damania are clearly not very helpful.

Link to factcheck: Fact Check: Mass Vaccination Amid The COVID-19 Pandemic Does NOT Create An 'Irrepressible Monster'

Continued on the next page…

Robert W Malone, MD
@RWMaloneMD

It looks like the U.K. data may support the vaccine-enhanced infection issue both FDA and I have raised.

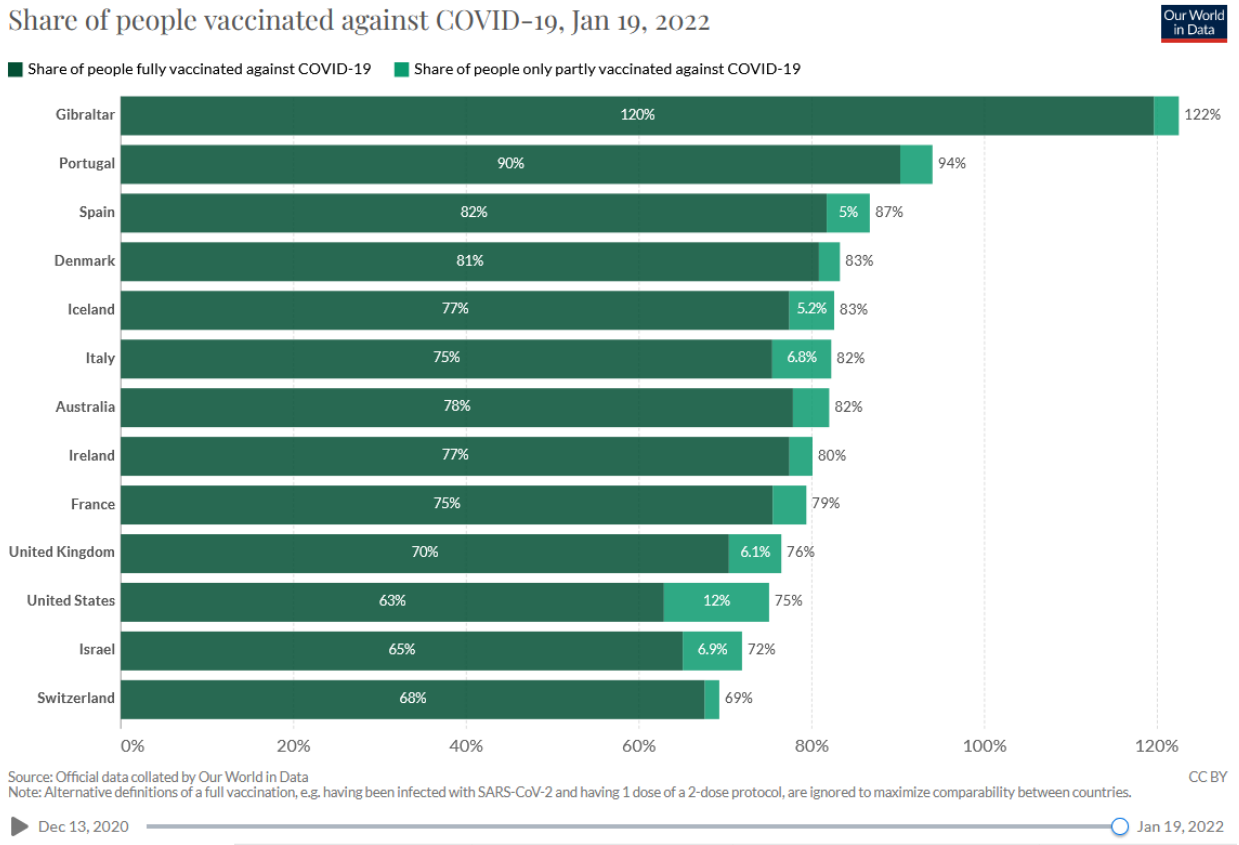


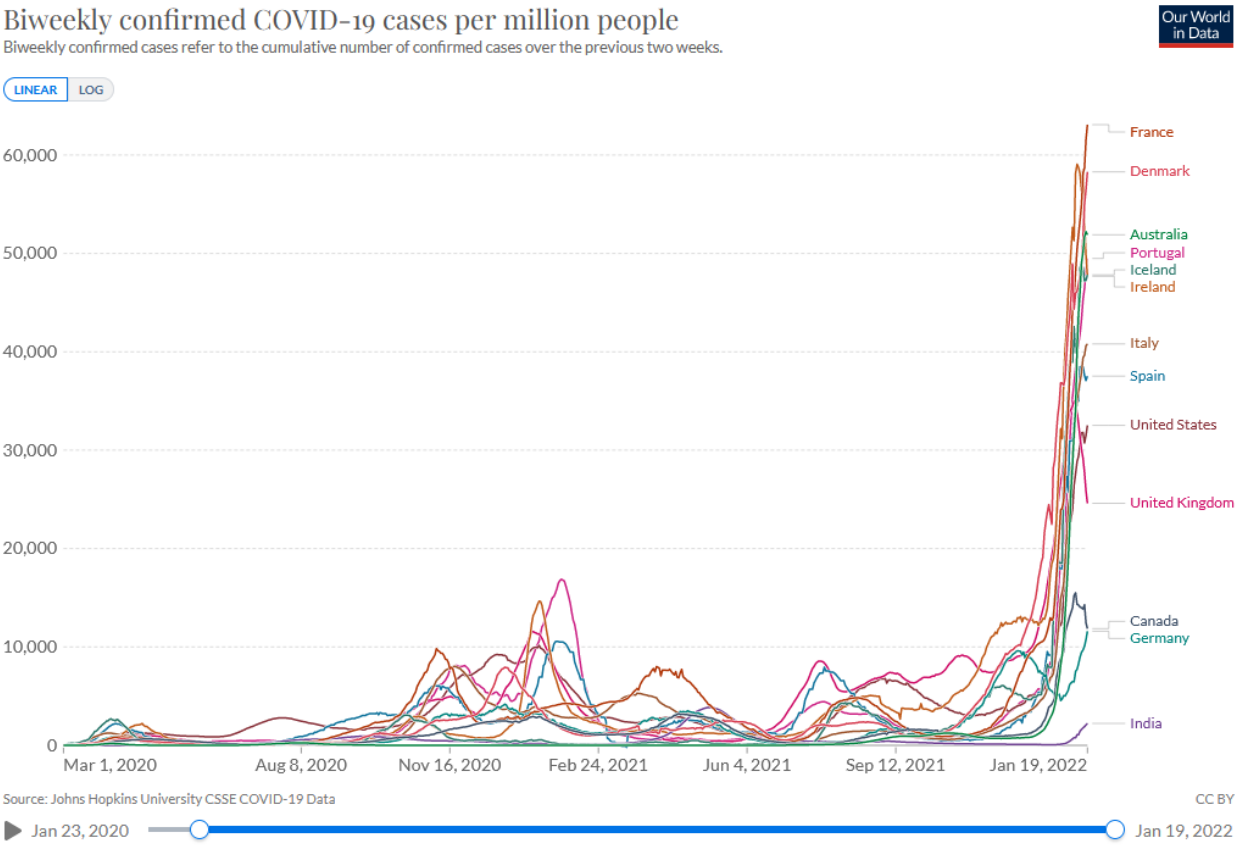
Triple-Vaccinated More Than FOUR Times As Likely to Test Positive For Omicron Than Unvaccinated, Data Shows – The Daily Sceptic

According to new ONS data, the triple-vaccinated are 4.5 times more likely to test positive for Omicron than the unvaccinated. The double-vaccinated, meanwhile, are 2.3 times more likely to have Omicron.

dailysceptic.org

Internationally, the highest vaxxed countries are seeing MASSIVE record high case counts





Fauci said three shots will be the ‘optimal regimen for vaccination’. The poor guy just can’t get anything right.

In a September 28th, 2021, article in the Washington Post titled, **Fauci says three shots will be the ‘optimal regimen’ of vaccination**, the grand poohbah of misinformation and wrong information has been proven wrong once again.

From the article

Anthony S. Fauci, director of the National Institute of Allergy and Infectious Diseases, said Tuesday that he believes the “optimal regimen” of vaccination against the novel coronavirus will include a booster shot.

His comments come after the Centers for Disease Control and Prevention announced last week that millions of Americans are now eligible for a booster dose — though the decision was not without controversy. The Biden administration has been pushing for expanded third dose eligibility.

As the highly transmissible delta variant continues to surge and hospitals nationwide are once again overwhelmed by covid-19 patients, Fauci said addressing waning immunity will be crucial.

“Ultimately I believe that the optimal regimen for the mRNA [vaccines] is going to include that third booster shot,” he said.

End of excerpts

https://www.washingtonpost.com/nation/2021/09/28/covid-delta-variant-live-updates/

There is plenty of data and evidence in this newsletter to support the contention that he was completely wrong about this proclamation. Including this next story…

And now data from the U.S., published in the *Journal of the American Medical Association* reveals a start reality about hospitalizations and deaths in fully vaccinated individuals

This study published December 28th, 2021, in the ***Journal of the American Medical Association (JAMA)***, titled, **Association Between Immune Dysfunction and COVID-19 Breakthrough Infection After SARS-CoV-2-CoV-2 Vaccination in the US**, reveals some very interesting data about breakthrough case outcomes.

There was a total of 664,722 people involved in this study, so it was quite large.

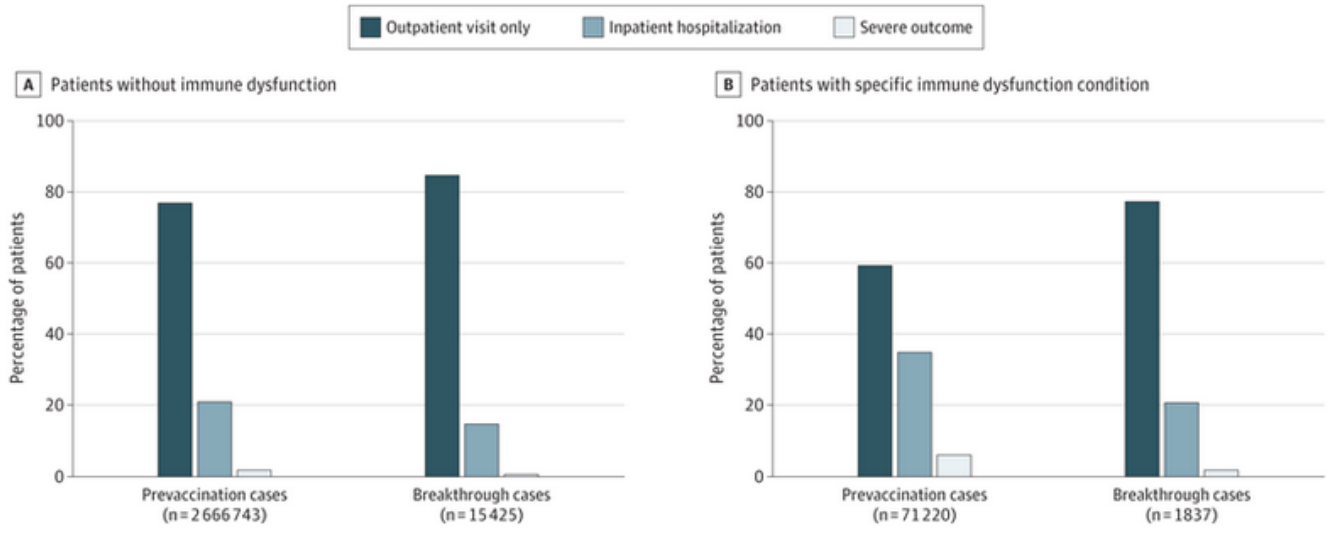
From the results section from the abstract

A total of 664,722 patients in the N3C sample were included. These patients had a median (IQR) age of 51 (34-66) years and were predominantly women (n = 378 307 [56.9%]).

Overall, the incidence rate for COVID-19 breakthrough infection was 5.0 per 1000 person-months among fully vaccinated persons but was higher after the Delta variant became the dominant SARS-CoV-2 strain **(incidence rate before vs after June 20, 2021, 2.2 vs 7.3 per 1000 person-months).** Compared with partial vaccination, full vaccination was associated with a 28%reduced risk for breakthrough infection (adjusted IRR [AIRR], 0.72; 95%CI, 0.68-0.76). People with a breakthrough infection after full vaccination were more likely to be older and women. People with HIV infection (AIRR, 1.33; 95%CI, 1.18-1.49), rheumatoid arthritis (AIRR, 1.20; 95%CI, 1.09-1.32), and solid organ transplant (AIRR, 2.16; 95%CI, 1.96-2.38) had a higher rate of breakthrough infection.

Note: Prevaccination means unvaccinated

Figure 2. COVID-19 Disease Severity in Prevaccination vs Breakthrough Infection Cases



Prevaccination cases were defined as those with a COVID-19 diagnosis before the first dose of a vaccine. Breakthrough infection cases were defined as those who contracted a COVID-19 infection on or after the 14th day of vaccination. Disease severity was assigned as the highest level of health care utilization within 45 days of breakthrough infection. Severe outcomes included inpatient hospitalization with invasive ventilation, extracorporeal membrane oxygenation, or death. Data are given in eTable 4 in Supplement 1.

Data for the graph above

eTable 4. COVID-19 Disease Severity Comparing Cases Prior to Vaccination Versus Breakthrough Infection Cases Identified in N3C Cohort

COVID-19 cases	COVID-19 outcomes	Patients without immune dysfunction		Patients with immune dysfunction	
		N	%	N	%
Cases prior to vaccination[2]	Outpatient visit only	2053896	77.0	42002	59.0
	Inpatient hospitalization	563027	21.1	24969	35.1
	Severe outcomes	49820	1.9	4249	6.0
Post-vaccine breakthrough infection cases	Outpatient visit only	13040	84.5	1418	77.2
	Inpatient hospitalization	2276	14.8	380	20.7
	Severe outcomes	109	0.7	39	2.1

Note: Post-vaccine breakthrough cases were defined as SARS-CoV-2 infection after 14 days following full vaccination.
Immune dysfunction conditions included people with HIV, multiple sclerosis, rheumatoid arthritis, solid organ transplant, and bone marrow transplant.
[1] Disease severity assigned as highest level of healthcare utilization within 45 days post-COVID-19 diagnosis. Severe outcomes included inpatient with invasive ventilation, extracorporeal membrane oxygenation, or death.
[2] Cases prior to vaccination were identified using the first COVID-19 diagnosis in the entire N3C COVID-19 cases. Among participants that received vaccination, we only included cases prior to first dose of vaccine.

https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2787643

While there were more **outpatient visits** for COVID-19 syndrome in vaccinated people **(7.5 percentage points difference)**, there were slightly more **hospitalizations (6.3% points difference)**, and **deaths (1.2 percentage points difference)** in unvaccinated individuals. A huge takeaway here though is that the differential is minimal, especially as compared to the broad sweeping claims of complete protection from those outcomes we hear from public health officials and parroted in the media.

It is interesting to note also that there was no mention of vaccine adverse side effects. And that is certainly the elephant in the room whenever claims are made about the safety and effectiveness of vaccines. With over 23,000 deaths, 250,000 hospitalizations and doctor visits and over 1.1 million adverse events reported to the VAERS system, a system that may capture only between 1% and 10% of all adverse events, that is a VERY LARGE elephant indeed!

COVID-19 deaths have always BEEN LOW VAXXED OR NOT

A recent Mercola article titled Pandemic Narrative Undergoes Radical U-Turn made some very good points on this topic

From the article

COVID Death Risk Has Always Been Low — Vaxxed or Not

For example, a 2020 study[10] found 88% of hospitalized COVID patients in New York City had two or more comorbidities, 6.3% had one underlying health condition and 6.1% had none.

In late August 2020, the CDC published data showing only 6% of the total death count had COVID-19 listed as the sole cause of death. The remaining 94% had had an average of 2.6 comorbidities or preexisting health conditions that contributed to their deaths.[11] So, yes, COVID is a lethal risk only for the sickest among us, just as Walensky said, but that's true whether you're "vaccinated" or not.

As for the study[12] Walensky discussed in that "Good Morning America" segment, it found that of the 1.2 million COVID jabbed subjects, only 0.0033% died of COVID between December 2020 and October 2021. (And of those, 77.8% had four or more comorbidities.) This study, Walensky claims as evidence that the COVID shot works wonders to reduce the risk of death.

But does it really? Recall studies[13] showing the noninstitutionalized infection fatality rate is on average just 0.26% to begin with, and people under the age of 40 have only a 0.01% risk of dying from COVID.[14] When we're talking about a fraction of a percentage point risk, we're talking about a risk that is close to statistical zero. So, does lowering your risk of death from 0.01% to 0.003% really translate into something worthwhile? And, more importantly, is that reduction worth the risks involved with taking the jab? Clearly, it's not a risk-free decision. OneAmerica, a national mutual life insurance company, recently warned that all-cause deaths among working age Americans (18 to 64) are up 40% over prepandemic norms,[15] and they cannot be attributed to COVID.

So, what's causing these deaths? What potentially deadly thing did tens of millions of Americans do in 2021 that they've never done before? I'll let you ponder whether Walensky's claim that the COVID jab is saving lives is an accurate one.

[10] JAMA April 22, 2020 DOI: 10.1001/jama.2020.6775 [Epub ahead of print]
[11] CDC.gov August 26, 2020, Comorbidities Table 3, updated October 14, 2020
[12] CDC MMWR January 7, 2022; 71(1): 19-25
[13, 14] Annals of Internal Medicine September 2, 2020 DOI: 10.7326/M20-5352
[15] Nature of the COVID-era public health disaster in the USA

Countries that are investigating all-cause mortality are noticing a significant increase of NON-Covid related deaths since the advent of the vaccine programs

A December 10th, 2021 *Substack* article by Alex Berenson titled, All-cause mortality in Germany is rapidly rising highlighted **one such example.** Alex's Substack subscription is called ***Unreported Truths***.

The article

During the second half of November Germany - the largest country in Europe - had a death rate almost 25% above normal, compared to 17% above normal in the first half of the month.

These extra deaths are mostly NOT from Covid.

For all of November, Germany reported almost 15,000 extra deaths. Excess deaths were almost normal in the spring and early summer; they have sharply risen since then.

Germany's mass vaccination campaign for most adults began late. On May 1, only 8 percent of German adults were fully vaccinated. On September 1, 61 percent were.

Is anyone even going to start asking questions, or are the public health authorities just too scared of what the answers might be?

SOURCE: https://www.destatis.de/EN/Themes/Society-Environment/Population/Deaths-Life-Expectancy/mortality.html;jsessionid=B6BDB79CE179B8A7D692A3EAE236B20D.live741

PANDA, a group of international doctors and scientists cite 10 reasons why mandatory vaccination must be rejected

P.A.N.D.A. stands for **Pan**demics **– D**ata **–** and **A**nalytics

About PANDA (from their web site). They are…

"A group of multi-disciplinary professionals, who perceived the global reaction to Covid, and lockdown in particular, as overwrought and damaging to the point of causing a great tear in the fabric of society, established PANDA (Pandemics Data & Analytics) in April 2020. As a politically and economically independent organisation, PANDA seeks to develop science-based explanations and test them against international data. Policy recommendations for governments and other institutions can be developed from these. PANDA stands for open science and rational debate, for replacing flawed science with good science and for retrieving liberty and prosperity from the clutches of a dystopian "new normal"."

This content is from the following section on their website: https://www.pandata.org/reject-the-divide/. I have left the hyperlinks because they are directed to excellent resources on this topic.

Reject the Divide- Say No to Dividing Society Based on Vaccination Status

Mandatory vaccination has no place in a free society

COVID-19 Risk

COVID-19 presents a high risk of severe illness and death to a few and a negligible risk to the majority of the population. The median age of death with COVID-19 is similar to that of natural mortality in most countries. 95% of deaths occur in individuals with 1 or more existing health problems. 99.95%< of individuals below 70 survive. Survival is even higher for healthy individuals. Children and young people have almost zero risk of death from COVID.

Focused Vaccine policy
Safe and efficacious vaccines should be offered to high-risk individuals (mostly people above 50, with other health problems) when the benefit of the intervention clearly outweighs the risk. This strategy achieves the best outcome for all.

Ten reasons why covid vaccination should never be mandatory

1. Non-maleficence

The Hippocratic duty of 'first, do no harm'. There is mounting evidence of serious adverse events, particularly myocarditis in the young, following COVID-19 vaccination. Adverse events reporting systems act as signalling systems so immediate action can be taken to prevent greater harm. There are currently strong enough signals to warrant an investigation. Vaccines are **also contraindicated** for individuals with certain health conditions. Vaccination of pregnant/breastfeeding women must be approached with great care – pregnant women were excluded from the vaccine trials; COVID-19 risk is low in healthy women of child-bearing age, while vaccine risks to the foetus/infant cannot be determined yet.

2. Beneficence

The duty to produce benefit for the individual. Health interventions should be based on **individual needs.** Vaccination is only indicated when the intervention clearly represents a greater benefit than risk for the individual. This criteria is not met for children and young people, individuals below 60 with no existing health problems, and individuals with a past SARS-CoV-2 infection (including asymptomatic infection).

3. Respect for autonomy

Allowing individuals to pursue their wellbeing as they perceive it. "Every person has a high value and cannot merely be treated as a means to the end of others' good". This entails seeking the individual's informed consent before any medical intervention: informing them of the risks and benefits of the intervention and getting their voluntary consent without "any element of force, fraud, deceit, duress, overreaching or other ulterior form of constraint or coercion". Currently, individuals cannot be provided with full information on vaccine side effects as no long-term data exists yet. The results of the vaccine trials should be replicated by independent scientists prior to vaccine rollout to the high-risk group. Public transparency of all efficacy and safety data is necessary.

4. Health Maximisation

Maximizing the health of all members of the general public requires a holistic and multi-layered approach: educating the public about a healthy lifestyle to improve their chronic illness, the importance of Vitamin D in fighting respiratory infections, the importance of home-based early treatment, the availability of life saving treatment protocols, safe and effective drugs (such as Ivermectin), as well as vaccines for the high-risk group. Vaccinating individuals who incur greater risk from the vaccine than benefit increases total harm.

5. Efficiency

The duty to produce as many benefits to as many people given limited resources. Vaccinating individuals who do not benefit from the intervention diverts valuable resources away from the vulnerable, as well as from far more devastating global health issues like TB, HIV, diabetes, cancer and cardiac diseases.

6. Justice

All humans have equal worth and no one should be discriminated against based on their health choices. Unfair practices such as denial of services, requirements for employment, restrictions on travel, higher insurance premiums for the unvaccinated create a two-tiered society. It breaks social **solidarity** and **cohesion**.

7. Proportionality

The reasonable balance between the benefits and costs of an intervention in terms of individual welfare versus collective benefit. Vaccines are designed to confer protection on the vaccinated. It is unethical for a person to incur any vaccine risk or lose personal freedoms for the sake of somebody else.

8. Transmission of SARS-CoV-2
can result from both vaccinated and unvaccinated individuals due to similar viral load. The virus can also be transmitted among animals. Even if everyone is vaccinated, transmission will continue and variants will keep on evolving. A Zero COVID strategy is unrealistic and unachievable.

9. Herd immunity
Can be reached through a combination of natural infection and vaccination. Natural immunity to SARS-CoV-2 is broad and long-lasting – more so than vaccine-induced immunity, especially in combating variants. Recovery from infection prevents serious illness if reinfected. It is not necessary to vaccinate the entire planet for the 'greater good' of society.

10. Non-derogable rights
As stated in Article 58 of the The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights(1958) apply under all circumstances, even under threat of 'national security':

***"*No state party shall, even in time of emergency threatening the life of the nation, derogate from the Covenant's guarantees of the right to life; freedom from torture, cruel, inhuman or degrading treatment or punishment, and from medical or scientific experimentation without free consent; … and freedom of thought, conscience and religion. These rights are not derogable under any conditions even for the asserted purpose of preserving the life of the nation."**

I had to look up the definition of the term non-derogable. This is what I found…there are certain rights that are considered to be 'non-**derogable**,' meaning that states have no legal basis, even in a state of emergency, to refuse to honor these rights.

CDC gets it wrong again as they continue to push boosters for everyone

Rochelle Walensky has become the poster child for spewing "vaccine" promotion against the reality of what is happening. The scare quotes are of course because CDC had to change the definition of vaccine to fit these novel biologicals. Walensky gets the dubious distinction of having to trot out in front of the media and make recommendations to the public that she has to know are unscientific and unsupported by what is happening not just in the U.S., but around the world in the most vaccinated and boosted countries. I've given several examples in this issue.

First some history…

From the New York Times September 24th, 2021…

C.D.C. Chief Overrules Agency Panel and Recommends Pfizer-BioNTech Boosters for Workers at Risk
In a highly unusual decision, the C.D.C. director, Rochelle Walensky, reversed a move by agency advisers and endorsed additional doses of the Pfizer-BioNTech vaccine for health care workers, teachers and other workers at risk.

https://www.nytimes.com/2021/09/24/world/covid-boosters-vaccine-cdc-director.html

Then a CDC release January 4th, 2022…

The CDC reduced the length of time to get boosted from 6 months to 5 months on January 4th, 2022.

CDC Recommends Pfizer Booster at 5 Months, Additional Primary Dose for Certain Immunocompromised Children

Media Statement
For Immediate Release: Tuesday, January 4, 2022

Today, CDC is updating our recommendation for when many people can receive a booster shot, shortening the interval from 6 months to 5 months for people who received the Pfizer-BioNTech COVID-19 Vaccine. This means that people can now receive an mRNA booster shot 5 months after completing their Pfizer-BioNTech primary series. The booster interval recommendation for people who received the J&J vaccine (2 months) or the Moderna vaccine (6 months), has not changed.

Additionally, consistent with our prior recommendation for adults, CDC is recommending that moderately or severely immunocompromised 5–11-year-olds receive an additional primary dose of vaccine 28 days after their second shot. At this time, only the Pfizer-BioNTech COVID-19 vaccine is authorized and recommended for children aged 5-11.

The following is attributable to CDC Director, Dr. Rochelle Walensky:

As we have done throughout the pandemic, we will continue to update our recommendations to ensure the best possible protection for the American people. Following the FDA's authorizations, today's recommendations ensure people are able to get a boost of protection in the face of Omicron and increasing cases across the country, and ensure that the most vulnerable children can get an additional dose to optimize protection against COVID-19. If you or your children are eligible for a third dose or a booster, please go out and get one as soon as you can. Additionally, FDA took action this week to authorize boosters for 12-15 year olds – and I look forward to ACIP meeting on Wednesday to discuss this issue.

https://www.cdc.gov/media/releases/2022/s0104-Pfizer-Booster.html

This is insanity! And this next study proves how insane it really is.

CDC, U. of Cal. Berkeley and So. Cal. Kaiser Permanente authored article finds that Omicron is much less dangerous than Delta, so much so that there was only one death out of 52,297 omicron cases

The study released January 11th, 2022, is a ***medRxiv*** preprint titled, **Clinical outcomes among patients infected with Omicron (B.1.1.529) SARS-CoV-2 variant in southern California.**

This study is a large study done in collaboration with the CDC and emphatically underscores how much milder the omicron variant is than the previous delta variant, or any other prior variants for that matter. Unfortunately, there are still some vulnerable people getting seriously ill and some even dying, but the virus seems to be evolving to become more transmissible and less lethal. And that is the natural evolutionary pattern for viruses since the beginning of time. If that didn't happen, species would be wiped out. Instead, as the virus mutates and infects more and more people, as large numbers recover it forms a barrier from infection of those without protection. This is the often mentioned herd immunity concept.

From the abstract

Methods:

We analyzed clinical and epidemiologic data from cases testing positive for SARS-CoV-2 infection within the Kaiser Permanente Southern California healthcare system from November 30, 2021 to January 1, 2022, using **S gene target failure (SGTF)** as assessed by the ThermoFisher TaqPath ComboKit assay **as a proxy for Omicron infection**. We fit Cox proportional hazards models to compare time to any hospital admission and hospital admissions associated with new-onset respiratory symptoms, intensive care unit (ICU) admission, mechanical ventilation, and mortality among cases with Omicron and **Delta (non-SGTF)** variant infections.

My comment: When referring to SGTF they mean Omicron variant. When referring to Non-SGTF they mean Delta variant.

Results:

Our analyses included 52,297 cases with SGTF (Omicron) and 16,982 cases with non-SGTF (Delta [B.1.617.2]) infections, respectively. Hospital admissions occurred among 235 (0.5%) and 222 (1.3%) of cases with Omicron and Delta variant infections, respectively. Among cases first tested in outpatient settings, the adjusted hazard ratios for any subsequent hospital admission and symptomatic hospital admission associated with Omicron variant infection were 0.48 (0.36-0.64) and 0.47 (0.35-0.62), respectively. Rates of ICU admission and mortality after an outpatient positive test were 0.26 (0.10-0.73) and 0.09 (0.01-0.75) fold as high among cases with Omicron variant infection as compared to cases with Delta variant infection. Zero cases with Omicron variant infection received mechanical ventilation, as compared to 11 cases with Delta variant infections throughout the period of follow-up (two-sided $p<0.001$). Median duration of hospital stay was 3.4 (2.8-4.1) days shorter for hospitalized cases with Omicron variant infections as compared to hospitalized patients with Delta variant infections, reflecting a 69.6% (64.0-74.5%) reduction in hospital length of stay.

Conclusions:

During a period with mixed Delta and Omicron variant circulation, SARS-CoV-2 infections with presumed Omicron variant infection were associated with substantially reduced risk of severe clinical endpoints and shorter durations of hospital stay.

From the study

…Kaiser Permanente of Southern California (KPSC) is an integrated, comprehensive healthcare organization serving 4.7 million members (~19% of the population of southern California) enrolled through employer-provided, prepaid, or federally sponsored insurance plans.

…While our analysis cannot infer absolute vaccine effectiveness against the distinct variants, our findings suggest vaccine protection against infection with the Omicron variant may be lower than protection against infection with the Delta variant. This result is consistent with studies showing reduced neutralization efficiency of two and three doses of BNT162b2 vaccine against the Omicron variant (versus non-Omicron variants) [3,26].

…Using data from a large, comprehensive healthcare system that captured information on SARS-CoV-2 testing and clinical outcomes among its members, and using SGTF as a proxy for Omicron versus non-Omicron (predominantly Delta) variant infections, we identified substantially reduced risk of severe clinical outcomes among patients with presumed Omicron variant infections.

…Within the subset of our cohort tested in outpatient settings, among whom prospective followup adverse outcomes was possible, Omicron variant infections were associated with 52%, 53%, 74%, and 91% reductions in risk of any subsequent hospitalization, symptomatic hospitalization, ICU admission, and mortality, relative to Delta variant infections.

… Among patients with Omicron variant infections, 7 received intensive care (including 5 whose infections were first identified in outpatient settings), 1 died, and none received mechanical ventilation, as compared to 23 ICU-admitted patients, 14 deceased patients, and 11 ventilated patients among those with Delta variant infections (**Table 1**).

…Median duration of hospital stay for patients admitted with symptomatic Omicron variant infections was approximately 70% (~3.4 days) shorter than that observed among patients with symptomatic Delta variant infections.

…Reductions in disease severity associated with Omicron variant infections were evident among both vaccinated and unvaccinated patients, and among those with or without documented prior SARS-CoV-2 infection. Prior vaccination against COVID-19 was associated with a dose-dependent lower risk of detection of the Delta variant as compared to the Omicron variant; likewise, Delta variant infections were less commonly detected among cases with documented prior SARS-CoV-2 infection.

…Several lines of evidence support the hypothesis that the Omicron variant might have a lower propensity to result in severe illness as compared with the Delta variant. Consistency of the association of Omicron variant infection with reduced risk of hospitalization across age and comorbidity categories, and regardless of prior immunity from vaccination or SARS-CoV-2 infection, during the same month and in the same population, argues against host or behavioral factors as causes of the observed disease attenuation with the Omicron

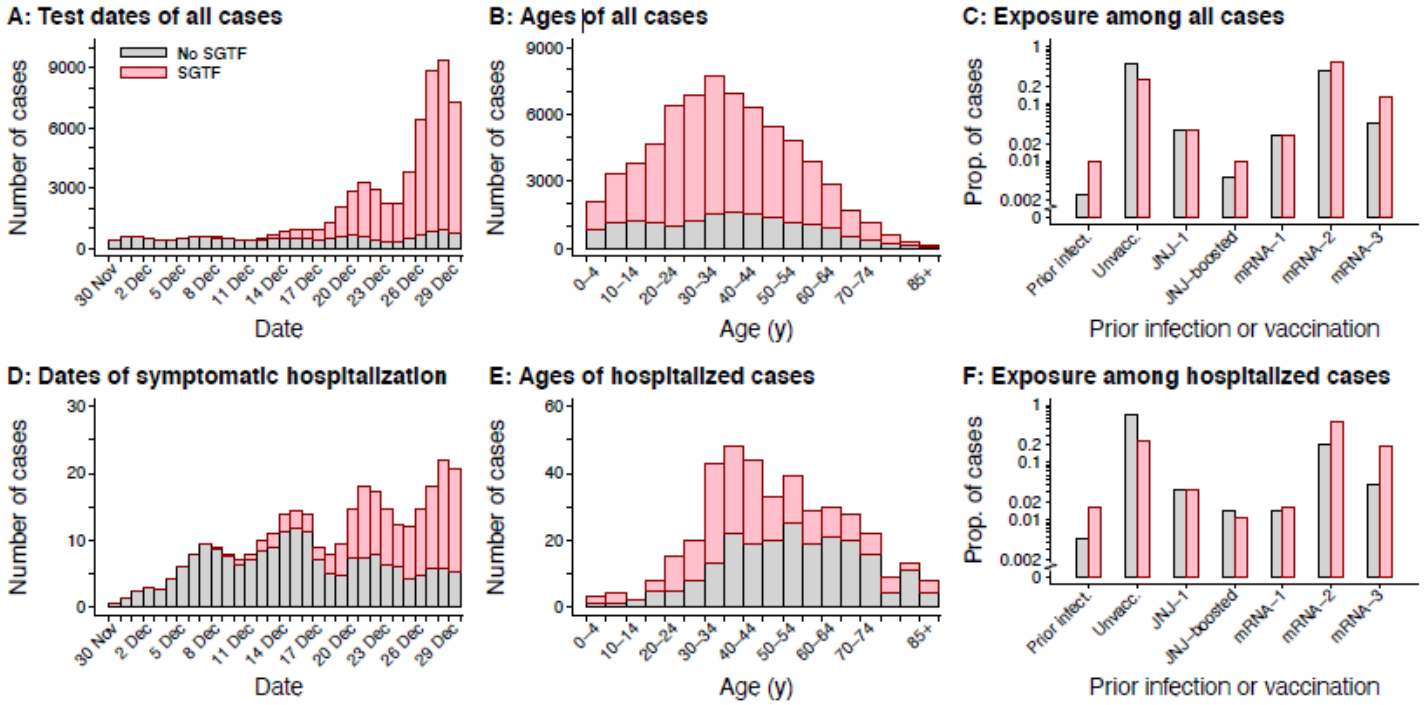
variant. Notably, the risk of symptomatic hospitalization was markedly reduced among cases who had tested positive for SARS-CoV-2 infection ≥90 days prior (0.32 vs 2.08 symptomatic hospitalizations per 1000 person-days at risk among cases with Omicron vs. Delta variant infections, respectively). Although ascertainment of SARS-CoV-2 infection history is imperfect because many infections may have gone untested or may not have been documented in a patient's EHR, prior infection among individuals with a history of a positive SARS-CoV-2 test result should be accurately coded and false positive PCR tests are rare. Thus, the finding of a reduction in severity of Omicron in patients with known prior infection is compelling evidence of an intrinsically less severe infection, rather than only different (more immune) persons becoming infected with the Omicron variant.

…Several studies have found similar reductions in severity with infection from Omicron compared to infection from other SARS-CoV-2 variants. In other settings, estimated reductions in risk of hospitalization with Omicron variant infection have ranged from 20-80% [9–11,22,23]. Variability in estimates between studies is likely in part due to different definitions of the primary endpoint (e.g. any attendance at hospital, admission to hospital, or admission to hospital with symptoms at the time of testing), differing lengths of follow-up, as well as varying levels of vaccination and prior infection across populations. However, these findings collectively suggest that differences in viral factors between the Omicron and the Delta variants, such as differences in viral tropism or virulence factors, might be driving the observed relative reductions in disease severity. Recent *ex vivo* studies demonstrate higher replication of the Omicron variant in the human upper respiratory tract as compared to the small airways of the lung [24], consistent with animal experiments suggesting that disease from infection with the Omicron variant might be confined to the large airway [25].

End of excerpts

Tables and graphs- For reference, SGTF are cases with Omicron infections

Figure 1: Attributes of cases with SGTF and non-SGTF samples detected.



My comment: Look at graph E above. And think about the fear mongering with regard to the push to get young children vaccinated. You can see that with omicron just like delta, the chances of young children even being hospitalized are dramatically lower than all the other age groups. And, if we had a chart showing deaths

in all age groups, it would show that children would be a minute speck on that graph compared to the higher age groups.

Figure 2: Times to severe outcomes among cases with SGTF and non-SGTF infections first detected in outpatient settings.

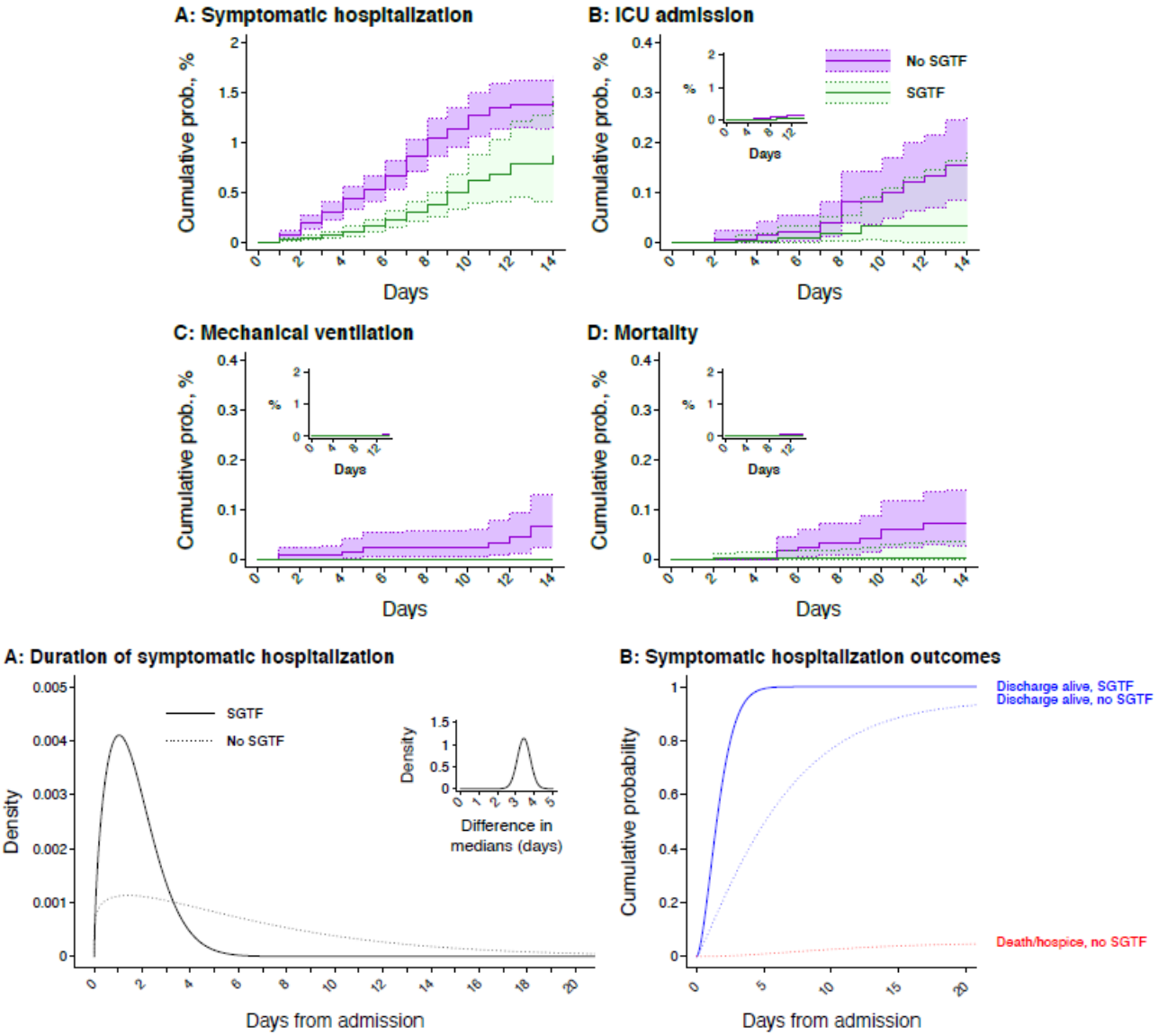


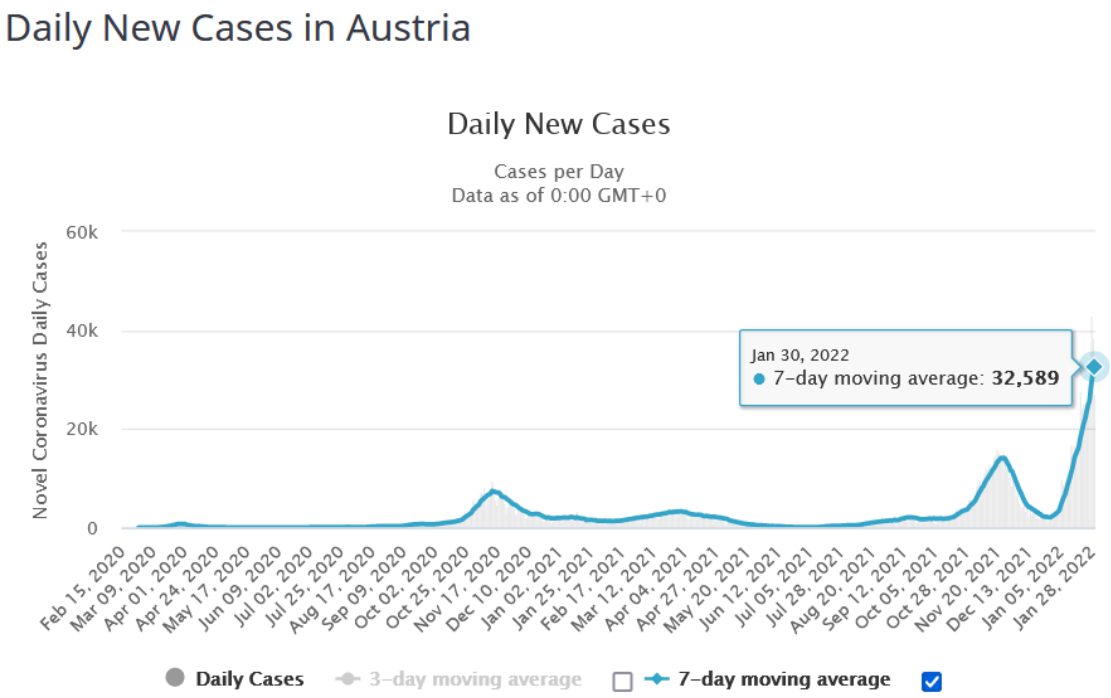
Table S5: Association of SGTF infection status with adverse clinical outcomes, limiting analyses to cases with ≥1 year of continuous enrollment.

Outcome	Case population[1]	Cumulative events over observed follow-up (*n* of events per 1000 cases)		Event rate per 1000 person-days observed (*n* of events/person-days at risk)		Hazard ratio (95% CI)	
		No SGTF	SGTF	No SGTF	SGTF	Unadjusted	Adjusted
Any hospital admission							
	Cases tested in outpatient settings	172 (11.6)	76 (1.7)	0.74 (172/233,310)	0.30 (76/250,226)	0.30 (0.23, 0.40)	0.46 (0.34, 0.63)
	All cases	199 (13.4)	209 (4.6)	0.85 (199/233,324)	0.84 (209/250,292)	0.56 (0.46, 0.69)	0.72 (0.58, 0.90)
Symptomatic hospital admission							
	Cases tested in outpatient settings	170 (11.5)	73 (1.6)	0.73 (170/233,310)	0.29 (73/250,226)	0.29 (0.22, 0.39)	0.44 (0.33, 0.60)
	All cases	194 (13.1)	163 (3.6)	0.83 (194/233,324)	0.65 (163/250,292)	0.46 (0.37, 0.58)	0.62 (0.49, 0.78)
ICU admission[2]							
	Cases tested in outpatient settings	20 (1.4)	4 (0.1)	0.08 (20/235,507)	0.02 (4/250,349)	0.24 (0.08, 0.76)	– –
	All cases	20 (1.3)	6 (0.1)	0.08 (20/236,005)	0.02 (6/251,189)	0.33 (0.13, 0.90)	– –
Mechanical ventilation[3]							
	Cases tested in outpatient settings	11 (0.7)	0 (0.0)	0.05 (11/235,576)	0.00 (0/250,346)	– –	– –
	All cases	11 (0.7)	0 (0.0)	0.05 (11/236,074)	0.00 (0/251,203)	– –	– –
Death[2]							
	Cases tested in outpatient settings	12 (0.8)	1 (<0.1)	0.05 (12/235,552)	<0.01 (1/250,343)	0.10 (0.01, 0.82)	– –
	All cases	12 (0.8)	1 (<0.1)	0.05 (12/236,050)	<0.01 (1/251,200)	0.10 (0.01, 0.82)	– –

SGTF: S gene target failure, here interpreted as a proxy for SARS-CoV-2 Omicron variant infection (vs. Delta variant infection with non-SGTF samples); CI: confidence interval
[1]Sample sizes include 45,712 and 14,848 cases with and without SGTF, respectively, among whom 45,569 and 14,804 were tested in outpatient settings, respectively. We define symptomatic hospital admissions as those occurring among cases with respiratory symptom onset dates on or ≤14 days before the date of admission.
[2]Adjusted hazard ratios were not estimated due to limited observations within covariate strata.
[3]Unadjusted and adjusted hazard ratios were not estimated due to the absence of SGTF infections resulting in ventilation.

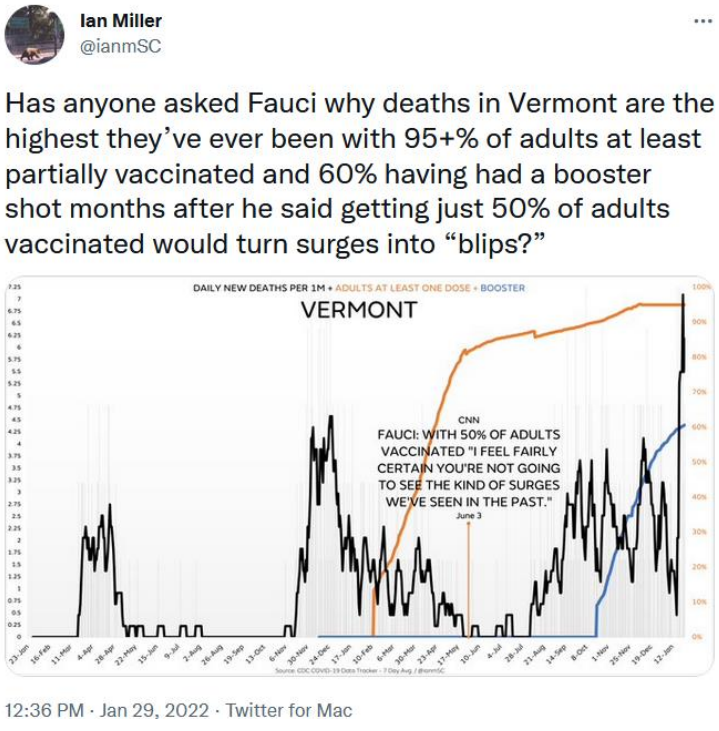
https://www.medrxiv.org/content/10.1101/2022.01.11.22269045v1

Look at Austria, fully vaxxed, boostered, vaccine passport policies and some of the harshest restrictions in the world



As you look at this, realize that Austria is in the top ten countries of the world for the most people boosted.

And, in the U.S., states with the highest percentage of boosted individuals are seeing record numbers of deaths, despite Fauci's June 3rd, 2021 assertion that with 50% of people vaccinated we won't see the "surges" we've seen in the past



CDC continues to ignore the evidence

And now on January 21st, 2022, in the face of an avalanche of cases, hospitalizations and deaths in fully vaccinated and boosted people from the most highly vaccinated and boosted countries world-wide and states in the U.S., she recommends a ONE SIZE FITS ALL booster recommendation for all people that are beyond 5 months of the second shot. Doesn't anyone at the CDC track the data? If the answer is yes, and it had better be with 10,000 employees whose sole job is to do just that, track the data and make public recommendations on the REAL data, we should be hearing truth. But we're not. So the alternative is very ugly. It means she is lying with a straight face.

The ***Daily Caller*** posted an article titled, **Walensky Says Americans Need To Be Boosted To Be Considered Vaccinated**.

"What we really are working to do is pivot the language to make sure that everybody is as up-to-date with their COVID-19 vaccines as they personally could be, should be, based on when they got their last vaccine," Walensky said. "So importantly, right now we're pivoting our language, we really want to make sure people are up-to-date."

"That means if you recently got your second dose, you're not eligible for a booster, you're up-to-date. If you are eligible for a booster and you haven't gotten it, you're not up-to-date and you need to get your booster in order to be up-to-date," she continued.

Then the article went on to say the following:

This week, the CDC released a study which found that natural immunity from prior infection provided more protection against reinfection or serious illness than vaccines alone for the Delta strain of COVID-19. Still, some institutions are beginning to require booster shots for students or employees, and natural immunity is typically not accepted as a substitute for vaccination.

Walensky's statement contradicts the guidance of the World Health Organization, which recommends children under age 18 don't get boosted and that the extra doses be prioritized for the most vulnerable.

End of excerpts

https://www.msn.com/en-us/health/medical/walensky-says-americans-need-to-be-boosted-to-be-considered-vaccinated/ar-AAT1y78

It almost seems like the CDC has a contract with Pfizer that has an absolute quota, with penalty clauses that are driving these recommendations. Just some include…

- Going against expert panel recommendations.
- Ignoring the mountain of evidence supporting the superiority of natural immunity, thus no need for the vaccines, especially for those under 60 and without significant co-morbidities.
- Vaccinating children, especially healthy children who have a statistically zero risk of dying from COVID-19.
- Ignoring all the evidence showing complete failure of the boosters from countries that are ahead of us with their vaccine programs, even NEGATIVE efficacy.

- Taking into consideration that Omicron is far less deadly than previous strains and has evaded the antiquated vaccines and boosters. It is literally like nature has provided us with a natural vaccine.
- Ignoring top vaccine developers and scientists that warn against continuing to vaccinate with this leaky vaccine during the pandemic and driving the virus to mutate more rapidly and dramatically in vaccinated people. We got lucky with Omicron, but what if continued pressure on the virus with these ineffective vaccines cause a dangerous variant to develop?
- And of course, the complete and utter ghosting of the CDC's own VAERS database that is overflowing with reports of serious injuries and deaths. This simply puts more Americans in the crosshairs of the increased risk of adverse reactions. There are 1,071,854 PEOPLE in the VAERS system that have already suffered. How many more must suffer?

Which leads me to this next story…

Israel finding second booster to be ineffective

On January 17th, 2022, the ***Times of Israel*** released an article titled, **Israeli trial, world's first, finds 4th dose 'not good enough' against Omicron.**

From the article

Prof. Gili Regev-Yochay, a lead researcher in the experiment said, "We see an increase in antibodies, higher than after the third dose," Regev-Yochay said. "However, we see many infected with Omicron who received the fourth dose. Granted, a bit less than in the control group, but still a lot of infections," she added.

End of excerpts

https://www.timesofisrael.com/israeli-trial-worlds-first-finds-4th-dose-not-good-enough-against-omicron/

In fact, according to reports, the Israeli Finance Minister tested positive for COVID-19 just 5-days after receiving his 4th dose.

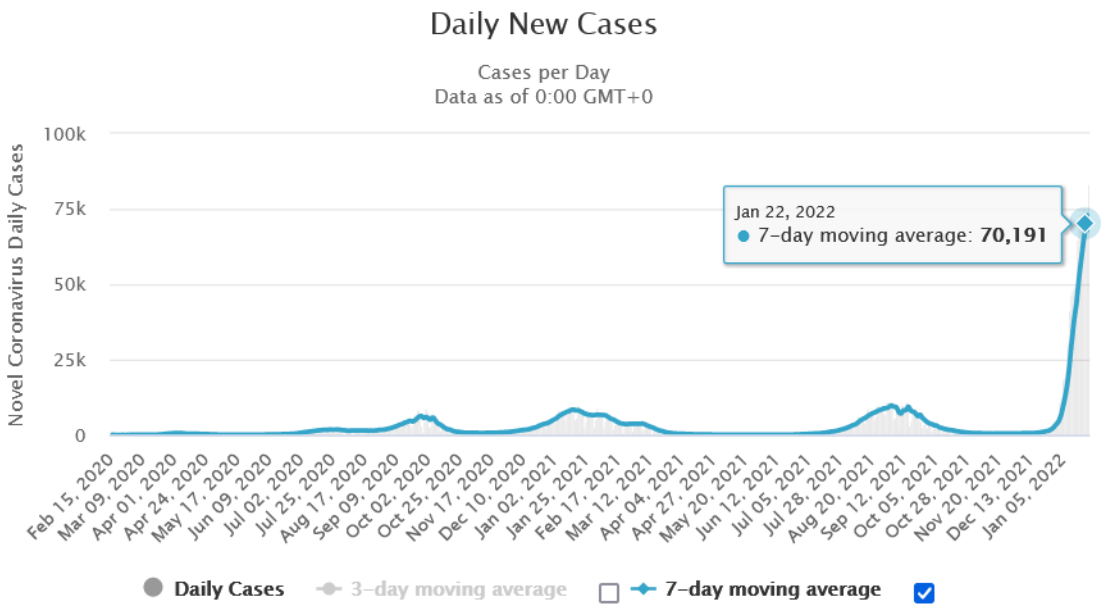
The claims that vaccination prevents serious outcomes and death are proving to be increasingly false

How are Israel and some of the other most vaxxed and boosted countries doing with regard to cases, hospitalizations and deaths?

Let's start with cases- and the great Tweet on the next page

Another look at Israel

Daily New Cases in Israel



“Well, that’s just cases. The vaccines prevent hospitalizations and deaths! Don’t they?”

Patients in ICU- Highest in the world per million people

https://ourworldindata.org/covid-vaccinations

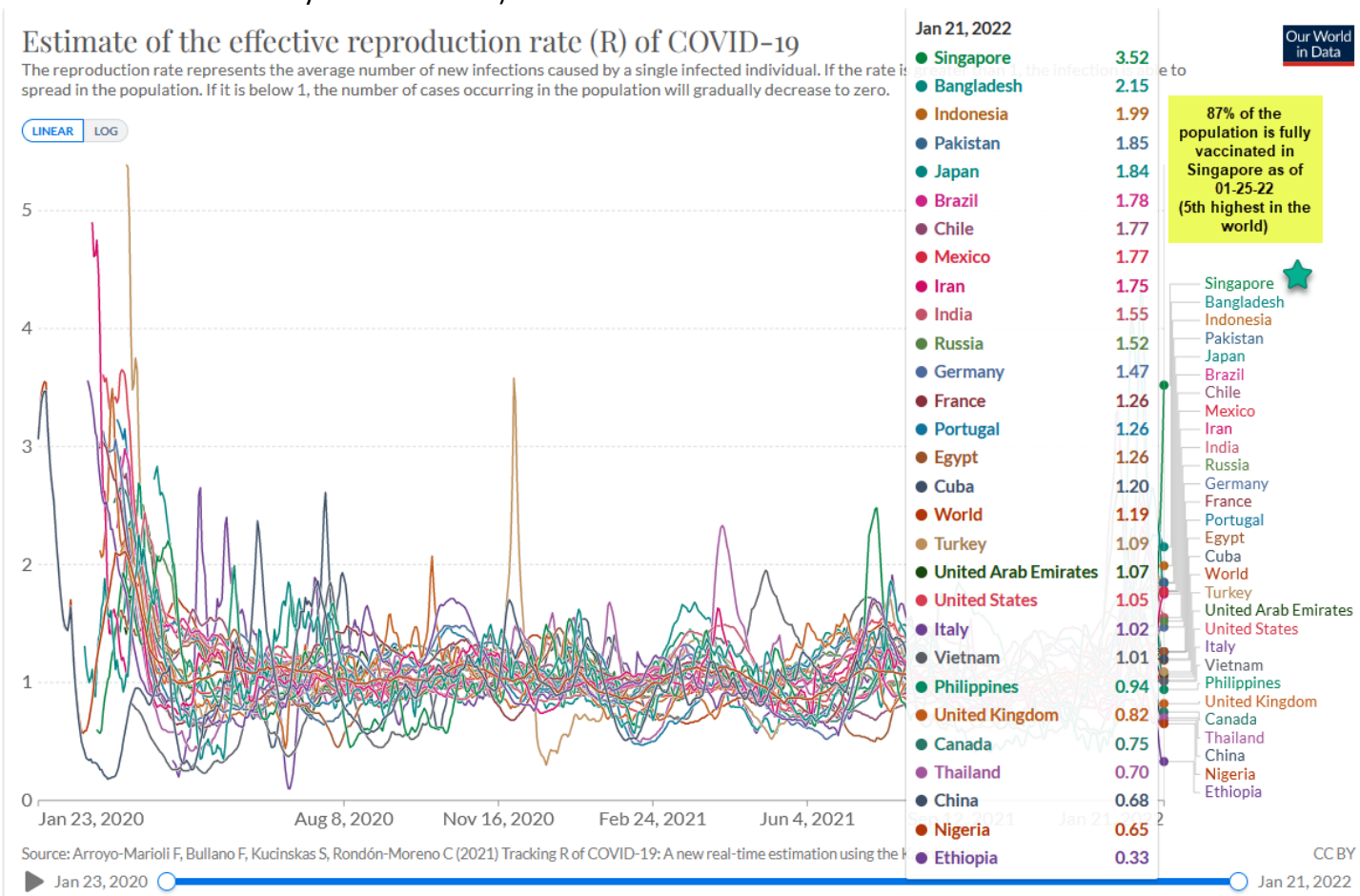
Patients in ICU per 1 million people Pa

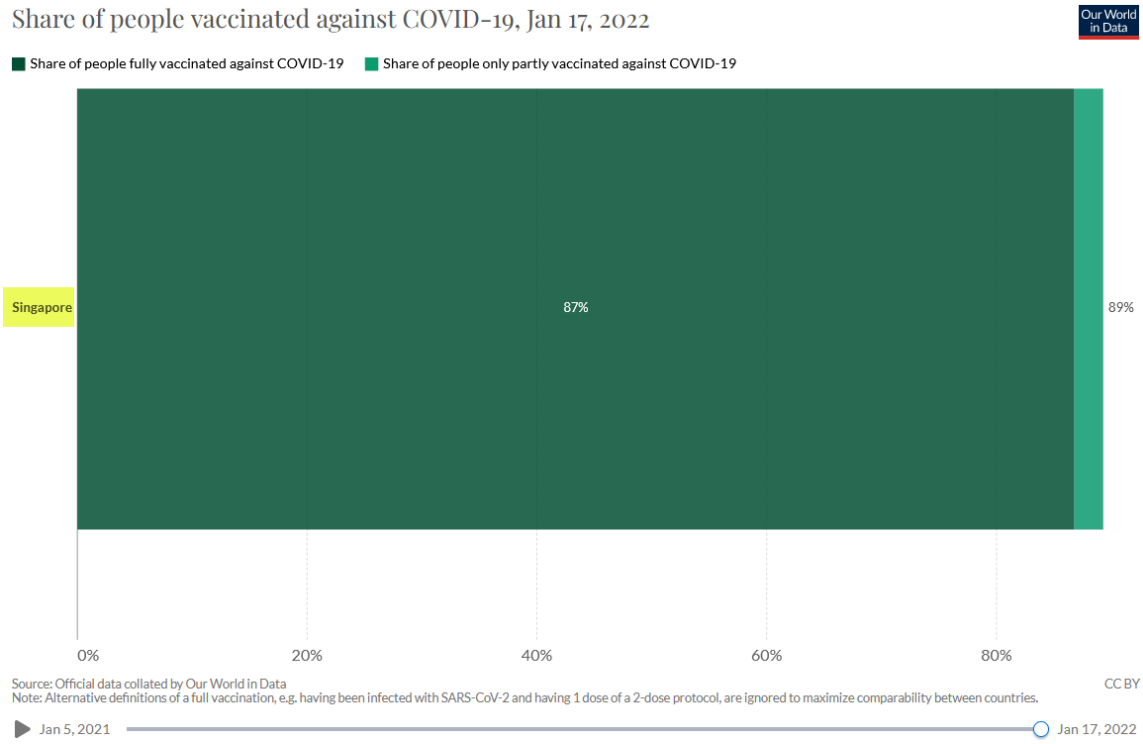
Country		Jan 28, 2020	Jan 24, 2022
Israel	4%	Mar 2, 2020 0.00	87.40
Bulgaria	9%	Apr 6, 2020 3.77	Jan 16, 2022 82.36
United States	0%	Jul 15, 2020 27.77	Jan 23, 2022 76.51

How about Singapore, the 5th most vaxxed country in the world?

The chart below shows the Reproductive Rate (R0) of the virus in those countries. The R0 number is the number of people that each infected person is expected to infect (on average). Anything above 1.0 means the rates are going up. Anything below 1.0 means that the cases are going down.

(For Singapore, see the highlighted portion in the upper right. You will see that their case rates are increasing at over 3 times what they are in the U.S.)





Mysterious surge in non-COVID mortality among 18-49 year olds

A January 14th, 2022, Epoch Times article titled, **EXCLUSIVE: States Investigating Surge in Mortality Rate Among 18–49-Year-Olds, Majority Unrelated to COVID-19**

EXCLUSIVE: States Investigating Surge in Mortality Rate Among 18–49-Year-Olds, Majority Unrelated to COVID-19

January 14, 2022

Health departments in several states confirmed to The Epoch Times that they are looking into a steep surge in the mortality rate for people aged 18 to 49 in 2021—a majority of which are not linked to COVID-19.

Deaths among people aged 18 to 49 increased more than 40 percent in the 12 months ending October 2021 compared to the same period in 2018–2019, before the pandemic, according to an analysis by The Epoch Times of death certificate data from the Centers for Disease Control and Prevention (CDC).

The agency doesn't yet have full 2021 figures, as death certificate data has a lag of up to eight weeks or more.

The surge differed greatly from state to state, with the most dramatic increase in young-to-middle age deaths in the South, Midwest, and the West Coast, while the northeastern states generally saw much milder spikes. Public health authorities in several states with some of the largest increases are examining the issue.

Texas saw the 18 to 49 age mortality jump 61 percent, the second-highest increase in the country. Of that, less than 58 percent was attributed to COVID-19.

“Our Center of Health Statistics is looking at the data,” said Chris Van Deusen, the head of Media Relations at the Texas Department of State Health Services, via email. “We’ll get back with you.”

Florida, which saw an increase of 51 percent, 48 percent of that attributed to COVID-19, is also probing the matter.

“I am looking into it to see if there is some sort of correlation/causation,” said Jeremy Redfern, spokesman for the Florida Department of Health via email.

Nevada saw the highest increase, 65 percent, of which just 36 percent was attributed to COVID-19.

Shannon Litz, a public information officer at the Nevada Department of Health and Human Services, said via email she passed on questions regarding the mortality spike to the agency’s Office of Analytics “for review.”

The District of Columbia experienced an increase of 72 percent, none of it attributed to COVID-19.

Robert Mayfield, spokesman for D.C.’s health authority, referred The Epoch Times to the district’s Office of Chief Medical Examiner (OCME), which suggested it lacked the expertise to analyze the phenomenon.

“OCME does not currently have an epidemiologist (the position is being advertised) so it has no present ability to analyze the data,” said the office’s spokesman Rodney Adams via email.

Arizona recorded a 57 percent increase, 37 percent of which was attributed to COVID-19.

Arizona’s Department of Health Services couldn’t respond to questions regarding the issue because its data is “not yet finalized,” said Tom Herrmann, the agency’s public information officer, via email.

Other states with some of the highest increases were Tennessee (57 percent up, 33 percent attributed to COVID-19), California (55 percent up, 42 percent attributed to COVID-19), New Mexico (52 percent up, 33 percent attributed to COVID-19), and Louisiana (51 percent up, 32 percent attributed to COVID-19). None of their health authorities responded to requests for comment.

The mortality surge seemed to be significantly milder in the northeast. New Hampshire saw no increase, Massachusetts had only a 13 percent spike (24 percent of it attributed to COVID-19), and New York, one of the worst-hit by the pandemic in the region, was up 29 percent (30 percent of it attributed to COVID-19).

CDC data on the causes of those excess deaths aren’t yet available for 2021, aside from those involving COVID-19, pneumonia, and influenza. There were close to 6,000 excess pneumonia deaths that didn’t involve COVID-19 in the 18 to 49 age group in the 12 months ending October 2021. Influenza was only involved in 50 deaths in this age group, down from 550 in the same period pre-pandemic. The flu death count didn’t exclude those that also involved COVID-19 or pneumonia, the CDC noted.

A part of the surge could be likely blamed on drug overdoses, which increased to more than 101,000 in the 12 months ending June 2021 from about 72,000 in 2019, the CDC estimated. About two-thirds of those deaths involved synthetic opioids such as fentanyl that are often smuggled to the United States from China via Mexico.

For those aged 50 to 84, mortality increased more than 27 percent, representing more than 470,000 excess deaths. Some 77 percent of the deaths had COVID-19 marked on the death certificate as the cause or a contributing factor.

For those 85 or older, mortality increased about 12 percent with more than 100,000 excess deaths. There were more than 130,000 COVID-related deaths in this group, indicating these seniors were less likely to die of a non-COVID-related cause from November 2020 to October 2021 than during the same period of 2018–2019.

Comparing 2020 to 2019, mortality increased some 24 percent for those aged 18 to 49, with less than a third of those excess deaths involving COVID-19. For those aged 50 to 84, mortality increased less than 20 percent, with over 70 percent of that involving COVID-19. For those even older, mortality jumped about 16 percent, with nearly 90 percent of it involving COVID-19.

For those under 18, mortality decreased about 0.4 percent in 2020 compared to 2019. In the 12 months ending October 2021, it fell some 3.3 percent compared to the same period in 2018–2019.

End of article

https://www.theepochtimes.com/several-states-examine-2021-mortality-surge-in-americans-aged-18-49_4213438.html

Is it possible that a significant portion of those deaths are related to the "vaccines?" Based on VAERS data, CMS whistleblower testimony and other evidence I think it is entirely possible.

The latest Omicron variant (BA.2) which is gaining steam, has 7 NEW mutations of the S-protein. This is predicted to make the "ancient" vax formula made to mimic the original Wuhan strain that is still being pushed, even more useless.

The graph below from a recent release in the ***Journal of Medical Virology***, shows the common mutations that the BA.1 (original Omicron) and the BA.2 ("Stealth" Omicron) share….and the unique mutations that they have. You will notice that there are seven unique mutations in the newest omicron variant (BA.2). Four of those which I have highlighted are in the receptor binding domain (RBD). The receptor binding domain is key for the virus to be able to attach to our ACE-2 receptors and infect our cells. It may be expected that with these additional mutations, it may make it more difficult for the virus to infect cells. But with seven additional mutations on the spike protein as compared to Omicron 1.0, it means that the antibodies produced in vaccinated people that are made to identify the engineered spike protein contained in the COVID-19 vaccines (patterned after the original Wuhan virus), will be an even greater mismatch for this new variant. This will make the vaccines even more antiquated.

See graph next page…

Mutational and phylogenetic analyses of the two lineages of the Omicron variant
https://onlinelibrary.wiley.com/doi/epdf/10.1002/jmv.27558

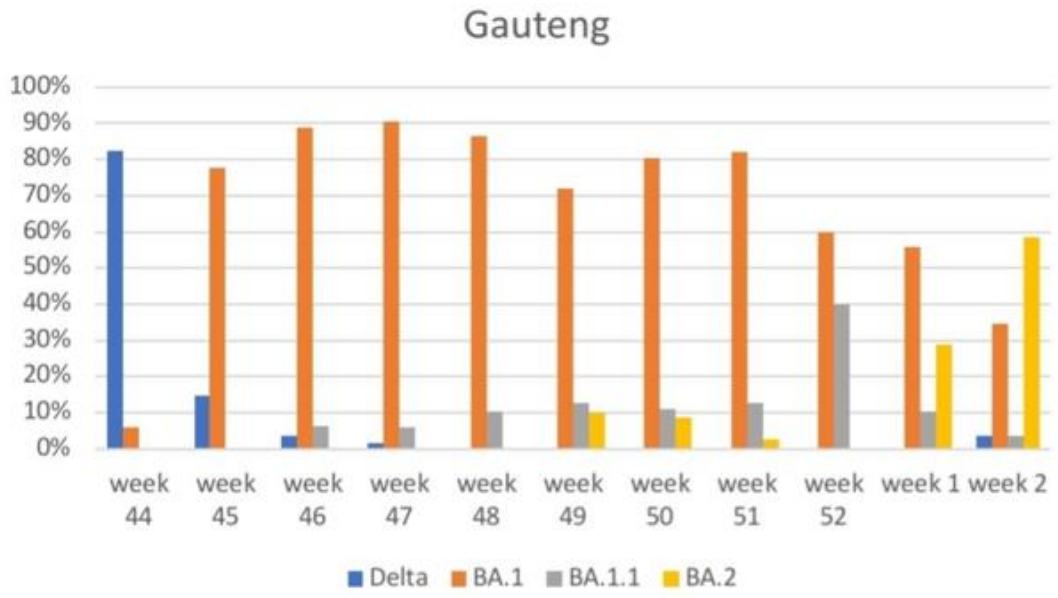
TABLE 1 List of common and unique mutations present within the genome of BA.1 and BA.2 lineages

Common mutations of BA.1 and BA.2 lineages ($n = 32$)	Unique mutations of BA.1 lineage ($n = 19$)	Unique mutations of BA.2 lineage ($n = 19$)
ORF1ab: T3255I, P3395H, SGF3675del, P4715L, I5967V	*ORF1ab*: K856R, SL2083I, A2710T, L3674F, I3758V	*ORF1ab*: S135R, T842I, G1307S, L3027F, T3090I, L3201F, F3677L, R5716C, T6564I
S glycoprotein: G142D, G339D, S373P, S375F, K417N, N440K, S477N, T478K, E484A, Q493R, Q498R, N501Y, Y505H, D614G, H655Y, N679K, P681H, N764K, D796Y, Q954H, N969K	*S glycoprotein*: A67V, HV69del, T95I, VYY143del, N211del, L212I, 215EPEins, S371L, G446S, G496S, T547K, N856K, L981F	*S glycoprotein*: T19I, LPPA24S, V213G, S371F, T376A, D405N, R408S
		ORF3a: T223I
E: T9I	*M*: D3G	
M: Q19E, A63T		*ORF6*: D61L
N: P13L, ERS31del, RG203KR		*N*: S413R

Note: Red color indicates the mutations of the receptor-binding domain (RBD) of S glycoprotein. Violet color indicates the mutation of the N-terminal domain (NTD) of S glycoprotein.

https://onlinelibrary.wiley.com/doi/epdf/10.1002/jmv.27558

This graphic shows how rapidly the BA.2 version of omicron has taken over the most populace region of South Africa.



FDA revokes the EUA for the two monoclonal antibodies because they are a mismatch for Omicron. YET, Fauci, Walensky and their minions in the media continue to push the completely mismatched vaccines.

A January 25th, 2020 article titled, **FDA stops use of antibody drugs that don't work against omicron**, makes the case for why the FDA has revoked the first generation monoclonal antibodies. The reason is that they are a mismatch for the latest variants including Omicron. WAIT, WHAT? If the FDA is going to pull emergency use authorization for the monoclonal antibodies that are not as effective anymore what about the "vaccines"? Isn't it interesting how the vaccines are always held to a different standard?

From the article

WASHINGTON (AP) — COVID-19 antibody drugs from Regeneron and Eli Lilly should no longer be used because they don't work against the omicron variant that now accounts for nearly all U.S. infections, U.S. health regulators said Monday.

The Food and Drug Administration said it was revoking emergency authorization for both drugs, which were purchased by the federal government and have been administered to millions of Americans with COVID-19. If the drugs prove effective against future variants, the FDA said it could reauthorize their use.

The regulatory move was expected because both drugmakers had said the infusion drugs are less able to target omicron due to its mutations. Still, the federal action could trigger pushback from some Republican governors who have continued promoting the drugs against the advice of health experts.

Omicron's resistance to the two leading monoclonal antibody medicines has upended the treatment playbook for COVID-19 in recent weeks.

… The FDA noted in its decision that omicron accounts for more than 99% of U.S. infections, making it "highly unlikely" the antibodies would help people now seeking treatment. The agency said restricting their use would also eliminate unnecessary drug side effects, including allergic reactions. (**My comment**: What about the side effects from the vaccines?)

… The move comes days after regulators broadened the use of remdesivir — the first drug approved for COVID-19 — to treat more patients.

On Friday, the FDA expanded the antiviral's approval to include adults and children with early COVID-19 who face a high risk of ending up in the hospital. Remdesivir previously had been limited to hospitalized patients.

An influential panel of federal experts had already recommended using the infused drug to try to head off hospitalization. The same guidelines from the National Institutes of Health panel recommend against continued use of Lilly and Regeneron's antibody drugs due to their reduced effectiveness against omicron.

End of excerpts

https://fox59.com/news/coronavirus/fda-stops-use-of-antibody-drugs-that-dont-work-against-omicron/

It's amazing to see the continued avoidance of safe, inexpensive, easy to access and proven effective early treatment re-purposed medications like Hydroxychloroquine and Ivermectin for pushing an expensive, far less safe, less effective medication that requires IV treatments. Or worse yet, experimental agents that have proven dangerous short-term adverse effects and unknown long-term effects.

Updates March 1st, 2022

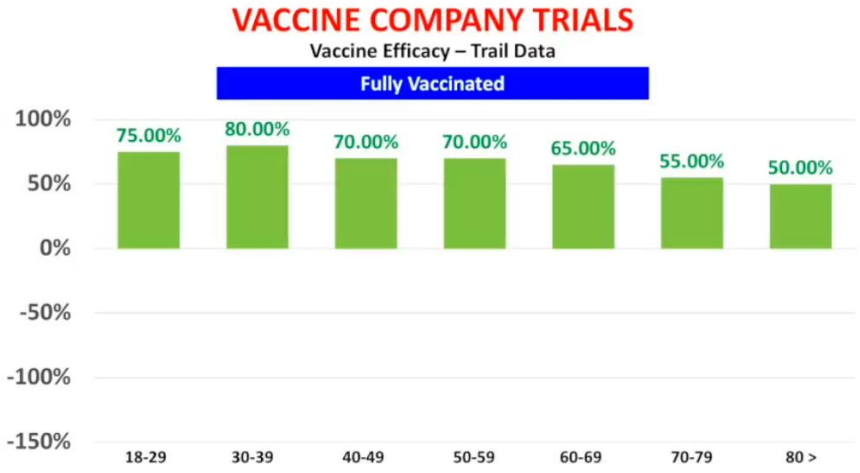
Vaccine effectiveness hit an all-time low. U.K. data shows a NEGATIVE efficacy of -206% in ages 40-49, -171% in ages 30-39 and -120% in ages 18-29 in fully vaccinated and boosted individuals.

In two videos posted by ***Voice for Science and Solidarity*** February 22nd, 2022, the data from the ***U.K.'s Health Security Agency's COVID-19 vaccine surveillance reports*** reveal a disastrous negative efficacy for people that have had 2 shots and even worse for those that are boosted. The app the data is also terrible for people over the age of 50 as you will see. A major question remains. Why in the world are we trying to force people under the age of 50 to continue to get the vaccine and to continue pushing the mandates, when we can clearly see that the "vaccines" dramatically increase the risk of people contracting the infection?

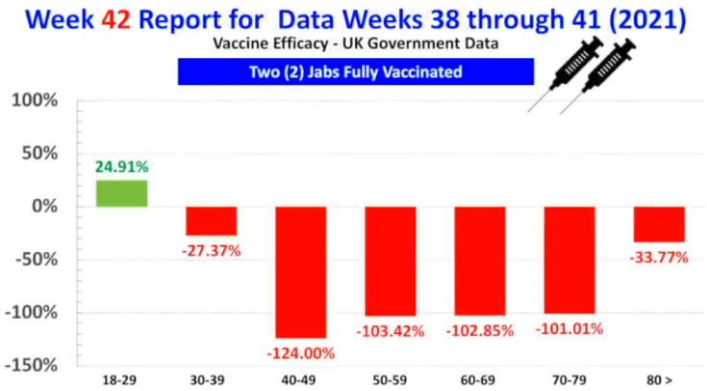
This mirrors data that I have reported on in past issues over nearly a year from data published in the U.K. and Israel as the vaccine efficacy began to wane in the first individuals vaccinated during the end of the first quarter of 2021 and dropping steadily through the summer of 2021. But as you will see in the video, it has continued to get much worse from late 2021 and into 2022.

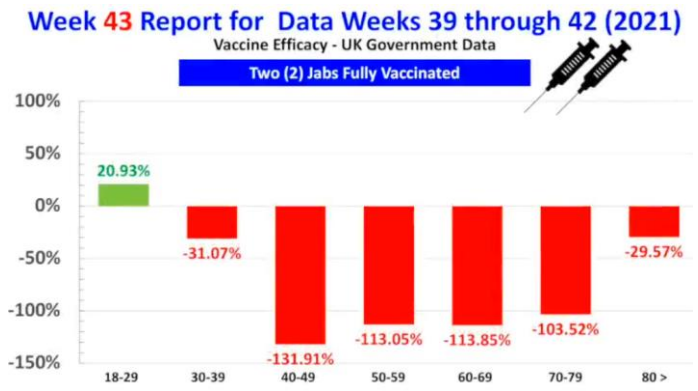
Before getting into the data, let's look at the graphs as to the way the efficacy was portrayed at the rollout of the shots (next page).

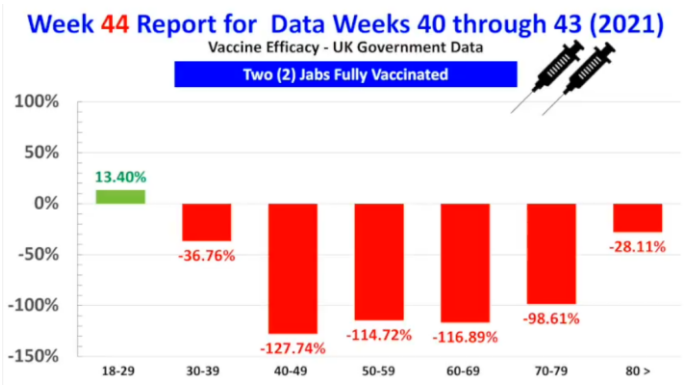
The governments of the world touted Pfizer's trial results which claimed 95% efficacy even higher than this graph shows. Also, remember Anthony Fauci saying that the bar for emergency use authorization would be 50% efficacy. And, that bar has been lowered ever since.

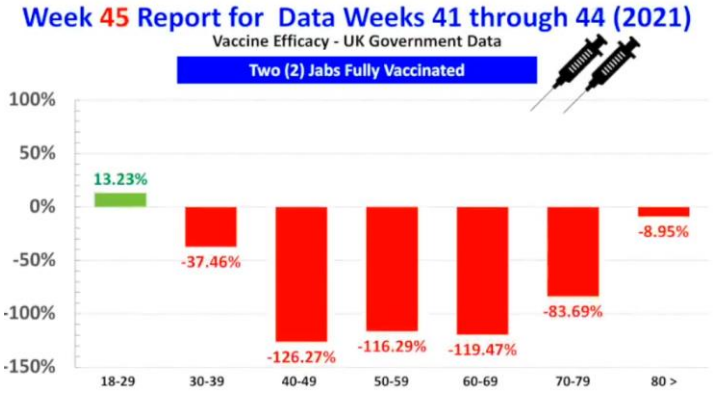


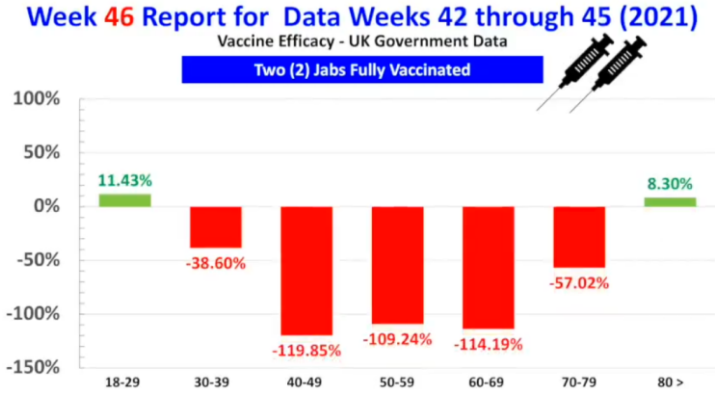
Now let's look at what the data reveals…

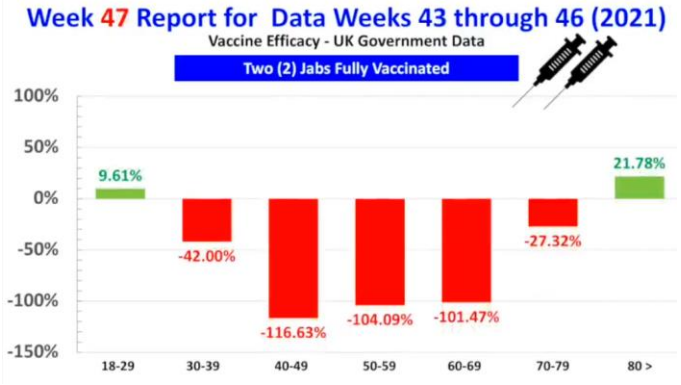


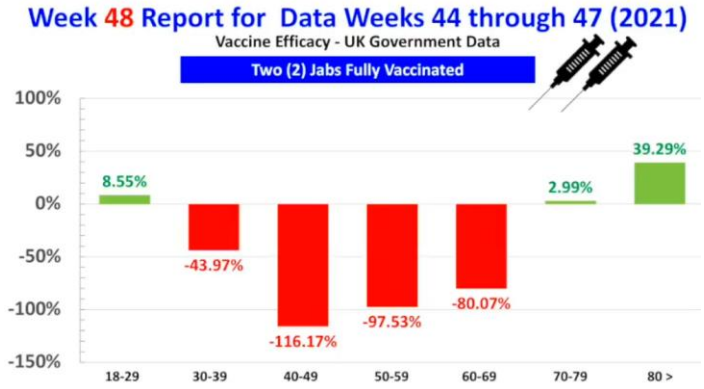


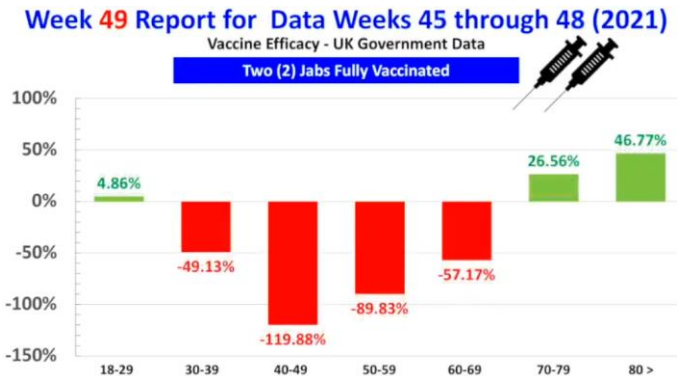


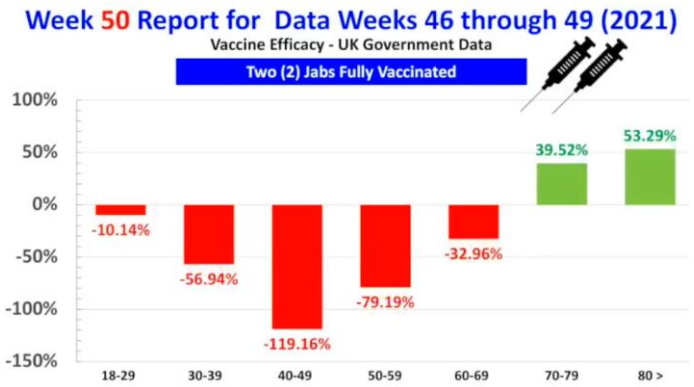


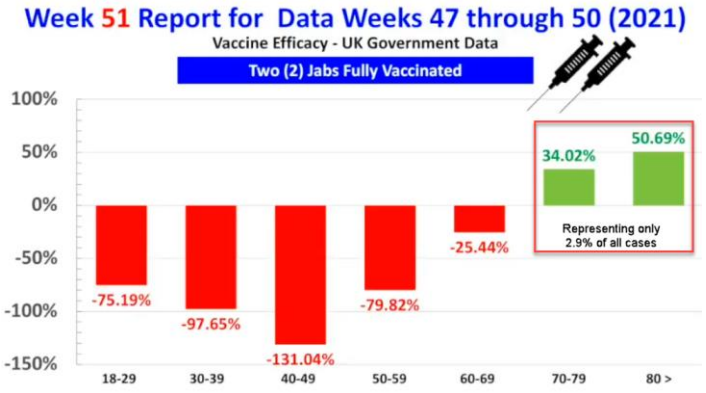


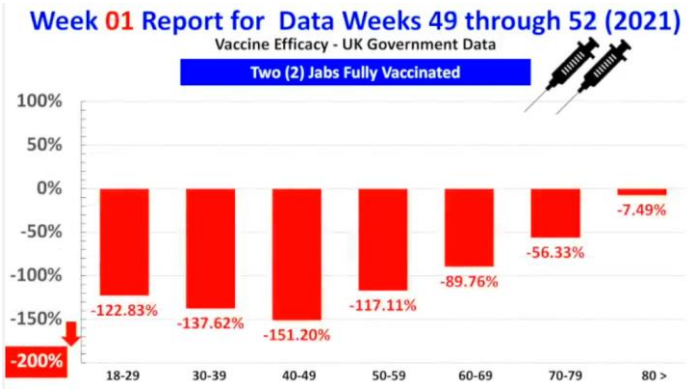


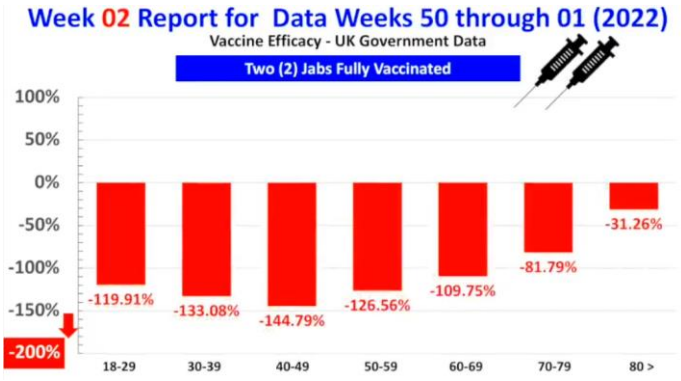




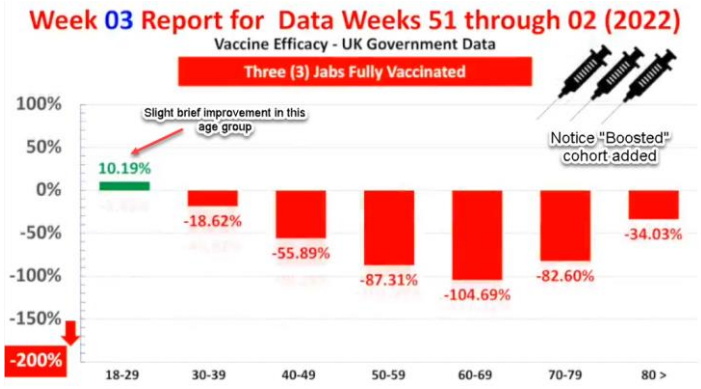


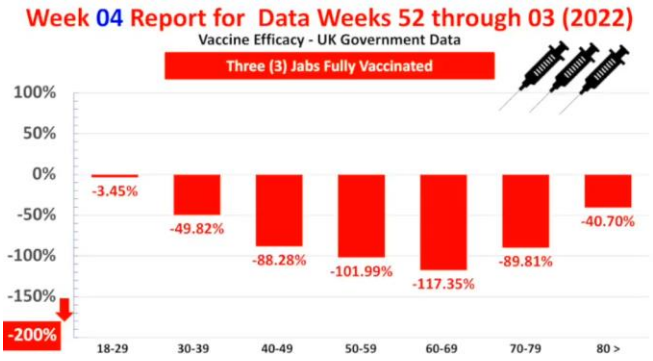


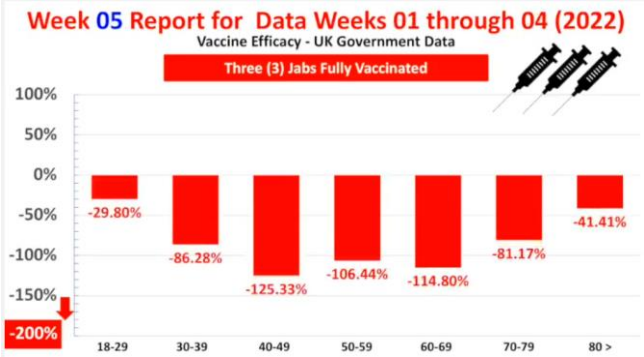


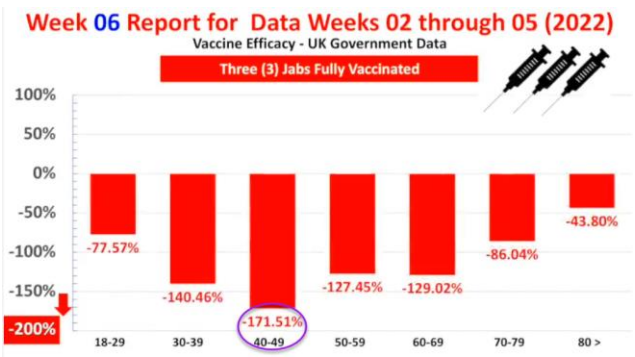


Now boosted added (note the 3 syringes)



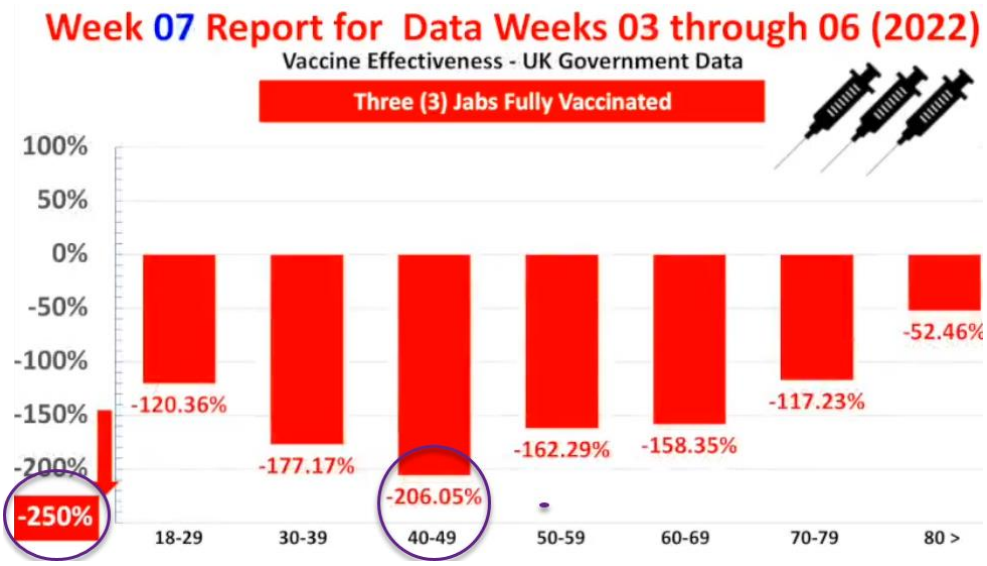




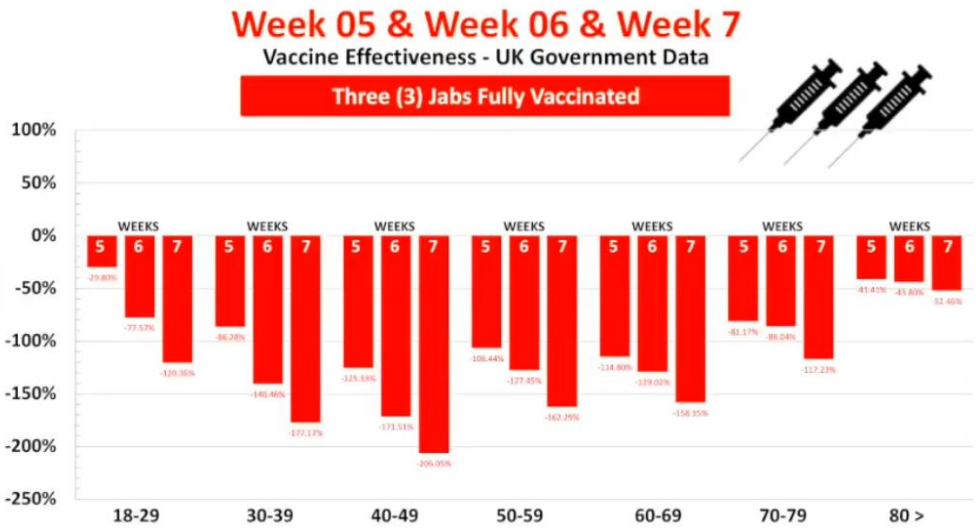


https://www.bitchute.com/video/b6l1NY2uPN04/

Then, the latest release of data for Week 7 showing data from weeks 4, 5 and 6 of 2022 shows a shocking additional drop in efficacy. Remember this only added week 6 to weeks 4 & 5 over what the previous chart was showing, which was weeks 3, 4 and 5.



In summary, a comparison of weeks 5, 6 and 7.



https://www.voiceforscienceandsolidarity.org/videos-and-interviews/uk-data-noose-on-the-masses-vaccine-stakeholders-what-have-you-done

Lord knows how low this will go at the rate efficacy is dropping in the vaccinated. Many scientists worry that the shots are causing a type of acquired immune deficiency syndrome.

Israeli Ministry of Health (MOH) posts Facebook survey asking about vaccine adverse reactions. They quickly freaked out after tens of thousands of comments flooded the post about adverse events

An February 18th, 2022 ***Substack*** post by Josh Guetzkow titled, **The Israeli Ministry of Health Actually Did a Survey of Adverse Events after The Booster Dose- And it's absolutely devastating**, opens a window into how widespread the vaccine adverse reaction after the COVID-19 shots may really be. His ***Substack*** is titled, ***Jackanape's Junction***

I have chosen to publish a large amount of this post because there is so much rich content and data there. I hope you enjoy it.

From the post- (MOH is Ministry of Health)

The MoH didn't have to look further than their own Facebook page to find plenty of evidence. On Sept. 30 they put up a Facebook post deriding all the "fake news" on social networks about side effects and touting the safety of the vaccines: only 19 serious adverse events reported out of 3 million booster doses, which might not even be related to the vaccine. The post was quickly flooded with thousands of comments from people describing in detail the severe adverse events they or their loved ones had experienced after the booster and previous doses. Somebody at the MoH apparently panicked, because they quickly started deleting hundreds if not thousands of comments. They were caught 'in the act' by people reading the comments who took videos of them being deleted, one by one. There are currently 27,000 comments on that post. It is unknown how many were deleted.

And apparently it had never occurred to the MoH to investigate why so many people never returned for the second dose, despite losing eligibility for the green pass or the right to work in countless workplaces requiring vaccination. One careful calculation I've seen estimated that by June 2021, there were about 180,000 people who had never returned for the second dose—a number that excludes people who recovered from a SARS-Cov-2 infection. That's over 3% of people who were vaccinated with one dose and eligible for the second at that time.

Here are some of the most important takeaways from the survey. Further down I'll present all the results and conclude with some discussion of unreported events:

- **0.5% of people reported hospitalization** as a result of the adverse event they experienced. Not just the emergency room, but actually being hospitalized. Think this is impossibly high? Read this footnote.1 If the numbers are wrong, the MoH needs to say so and explain how they messed up.
    - Israel has administered about 4.5 million booster doses so far, which equates to over 22,000 hospitalizations.

    - Over 92 million booster doses have been distributed in the U.S., which equates to 460,000 hospitalizations.
- **29% reported that they had difficulty performing daily activities as a result of the adverse event.** That is 44% of the 66.4% of the sample that reported at least one adverse event. Like in VAERS, women were more likely to report than men (75% vs. 58%) and also more likely to report difficulty in daily functioning (51% vs 35%).
- **4.5% of respondents reported neurological problems** (again, more women than men), including:
    - Bell's Palsy (0.5%)
    - Blurred or disturbed vision (0.5%)
    - Seizures/Convulsions (0.15%)
    - Loss of consciousness (0.2%)
    - 16% of these neurological problems occurred within an hour of vaccination, an additional 27% within 24 hours, and 47% were ongoing by the time of the survey 3-4 weeks after vaccination.
    - In the US, this translates to 460,000 cases of Bell's Palsy and blurred or disturbed vision, 135,000 seizures and 180,000 people losing consciousness.
    - Have you ever heard of a vaccine that is associated with seizures in 0.15% of adults who take it — let alone one that is mandated by many colleges and workplaces?
- **About 25% of people with pre-existing auto-immune disorders, depression or anxiety reported a worsening of their symptoms** following the booster. Five to ten percent of people with diabetes, hypertension, and lung & heart disease also reported a worsening of their condition.
- **Nearly 10% of women under-age of 54 had disruptions to their menstrual cycle** after the booster (apparently they did not ask women above this age). About half of those women reported that the problems persisted at the time of a follow-up interview, which was anywhere from 10-16 weeks after vaccination.
    - Of these, 31% sought medical treatment as a result and 9% were on medication for it.
    - Notably, 39% of these women reported similar disruptions following prior doses, of whom 1/3 (which is a little over 6% of all women under the age of 54) were still experiencing symptoms at the time of the 3rd dose. Given that the vast majority of vaccinated Israelis were "fully vaccinated" by the end of March and the booster campaign for that age group didn't get into full swing until late August, this means that these women were likely experiencing these symptoms for somewhere between 4-months.
- How badly did the Israeli vaccine adverse event reporting system undercount adverse events? We can calculate an approximation by comparing the MoH's Sept. 25 report on adverse events from this system to the survey results to calculate an "underreporting factor" (URF). If the URF is 100, this means you have to multiply the number of reported events by 100 to approximate the true number of adverse events.2 It's especially important to know the URF when public health officials disingenuously play down the risks of a medical product by saying that there have been very few reports of adverse events, while knowing full well that the true number must be much larger. The only question is — how much larger?
    - **The URF varies from a low of 1,700 for loss of consciousness to 48,800 for difficulty breathing. Some other highlights: a URF of 6,500 for seizures, nearly 6,000 for Bell's Palsy, and over 4,000 for blurry or disturbed vision.**
    - Actually the URF was even higher for some milder, general AE's and for local site reactions: 54,000 for chest pains, 230,000 for limited arm movement, and 540,000 for injection site pain. That these types of AE's are so underreported is hardly surprising: the public was told to expect these kinds of reactions, and for the most part they are relatively minor (though note in the last table below how long some of them persist for).
    - Note that these URF's cannot be applied to VAERS, for two reasons:

- The underreporting in Israel is probably much worse than in the US for a variety of reasons.
- Israel does not conform to the international classification standard for AE reporting. The US, UK and Europe use the MedDRA system. The Israeli MoH apparently decided to make up its own classification system and continues to use it, for reasons unknown. So comparison to other countries is difficult.

Still we can use the survey results to estimate VAERS underreporting for three specific adverse reactions: Seizures, Bell's Palsy, and shingles (herpes zoster).

- **VAERS URF for Seizures/Convulsions is 731**:
  - As of Feb. 11, there were 243 reports of seizures and convulsions reported in VAERS that occurred within 30 days of receiving the booster dose in the US and territories (143 of these were after Pfizer).
  - As of Feb. 11, about 91 million booster doses had been administered in the US, of which about 50 million were from Pfizer.
  - The rate of per million doses of seizures/convulsions in the MoH survey was 1952 (see footnote 3 for method of calculation).
  - From that rate the expected number of seizures/convulsions after the booster in the US by Feb. 11 is 177,600.3
  - 177,600/91 = 731. If we want to make a strict apples-to-apples comparison, we need to look at reports after Pfizer only, in which case the URF is 683.
- **VAERS URF for Bell's Palsy is 3,034**:
  - As of Feb. 11, there were 161 cases of Bell's Palsy listed in VAERS (95 of these were after Pfizer).
  - The rate per million doses of Bell's Palsy in the MoH survey was 5,368.
  - The expected number of cases of Bell's Palsy after the booster is 488,500.
  - 488,500/161 = 3,034. For Pfizer it's 2,825.
- **VAERS URF for shingles (herpes zoster) is 401.**
  - As of Feb. 11, there were 332 cases of shingles reported in VAERS (196 after Pfizer).
  - The rate per million doses of herpes zoster in the MoH survey was 1,464.
  - The expected number of Herpes Zoster cases after the booster in the US is 133,200.
  - 133,200/332 is 401. For Pfizer only it's 373.
- Here is a table summarizing the URF calculations for these three AE's:

Estimated VAERS Underreporting Factor from Israeli MoH Survey

Adverse Event	Rate per Million Booster Doses (MoH Survey)	Expected Number of Adverse Events Following Booster	Number of Cases Reported to VAERS after Booster All (Pfizer Only)	URF All (Pfizer Only)
Seizures/Convulsions	1952	182,000	243 (143)	731 (683)
Bell's Palsy	5368	455,000	161 (95)	3,034 (2,825)
Herpes Zoster (shingles)	1464	136,500	332 (196)	401 (373)

Do you know of any other mandated medical treatment or vaccine that causes so many problems in such a high proportion of the population? For that matter, how many mandated medical treatments have you ever even heard of? The results of this survey should have put an immediate end to the plans of governments

around the world to continue to offer booster doses to their citizens, let alone condition basic liberties on getting one. And yet, here we are. The only question now is how much lower this report can limbo under the radar.

Below are tables showing the number and percent of reports from the survey and comparing those results, where possible, to the MoH report based on the passive surveillance system. I've also calculated the estimated total number of events that would be expected to occur in the US and Israel based on the survey reporting rate per million and the total number of booster doses administered in each country, based on approximately 92 million doses administered in the US and 4.5 million in Israel. The full tables, including a gender breakdown, are available here. To read more about how the URF was calculated, read this footnote.4 I'm not going to add much commentary on the tables as they sort of speak for themselves. I'm also not going to show a table for local administration site reactions, as they are relatively less sever and less interesting (though note in the last table how long many of them last for).

Let's start with some of the more serious AE's, starting with Neurological:

NEUROLOGICAL ADVERSE EVENTS

		Rate per Million Doses				
	N	Survey	Surveillance System	URF	Estimated # of Events in U.S.	Estimated # of Events in Israel
Tingling or Itching Sensation	63	30747	7.5	4100	2,828,697	138,360
Bell's Palsy	11	5368	0.9	5965	493,899	24,158
Blurred / Disordered Vision	11	5368	1.3	4130	493,899	24,158
Memory Problems	8	3904	--	--	359,200	17,570
Acute Hearing Disorders	7	3416	--	--	314,300	15,373
Seizures/Convulsons	4	1952	0.3	6507	179,600	8,785
Loss of Consciousness	3	1464	0.9	1627	134,700	6,589
Other*	5	2440	2.8	872	224,500	10,981

* Other includes includes tics, involuntary movement and vertigo

Here is the table for allergic reactions. They say no cases of anaphylaxis were reported during the survey, but difficulty breathing and throat swelling are anaphylactic reactions, even if they do not reach the severity of full-blown anaphylaxis.

ALLERGIC REACTIONS

	Rate per Million Doses				
	N	Survey	Surveillance System	URF	Estimated # of Events in U.S.	Estimated # of Events in Israel
Rash	40	19522	1.2	16268	2,828,697	138,360
Itching	34	16593	0.6	27656	493,899	24,158
Difficulty Breathing	30	14641	0.3	48804	493,899	24,158
Swelling of Face/Throat	13	6345	0.6	10574	359,200	17,570

* Other includes includes tics, involuntary movement and vertigo

Here are reactions classified as “general:"

GENERAL ADVERSE EVENTS

	Rate per Million Doses				
	N	Survey	Surveillance System	URF	Estimated # of Events in U.S.	Estimated # of Events in Israel
Weakness/Tiredness	856	417,765	86.6	4824	38,434,358	1,879,941
Headache	529	258,175	51.1	5052	23,752,074	1,161,786
Muscle/Joint Pain	520	253,782	57.7	4398	23,347,975	1,142,020
Shaking	344	167,887	22.9	7331	15,445,583	755,490
Fever > 101.4 F	306	149,341	53.3	2802	13,739,385	672,035
Dizziness/ Feeling Faint	186	90,776	12.2	7441	8,351,391	408,492
Nausea/Vomiting	139	67,838	17.6	3854	6,241,093	305,271
Chest Pain	110	53,685	--	--	4,938,995	241,581
Digestive System Disorders*	101	49,292	12.3	4008	4,534,895	221,816
Enlarged Lymph Nodes**	84	40,996	6.6	6211	3,771,596	184,480
Coughing	78	38,067	--	--	3,502,196	171,303
Anxiety	41	20,010	--	--	1,840,898	90,044
Other***	40	19,522	--	--	1,795,998	87,848

* Includes: abdominal pain / constipation / diarrhea / heartburn; ** Refers to lymph nodes not near injection site; *** Includes: colds / phlegm or mucus / sore throat, side-effects on the legs (swelling / heaviness / weakness), low fever / feeling cold, sores in the mouth, hot flashes, hair loss, contractions in pregnant women, restlessness, insomnia, clouding of consciousness and shortness of breath on exertion.

Here is a table showing what percentage of respondents had pre-existing chronic illnesses and, *of those*, what percentage experienced a worsening of symptoms after the booster dose:

Exacerbation of Pre-Existing Chronic Illness Following Booster Shot

Illness	% With Pre-existing Chronic Illness	% with Worsening of Symptoms Following Booster
Hypertension	14%	6%
Lung disease	10%	7%
Diabetes	8%	9%
Heart diseases	5%	5%
Anxiety / Depression	5%	26%
Autoimmune disease	3%	24%

Wait, weren't the vaccines were supposed to protect people at greater risk of severe COVID outcomes, not make them worse?

Here are three AE's that were not reported by the MoH in its report on its spontaneous AE monitoring system, so a URF cannot be calculated (Note: table is corrected from earlier draft):

OTHER SELECTED ADVERSE EVENTS

	N	Rate per Million Doses	Estimated # of Events in U.S.	Estimated # of Events in Israel
Herpes simplex	4	1,952	179,584	8,784
Herpes zoster	3	1,464	134,688	6,588
Menstrual Changes*	59	56,567	2,845,350	127,277

* Rates and estimates calculated for women only

Continued next page…

A follow-up study of the women who reported menstrual changes was conducted 7-12 weeks after the first interview. About half of them were still experiencing problems at the time of the follow-up. Here is the breakdown of the kinds of changes they experienced (categories are not mutually exclusive).

MENSTRUAL CHANGES

	N	% of All Women in Follow-up Survey
Delayed Menstruation	17	38%
Increase in Menstrual Bleeding	14	31%
Early Onset of Menstruation	13	29%
Extended Duration of Menstrual Bleeding	12	27%
Repeated Bleeding During Cycle	11	24%
Strong Pains During Menstruation	9	20%
Weakened Menstrual Bleeding	4	9%
Cessation of Menstruation	3	7%
Reduced Duration of Menstrual Bleeding	2	4%
Other*	6	13%

* Other includes re-occurrence of bleeding after end of menstruation, unexpected vaginal bleeding after vaccination, blood clotting, decreased pain, irregularity and premenstrual syndrome including irritability and pain.

Finally, here is a table reporting how soon after vaccination they experienced the adverse event for different categories and the duration of the symptoms. Note that a sizeable percentage of symptoms are listed as "ongoing," meaning they were still experiencing symptoms from the adverse event at the time of the interview 3-4 weeks following receipt of the booster dose.

ONSET AND DURATION OF ADVERSE EVENTS

	Local (N=1140)	General (N=995)	Neurological (N=91)	Allergic (N=80)	Other (N=83)
Time to Onset					
Immediately - 1 hr	9%	3%	16%	4%	4%
1 hour to 24 hrs	67%	57%	27%	31%	10%
1-7 days	23%	34%	29%	35%	39%
8-30 days	1%	7%	29%	30%	47%
Duration					
Up to 24 hrs	24%	27%	21%	9%	2%
1-3 Days	56%	43%	20%	25%	13%
4-7 Days	14%	12%	8%	18%	18%
> 1 Week	4%	6%	3%	15%	24%
Ongoing	2%	13%	47%	33%	42%

* Note: columns may not add to 100 due to rounding.

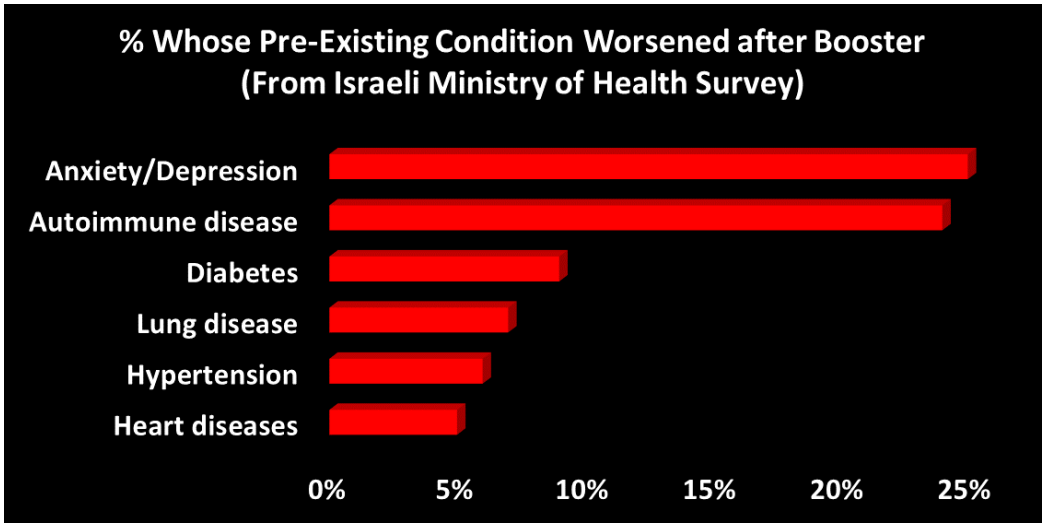
A sizeable percentage of events began on the same day as the vaccination. But as we saw at the top, even if you have a stroke the moment the shot goes into you, it may still be ruled a "coincidence" by the wise sages in the Ministry of Health. To them I say: don't piss on my leg and tell me it's raining. They're engaged in an exercise of ghoulish gaslighting, and I honestly wonder how they sleep at night. To give them the benefit of the doubt, instead of being motivated by malevolence their actions might be due to arrogance allied with ignorance: since *they* don't know how the vaccines could possibly cause a particular problem, then obviously they couldn't have. Because they know everything. Apparently. And you dare not question them or you will be shunned from polite society.

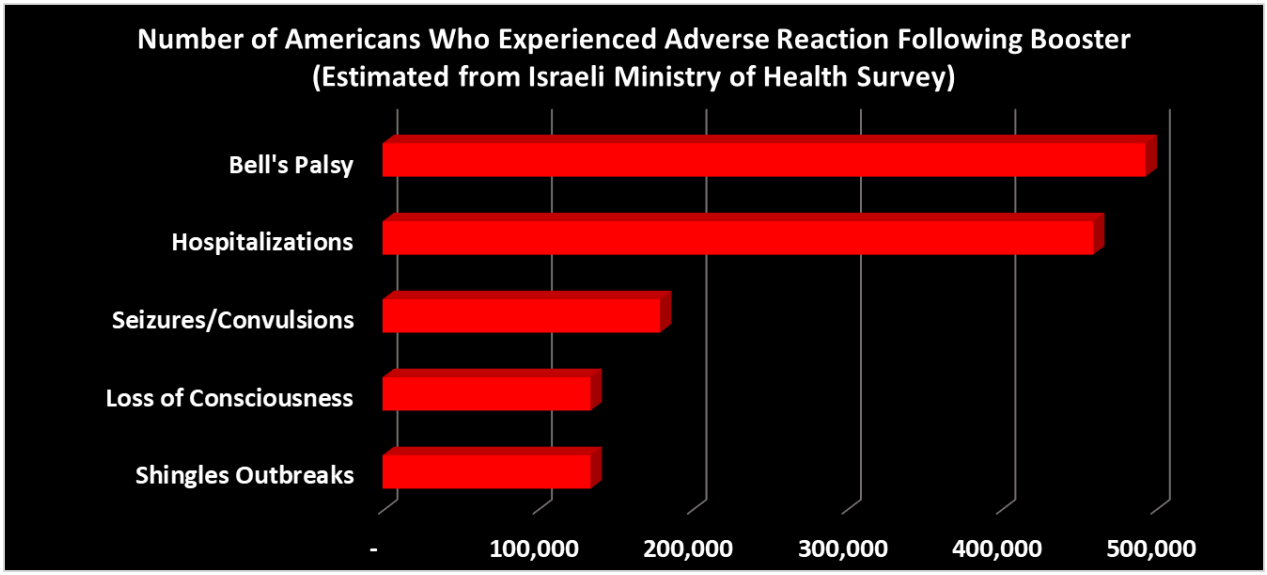
I will save a deep-in-the-weeds methodological discussion for the final footnote,[5] but it's worth pointing out as I wrap this up that the survey is also notable for the events it *doesn't* include. They did report one case of myocarditis. According to Israeli figures, the highest rate of myocarditis following the *second* dose for every 6,600 boys aged 16-19 and significantly less for older people and females. So it is quite remarkable that even 1 case was observed in this survey of 2,049 people, few of whom were in the highest risk category for myocarditis. This means either that it was a fluke or that the chances of myocarditis are significantly larger following the booster dose.

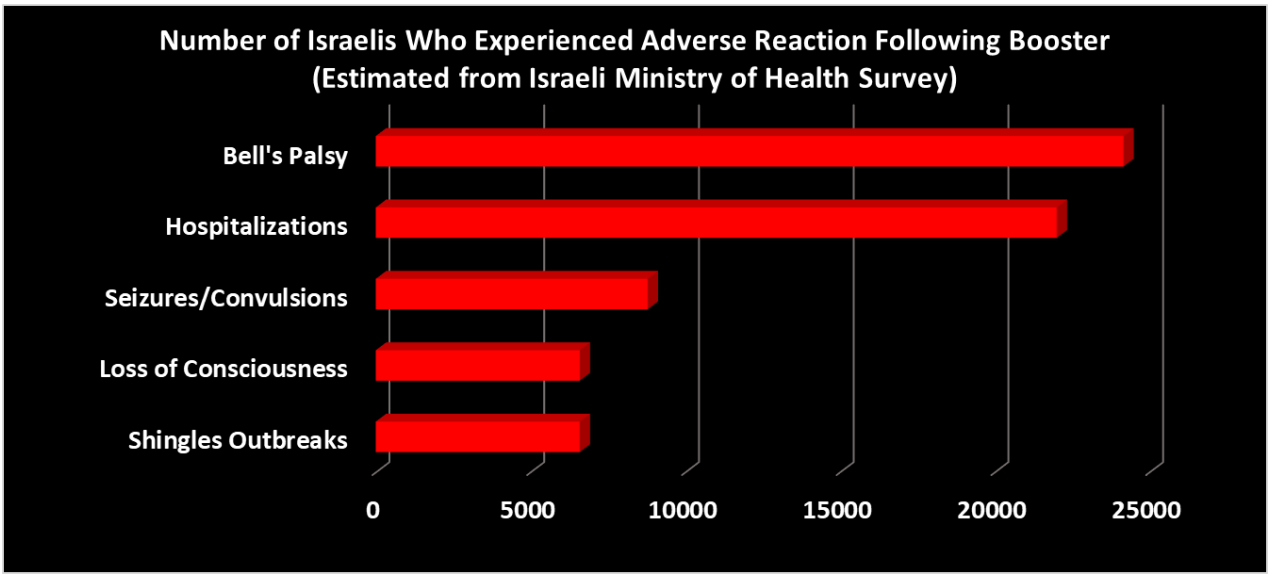
It also means that to detect the events they did for relatively rare conditions like Bell's Palsy or seizures means that these events must be far more common than myocarditis, at least among the population under study in this survey. (And VAERS has over 11,000 unique types of events that have been reported for COVID-19 vaccines.) At a later date I may do a power analysis on this survey to try to estimate the likelihood of detecting certain types of events, but even without that it is stating the obvious to say that the survey was unlikely to pick up any event that was less likely to occur than, say myocarditis. But since we're talking about millions or even billions of vaccinations, even events as rare as 1 in 10 or 20 thousand equate to hundreds or hundreds of thousands of cases.

One of the other things you won't see in this survey is the percentage of people who died within a month of being vaccinated, for the simple reason that you can't phone up dead people to find out what happened to them after vaccination, unless perhaps you use a Ouija board. But I haven't seen a legitimate survey that uses that kind of methodology. On the other hand I haven't seen a legitimate adverse event report organized using the MoH's categories, so maybe they'd be up for it. Frankly, I'm surprised they did this survey in the first place, and even more surprised that they released this report at all. It will be interesting to see how they will tie themselves up in knots to deny the results of their own study. Or maybe they'll just ignore it and hope it goes away. It's up to us to make sure that doesn't happen.

On the next page are some bar charts summarizing some key takeaway points…







1). Some people have said the rates reported here for some events are impossibly high. And I agree they seem almost unbelievably high. But they are in line with figures from the CDC's v-safe program, which is the closest

thing they have to a survey. It's an app that people can voluntarily download to their phone after vaccination, and it nudges them to answer questions at certain intervals after vaccination. (Apparently, Israel "start-up nation" was unable to do even this.) Based on v-safe data, the CDC reported an overall hospitalization rate within a week of the first dose of 0.1%, which was also the rate for people who received a booster and primary series all from Pfizer only. Overall, 28% were unable to perform normal daily activities, or 22% of the 'Pfizer only' group (this compares to 29% in the MoH survey). 1.2% of v-safe respondents developed a non-injection site rash (1.9% of 'Pfizer only') vs. 2% in the MoH survey. Other results from v-safe are also quite similar to the MoH survey, and overall the similarities lend credibility to the validity of the survey results.

However, it should be noted that that MMWR report was based on boosters received by about 22,000 immuno-compromised individuals. A recent MMWR report (dated Feb. 18) on non-immunocompromised individuals enrolled in v-safe who received a booster (N is about 720,000; or 332,000 'Pfizer only' — however less than 1% of booster recipients registered in v-safe). But the report is *very* light on details about specific adverse events. We can compare 'systemic' reactions to the MoH's 'general reactions' where we see the CDC reporting 58.4% among 'Pfizer only' vs. 48.6% in the MoH survey. These numbers are 64.3% vs. 55.7% for local injection-site reactions. Beyond that, we can glean that 0.9% of Pfizer-only recipients sought medical care following the booster dose, but we don't know what the rate of hospitalization was. Nevertheless, the other comparisons suggest the estimates from the MoH survey are lower than from the CDC v-safe data. Note that the CDC has resisted FOIA requests for more detailed breakdowns of the v-safe data, though it is known that they possess the requested information.

A clinical trial testing 'mixing-and-matching' boosters published in the NEJM can also be used as a point of reference, although there were only 50 people in the "Pfizer only" group. Among that group, the trial reports higher rates of myalgias, arthralgias, headaches, nausea and injection site pain than the MoH survey, again suggesting the MoH survey may be underestimating the rates of adverse events. Unfortunately there is no further detail about adverse events reported, and in any case they only have an N of 50 in the Pfizer-only group.

For menstrual disruptions, we can compare to a survey that was conducted in the UK in March of 2021. They found that 20% of women who responded to the survey had experienced menstrual changes following vaccination. That was after the first or second dose, not the booster. The difference between that and the 10% found in this survey could be due to multiple factors: 1. In the UK many women received the AstraZeneca vaccine; 2. Respondents were recruited through a Facebook campaign, and women whose menstruation was affected adversely by the vaccine might have been more motivated to respond (even though the survey was not specifically about that); 3. Women who experienced menstrual disruption after the 1st and 2nd doses may have been less likely to go back for the 3rd, which would skew the distribution of women receiving the 3rd shot towards women less likely to be affected.

2). Yes, it's true that adverse events reported either through the safety monitoring system or in the survey are not necessarily caused by the vaccine. That doesn't matter, because monitoring systems are not meant to determine causality (though they arguably can). Their purpose is to collect reports on adverse events experienced after a medical intervention, regardless of whether the person reporting thinks there is a causal relationship. If people don't report, then they don't work as intended. Simple as that.

3). There should actually be more cases, because the survey included people who had received their booster 3-4 weeks earlier. Here I am including both reports and vaccination numbers through Feb. 11. That means that for somebody vaccinated on Feb. 11, they still have 4 weeks to have an outbreak of Herpes Zoster case and report to VAERS in order to be included in the count of cases. This is therefore a conservative estimate. I could

have constrained VAERS to an earlier vaccination date (say, Jan 11), but there are so many missing fields in VAERS data that doing so would likely exclude many cases with an unknown vaccination date.

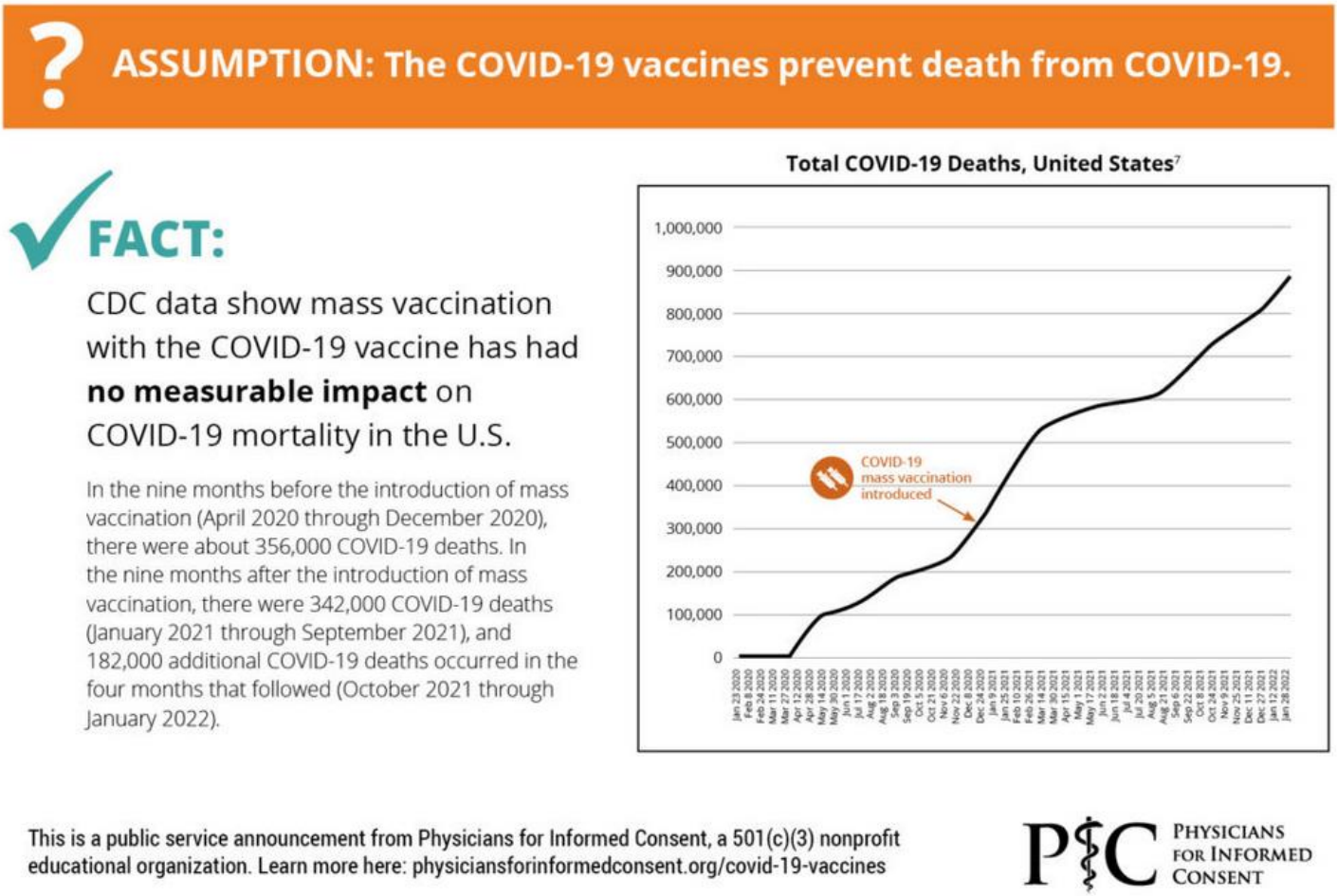
4). The survey results were based on responses from 2,049 Israelis. The MoH reports based on passive surveillance were reported as events per million doses. You have to multiply 2,049 by 488 to get to a million. So the number of each type of event was multiplied by 488 to approximate the total number of reports per million that should have been documented in the passive system if there was no underreporting (on the assumption that the survey is not underreported). Another option would have been to multiply the percentage by 10,000 to get the rate per million. The problem is that for many events the number of events did not line up with the percentage. What I mean by that is that if you took the number of events reported and divided by 2,049, the result did not quite equal the percentage reported by the MoH. I can only guess as to why this was. Perhaps for each question they excluded people who didn't answer the question and only used those who provided an answer as the denominator. I don't know and it isn't written. However, since we know the full sample size, using the total number of people who reported an event as our baseline is a sound methodological choice. In any case the differences between the two methods yield very similar numbers and reveal the same magnitude of underreporting. I thank Oz Koren for laboring to compare the reports and calculate the URFs.

5). I've been plugging away at this post for most of the day, and I'm running out of steam. I will make two quick methodological notes here and perhaps add some more at a later date. First of all, how precise are the results from the survey? It isn't reported. Usually with a survey they report a margin of error, typically +/- 3%. That means that if the percent of people saying X is, say 10%, you can be confident that if you did the same survey on a different random sample, you would get a number between 7 and 13 at least 95% of the time. Here there is no margin of error, so we are left to wonder. The survey was carried out by a reputable survey research firm, so we may assume that the margin of error is within that range, if not smaller. I could probably do the calculations myself if I had the time.

Another thing I want to touch on is non-response bias. First of all, they sampled from the complete list of people who were registered as having taken the booster, of whom only 75% had telephones. I don't know any child in Israel above the age of 5 without their own phone, so I have to wonder who these 25% are without phone numbers listed. But set that aside. Of the people with phone numbers, there were a sizeable number of people they were either unable to make contact with (347) or who refused to be part of the survey (469). If those people were more likely to have suffered or be currently suffering from some serious adverse event, then the survey would tend to undercount those events. For example, if you are dealing with a severe health problem, you might be less able to answer the phone or less willing to talk to representatives of the Ministry of Health if you are angry at them. This is pure speculation, of course. It's impossible to know whether and how the non-response bias could affect the results, if at all. If it's random, then it won't. If it skews towards people who had an AE, then it will lead to an undercount. If it skews towards people who didn't have an AE (nothing happened to me, why waste my time talking to them?), then it will lead to an overcount.

https://jackanapes.substack.com/p/the-israeli-ministry-of-health-actually-db7?utm_source=url

Physicians for Informed Consent: CDC Data Show COVID-19 Mass Vaccination Has Had No Measurable Impact on COVID-19 Mortality in the U.S.



https://physiciansforinformedconsent.org/physicians-for-informed-consent-cdc-data-show-covid-19-mass-vaccination-has-had-no-measurable-impact-on-covid-19-mortality-in-the-us/

Another great resource from P.I.C. is this PDF titled, **COVID-19 VACCINE MANDATES: 20 Scientific Facts That Challenge the Assumptions**

https://physiciansforinformedconsent.org/COVID-19-Vaccine-Mandates.pdf

A sophisticated analysis of the COVID-19 mortality data reveals SHOCKING data that the risk of death from the "vaccines" is greater than the risk from COVID-19 itself for all age groups under 80 years of age

The paper by Kathy Dopp, MS Mathematics and Stephanie Seneff, PhD from M.I.T. dated February 13th, 2022 titled, **COVID-19 and All-Cause Mortality Data by Age Group Reveals Risk of COVID Vaccine-Induced Fatality is Equal to or Greater than the Risk of a COVID death for all Age Groups Under 80 Years Old as of 6 February 2022**, reveals shocking data and exposes the significant risk from these experimental injections.

*The article itself goes into great detail about the methodology of their analysis. For those interested in the complex details of all that you can follow the link at the end of this story.

The abstract

As of 6 February 2022, based on publicly available official UK and US data, all age groups under 50 years old are at greater risk of fatality after receiving a COVID-19 inoculation than an unvaccinated person is at risk of a COVID-19 death. All age groups under 80 years old have virtually no benefit from receiving a COVID-19 inoculation, and the younger ages incur significant risk. This analysis is conservative because it ignores the fact that inoculation-induced adverse events such as thrombosis, myocarditis, Bell's palsy, and other vaccine-induced injuries can lead to shortened life span. When one takes into consideration the fact that there is approximately a 90% decrease in risk of COVID-19 death if early treatment is provided to all symptomatic high-risk persons, one can only conclude that mandates of COVID-19 inoculations are ill-advised. Considering the emergence of antibody-resistant variants like Delta and Omicron, for most age groups COVID-19 vaccine inoculations result in higher death rates than COVID-19 does for the unvaccinated.

From the article

Introduction

To rationally determine COVID vaccination policy, it is essential to determine whether the COVID-19 vaccines are beneficial or harmful. COVID vaccine manufacturers' studies claimed benefit based on the relative risk reduction of testing positive and having symptoms of a SARS-CoV-2 viral infection in their vaccinated versus unvaccinated study participants. However, vaccine manufacturers neglected to calculate absolute risk reductions based on the prevalence or likelihood of a person developing symptomatic COVID illness, which varies by age; and they failed to take into consideration the potential costs of COVID vaccine-induced serious illness and death outcomes [1]. Furthermore, vaccine manufacturers quickly allowed the control groups to be vaccinated, thus eliminating the opportunity for long-term safety analysis. In other words, the COVID vaccine manufacturers failed to provide any cost/benefit analyses for their products.

Results and Discussion

Absolute real-life risk reductions (ARRs) of a COVID death obtained from the COVID vaccine inoculation are shown below in Table 2, column P. Risk reductions from COVID inoculations vary from a low of negative 0.00007% (an increased risk of a COVID death from inoculation) for children under age 18 to a positive 0.183% (0.00183) risk reduction of a COVID death for persons over age 80. However, column R in Table 2 shows the vaccine fatality rate (VFR) for each age cohort, derived by Pantazatos and Seligmann from US Census and CDC data, as described in Appendix A. COVID vaccine inoculations increase risk of death and produce a net negative benefit, aka increased risk of death (shown by the negative numbers in column S = ARR-VFR) for all age groups younger than 60 years old. In other words, the COVID inoculations cause a net increase, rather than decrease, in the likelihood of death for all persons under 60 years old. For those over 60 years old, the benefit of COVID inoculations is negligible, ranging from a 0.0016% (16/1,000,000th) reduction in likelihood of death for 60- to 69-year- old persons to a 0.125% (125/100,000th) reduction in likelihood of death for those over 80 years old. Because preventative treatments are often given to well persons, a vaccine is supposed to provide very small risk compared to benefit. Thus, such high fatality risks (VFRs) versus low benefit of risk reduction (ARRs) from the COVID inoculations are not acceptable, especially considering that low-cost, effective treatments are available that would additionally reduce COVID-19 death rates by as much as 90% or more if provided as soon as symptoms appear in high-risk persons [5,9]. Pantazatos and Seligmann's estimates

of overall US vaccine fatality rates (VFRs) agree with credible analyses of the US CDC's vaccine adverse events reporting system (VAERS) showing US death reports to VAERs are under- reported by a factor of 20 [6].

Calculations in Table 2 are calculated from the data columns in Table 1 columns. Formulas are shown at the bottom of column headings. Results include: Percentages of COVID Deaths in the Surveilled UK NIMS population by vaccination status and age cohort, in columns M and N; Relative and Absolute Risk Reduction benefits of the COVID vaccine, in columns O and P; Number needed to treat or vaccinate to prevent one COVID death, 1/ARR in column Q; Vaccine Fatality Rates in column R (See Appendix A for calculations); Cost/benefit in column S are the result of subtracting vaccine-induced fatality rate (VFR) from absolute risk reduction (ARR). If negative, risks exceed benefits; if positive, benefit exceeds risk of the COVID inoculations; Column T is the number of expected vaccine-induced deaths to prevent one COVID-19 death; column U is the relative risk of death by vaccine status.

Table 2: Calculations for **Absolute Risk Reduction, Risk/Benefit, Number Needed to Treat/Vaccinate, Number of Vaccine-Induced Fatalities to Prevent One (1) Covid Death, Relative Risk of Death by Vaccination Status.**

col L	col M	col N	col O	col P	col Q	col R	col S	col T	col U
UK: Death within 60 days of positive COVID-19 test between week 51 2021 and week 02 2022 (16 Jan 2022)	**% COVID-19 Deaths out of Total NIMS Population NOT Vaccinated = col E/ (colD*(1-colF))**	**% COVID-19 Deaths out of Total NIMs Vaccinated = col K / (col D*col F)**	**RRR Vaccine Relative Risk Reduction of COVID Death = 1 - col N/col M**	**ARR Absolute Risk Reduction of COVID Death by Vaccination = col M -col N**	**NNT Number needed to Treat/Vaccinate to Prevent 1 COVID death = 1 / col P**	**VFR Vaccine Fatality Rate from "*COVID vaccination and age-stratified all-cause mortality risk*" Source 3**	**Risk (negative) of Death or Benefit (positive) against Death from "vaccine" = col P - col R**	**Expected vaccine fatalities to prevent 1 COVID death = col R * col Q**	**Relative rate of vaccine fatalities to COVID fatalities when unvaccinated = col R/ col M**
under 18	0.00008%	0.00015%	-94.32%	-0.00007%	vaccine causes higher COVID death rate	0.0040%	-0.0041%	vaccine causes higher COVID death rate	**51**
18 to 29	0.0006%	0.0003%	49.77%	0.0003%	**318,497**	0.0050%	-0.0047%	**16**	**8**
30 to 39	0.0013%	0.0007%	45.56%	0.0006%	**164,538**	0.0090%	-0.0084%	**15**	**7**
40 to 49	0.0035%	0.0017%	52.15%	0.0018%	**55,516**	0.0170%	-0.0152%	**9**	**5**
50 to 59	0.0123%	0.0038%	69.32%	0.0085%	**11,760**	0.0160%	-0.0075%	**2**	**1**
60 to 69	0.0374%	0.0098%	73.82%	0.0276%	**3,624**	0.0260%	0.0016%	**1**	**1**
70 to 79	0.1044%	0.0275%	73.67%	0.0769%	**1,300**	0.0480%	0.0289%	**1**	**0**
80 or older	0.3255%	0.1428%	56.13%	0.1827%	**547**	0.0575%	0.1252%	**0**	**0**

Data in Table 3, from the columns of Table 2, summarize the cost of vaccine fatality derived from US Census and CDC data in 2021 vaccination rollouts, compared to vaccination benefit or risk reduction in COVID fatality rates, derived from UK data on COVID death rates from weeks ending 16 January to 6 February 2022. Altogether, the data show a COVID inoculated person is more likely to die within 30 to 60 days of "vaccination" than an unvaccinated person is to die of COVID-19 within 60 days of a positive COVID test, in all age cohorts under 60 years old.

Table 3. Number of Expected Vaccine Fatalities to Prevent One COVID Death and Number of Expected Vaccine Fatalities for each One COVID Fatality

Death within 60 days of positive COVID-19 test between week 2 (w/e 16 January 2022) and week 5 2022 (w/e 6 February 2022)	Vaccine Risk US: Vaccine Fatality Rate	COVID-19 Risk %COVID-19 Deaths out of Total NIMS Population NOT Vaccinated	Vaccine Absolute Risk Reduction (ARR)	NNT Number needed to Treat or Vaccinate to Prevent 1 COVID death	Number expected to die from from the vaccine to prevent one COVID-19 death	Epected number of vaccine fatalities compared to COVID fatalities	Increased Risk (negative) of Death or Benefit (positive) against Death from "vaccine"
under 18	0.0040%	0.00008%	-0.00007%	increases #COVID deaths	increases #COVID deaths	51	-0.00407%
18 to 29	0.0050%	0.00063%	0.00031%	318,497	16	8	-0.00469%
30 to 39	0.0090%	0.00133%	0.00061%	164,538	15	7	-0.00839%
40 to 49	0.0170%	0.00345%	0.00180%	55,516	9	5	-0.01520%
50 to 59	0.0160%	0.01227%	0.00850%	11,760	2	1	-0.00750%
60 to 69	0.0260%	0.03738%	0.02759%	3,624	1	1	0.00159%
70 to 79	0.0480%	0.10438%	0.07690%	1,300	1	0	0.02890%
80 or older	0.0575%	0.32552%	0.18273%	547	0	0	0.12523%

The results by age cohort are that within the same or subsequent month of receiving a COVID “vaccine” inoculation:

- For those under age 18, vaccination increases their COVID death rate, and those under 18 are 51 times more likely to die from the inoculation than to die from COVID if not vaccinated.
- Those aged 18 to 29, are 16 times more likely to die from COVID vaccination than to prevent one COVID death and are 8 times more likely to die from vaccination than to die from COVID if not vaccinated.
- Those aged 30 to 39, are 15 times more likely to die from COVID inoculation than to prevent one COVID death, and 7 times more likely to die from the inoculation than to die from COVID COVID if not vaccinated.
- Those aged 40 to 49, are 9 times more likely to die from the COVID inoculation than likely to prevent one COVID death in this age group, and 5 times more likely to die from the inoculation than to die from COVID if not vaccinated.
- Those aged 50 to 59, are twice (2 times) more likely to die from the COVID inoculation than to prevent one COVID death and are slightly more likely to die from the inoculation than to die from COVID if not vaccinated.
- Those aged 60 to 79, are virtually equally likely to die from the COVID inoculation as to prevent one COVID death or die from COVID if not vaccinated.
- Those aged 80+ are 0.13% less likely to die from the COVID inoculation than to die from COVID if not vaccinated.

Conclusion

The benefits of vaccination against COVID-19 have not lived up to expectations. There has been a rapid drop in vaccine-induced antibody levels over time [7] and the rapid emergence of SARS-CoV-2 variants that are resistant to the vaccinal antibodies to the spike protein [8]. When COVID-19 death data by vaccination status from early 2022 are analyzed to estimate the degree of protection from mortality afforded to the vaccinated population, the protection from COVID-19 death falls far short of the risk of dying from the vaccine, for anyone below 50 years old.

With Omicron now the dominant strain, the vaccinated population are still catching the disease in large numbers and spreading it. The mRNA vaccines were designed to target the original SARS-CoV-2 strain, and the arrival of variants like Delta and Omicron have changed the risk/benefit ratio. With such a large percentage of

the population catching omicron and recovering, we now have a much larger base of a naturally resistant population, whose immunity is much longer lasting and robust than that achieved with the vaccine [10]. With Omicron being both less deadly and more resistant to vaccine antibodies, the benefits of vaccination are further weakened, while the risks of dying from the vaccine remain unaltered. Even if we roll out new versions of the vaccines, the virus will continue to mutate in a futile cat-and- mouse game.

According to the data analysis presented in this paper, all age cohorts under 50 years old are at greater risk (from 5 to 51 times higher) of vaccine-induced fatality within the same or subsequent month of receiving a COVID-19 inoculation than they are at risk of a COVID-19 death within 60 days of a positive test if unvaccinated. All age cohorts have less than ¼ of 1% benefit of absolute risk reduction of a COVID-19 death from receiving a COVID-19 inoculation. Children under age 18 years have 51 times higher chance of fatality after a COVID inoculation than risk of dying from COVID if unvaccinated. Vaccinations in the under 18 age group are more likely to increase the number of COVID deaths in this age group rather than prevent any. Young adults age 18 to 29 have an 8 times higher risk of fatality from the inoculation than from COVID if not inoculated. This analysis is conservative because it ignores the inoculation-induced risk increases of later fatalities and shortened life spans from thrombosis, myocarditis, Bell's palsy, and other known vaccine-induced injuries and ignores the 90% or more decreases in risk of COVID-19 death if early, effective treatments were provided to all symptomatic high-risk persons [5,9]. Mandates of COVID inoculations are ill-advised because the alleged vaccines result in higher death rates than COVID itself.

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

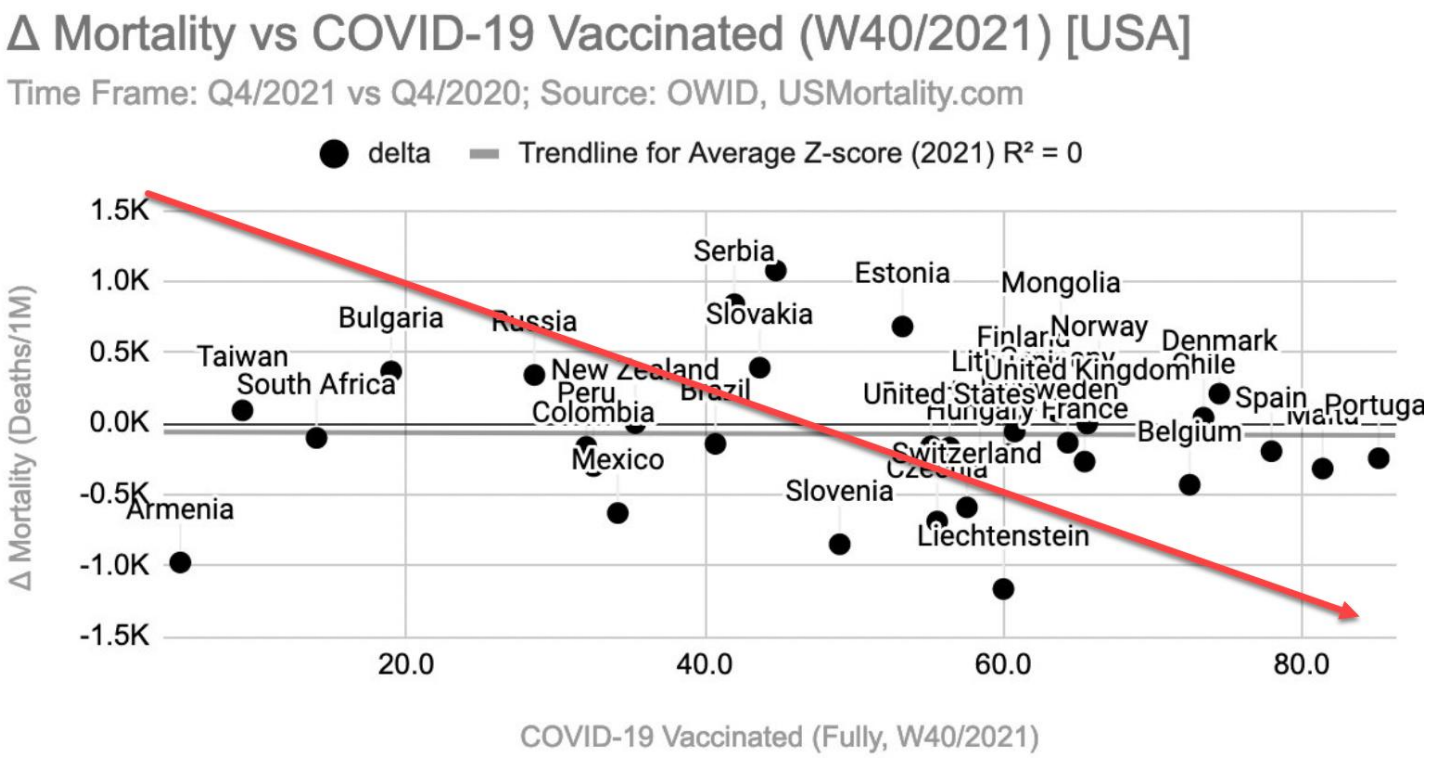
No relationship in mortality trend line with higher vaccination rates in 35 countries. Interpretation: The vaccines are not saving lives.

Once again, graphs are proving to be one of the best ways to see clear evidence of whether interventions have proven effective or not.

In the scattergram below, if there was a positive correlation between vaccination rates and lowered mortality you would see the dots following the red arrow I've placed over the graph, rather than the way they are scattered. As you can clearly see, that is not the case.

- **The Deaths per Million are on the vertical axis on the left. Countries with the highest death rates are higher on the chart.**
- **The rate of Fully Vaccinated is on the horizontal axis. Countries with lowest rates to the left and highest to the right.**

Continued on the next page…



This next story puts an exclamation point on the findings presented above.

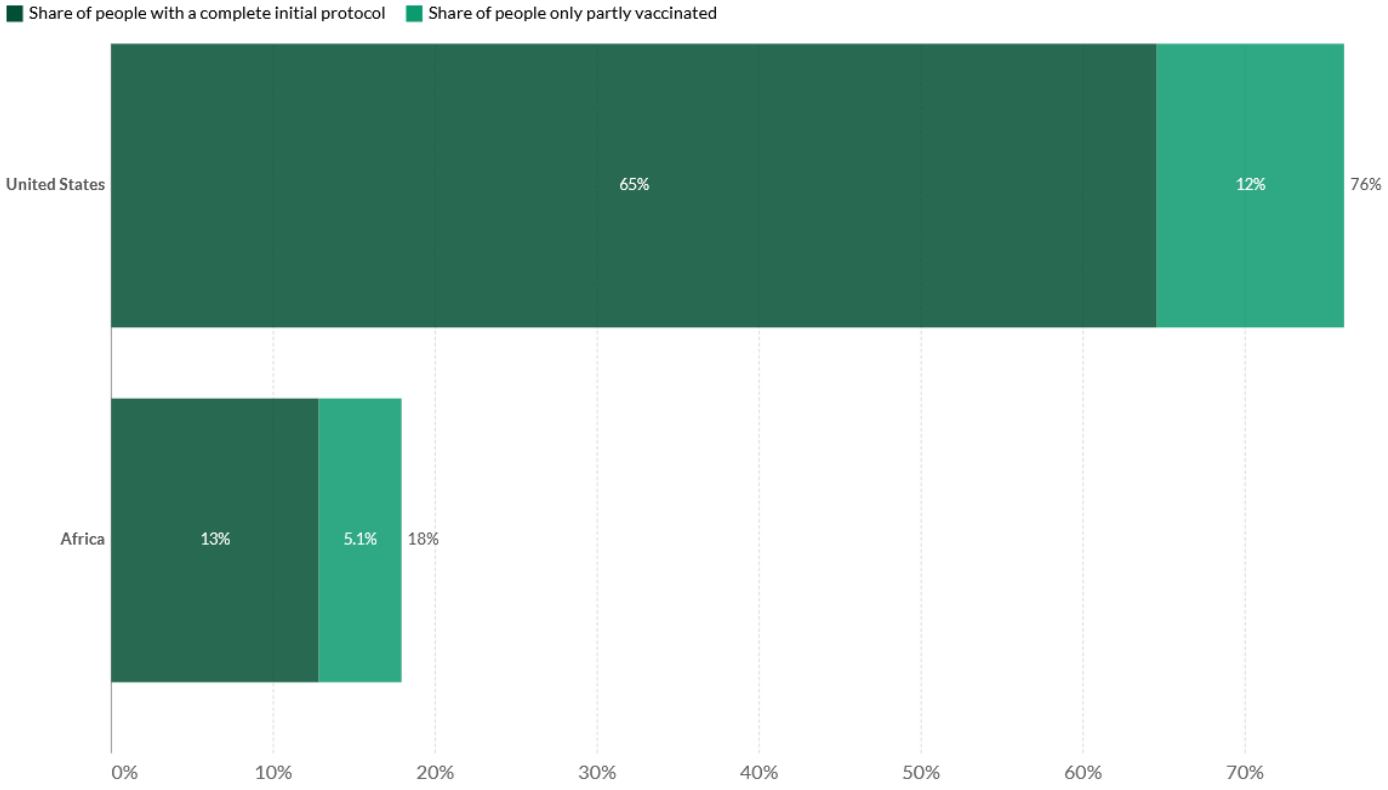
The continent of Africa, with four times the population of the U.S. (1.4 billion) and only 13% fully vaccinated, has only 25% of the COVID-19 deaths

It's crazy when you see and compare the statistics on COVID-19 mortality between the USA and Africa. Africa has nearly 1.4 billion people as compared to 330 million in the U.S. That makes the population of Africa 4.24 times the United States of America. Yet, there have been 970,000 reported deaths "from" COVID-19 in the U.S. compared to 249,000 deaths in Africa. To put it another way, 0.018% of the population of Africa have succumbed to the virus that causes COVID-19. Whereas in the U.S. 0.294% of the population has reportedly died as a result of COVID-19. That is a 16.33 times greater death rate in the U.S. than Africa.

What can account for that?

- Age of the population?
- The regular use of Ivermectin and Hydroxychloroquine in parts of Africa to stave off malaria and other tropical diseases?
- It certainly can't be a high vaccination rate, as only 13% of the people are fully vaccinated in Africa compared to 65% fully vaccinated in the U.S.

Share of people vaccinated against COVID-19, Feb 23, 2022

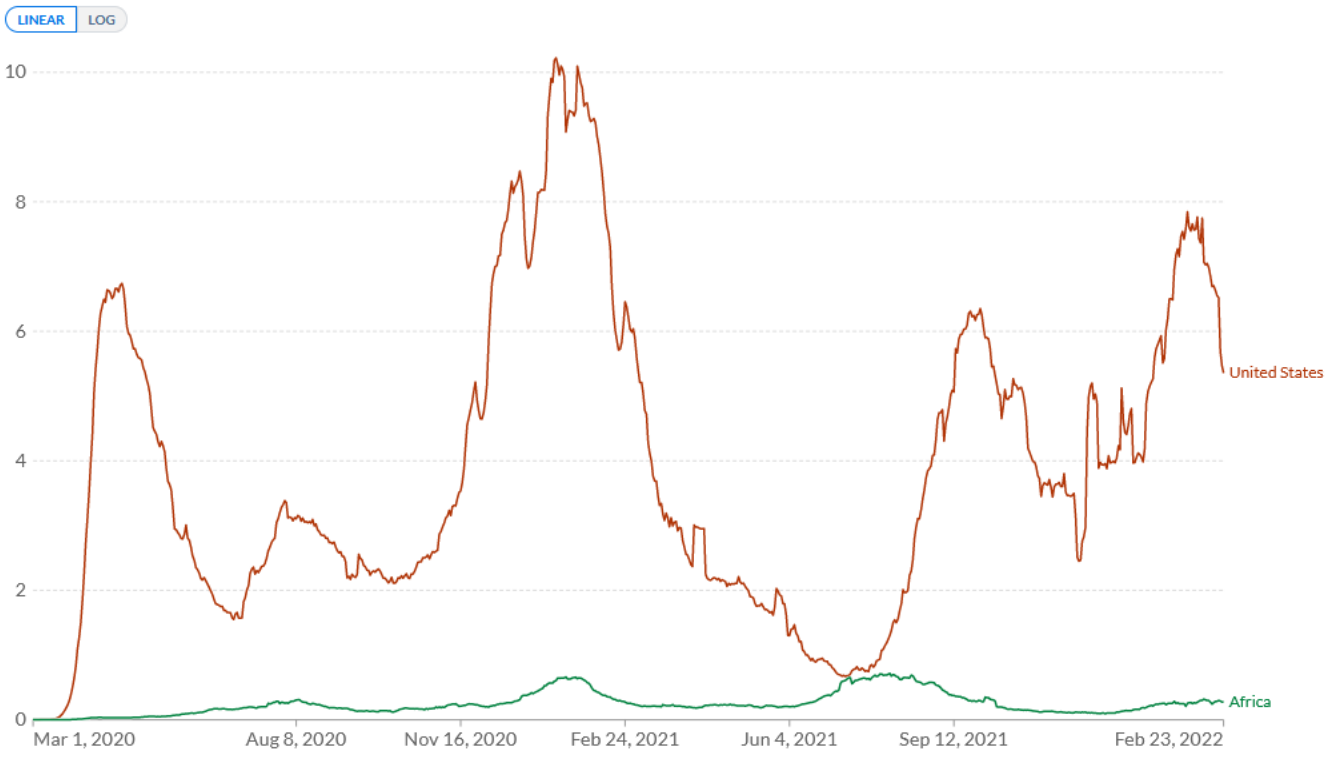


Source: Official data collated by Our World in Data
Note: Alternative definitions of a full vaccination, e.g. having been infected with SARS-CoV-2 and having 1 dose of a 2-dose protocol, are ignored to maximize comparability between countries.

Dec 13, 2020 — Feb 23, 2022

Daily new confirmed COVID-19 deaths per million people

7-day rolling average. For some countries the number of confirmed deaths is much lower than the true number of deaths. This is because of limited testing and challenges in the attribution of the cause of death.

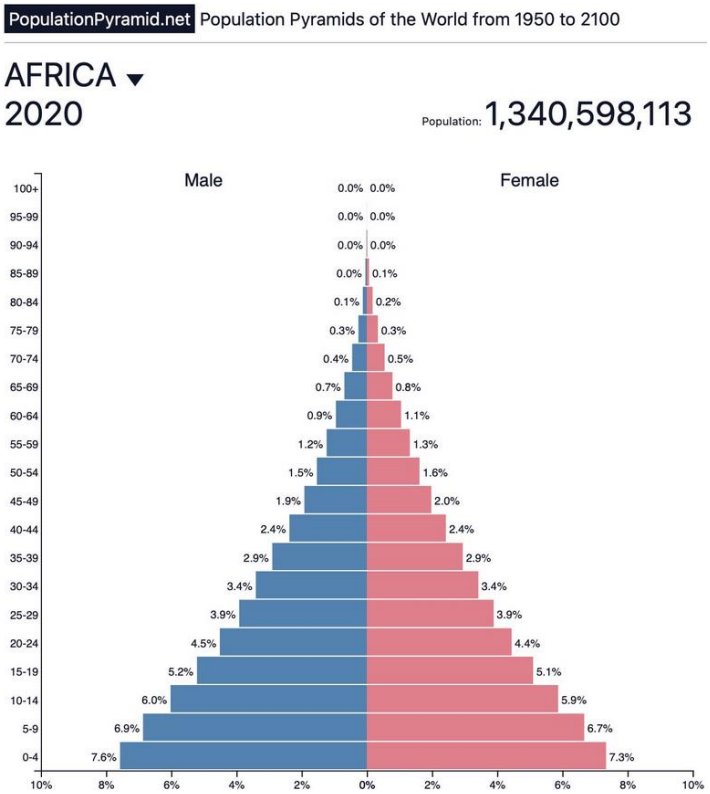


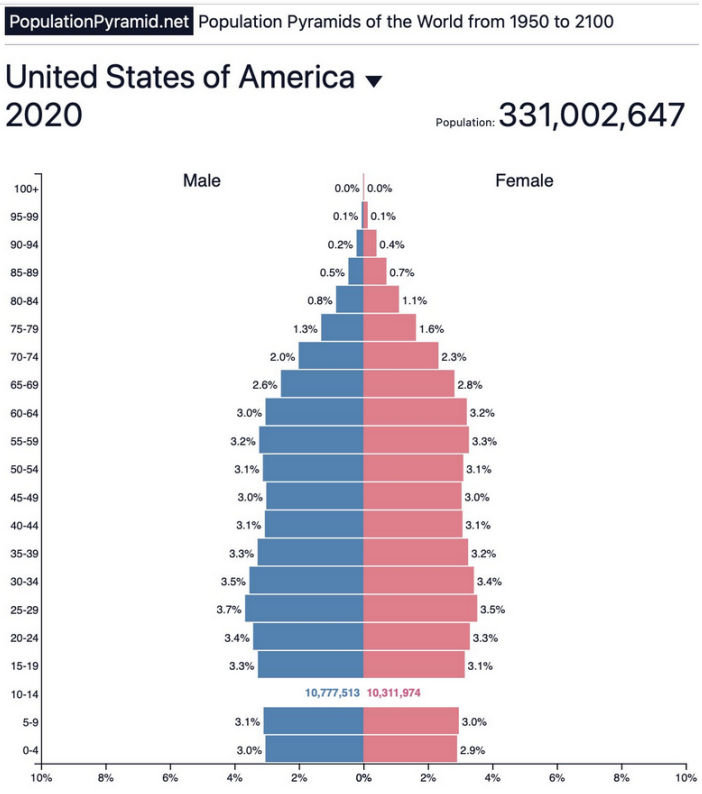
Source: Johns Hopkins University CSSE COVID-19 Data

Feb 19, 2020 — Feb 23, 2022

Age may be a factor

These graphs are slightly outdated as they are from 2020, but you can see the wide disparity in average age.



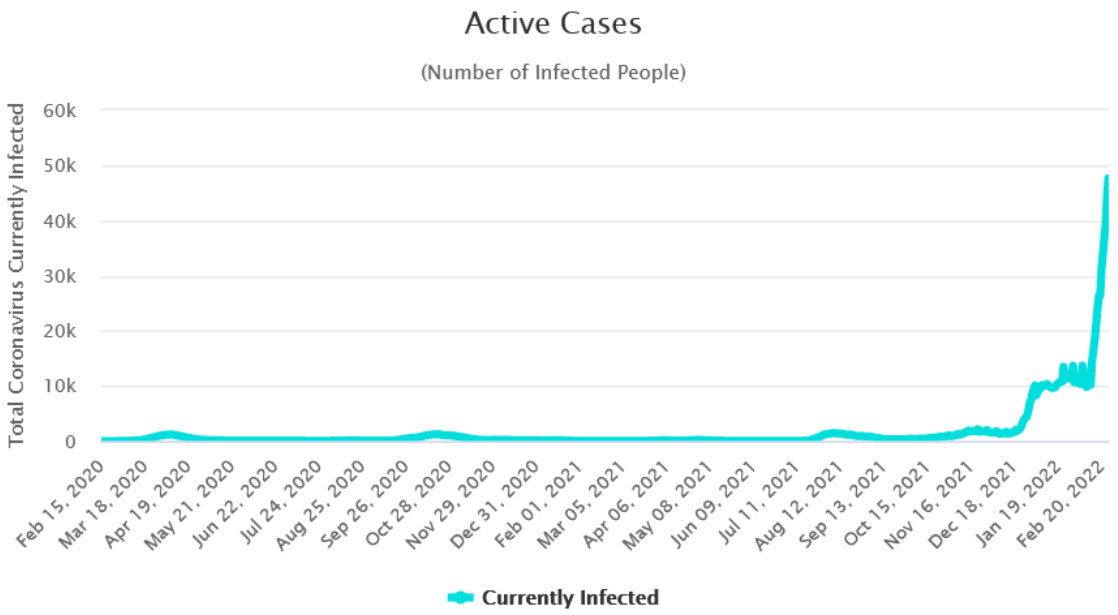


However, consider that one of the reasons that the average age in Africa is in part due to early deaths from infectious disease and malnutrition. However, that tragic fact would seem to make them more vulnerable to an infection like that from the virus that causes COVID-19. Of course, the common prophylactic use of Hydroxychloroquine and Ivermectin could be the wild card here!

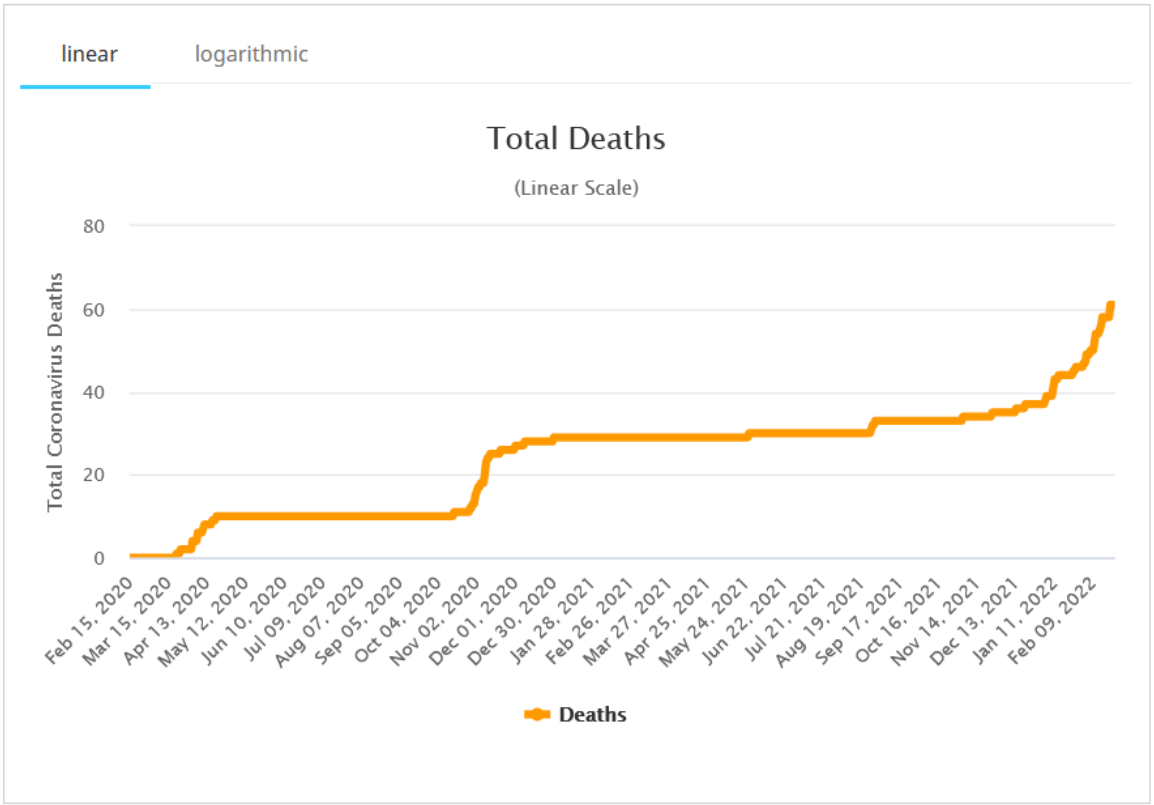
Continued on the next page…

Iceland, with 78% fully vaccinated and 67% boosted has the highest case rate in the world per million population

Active Cases in Iceland

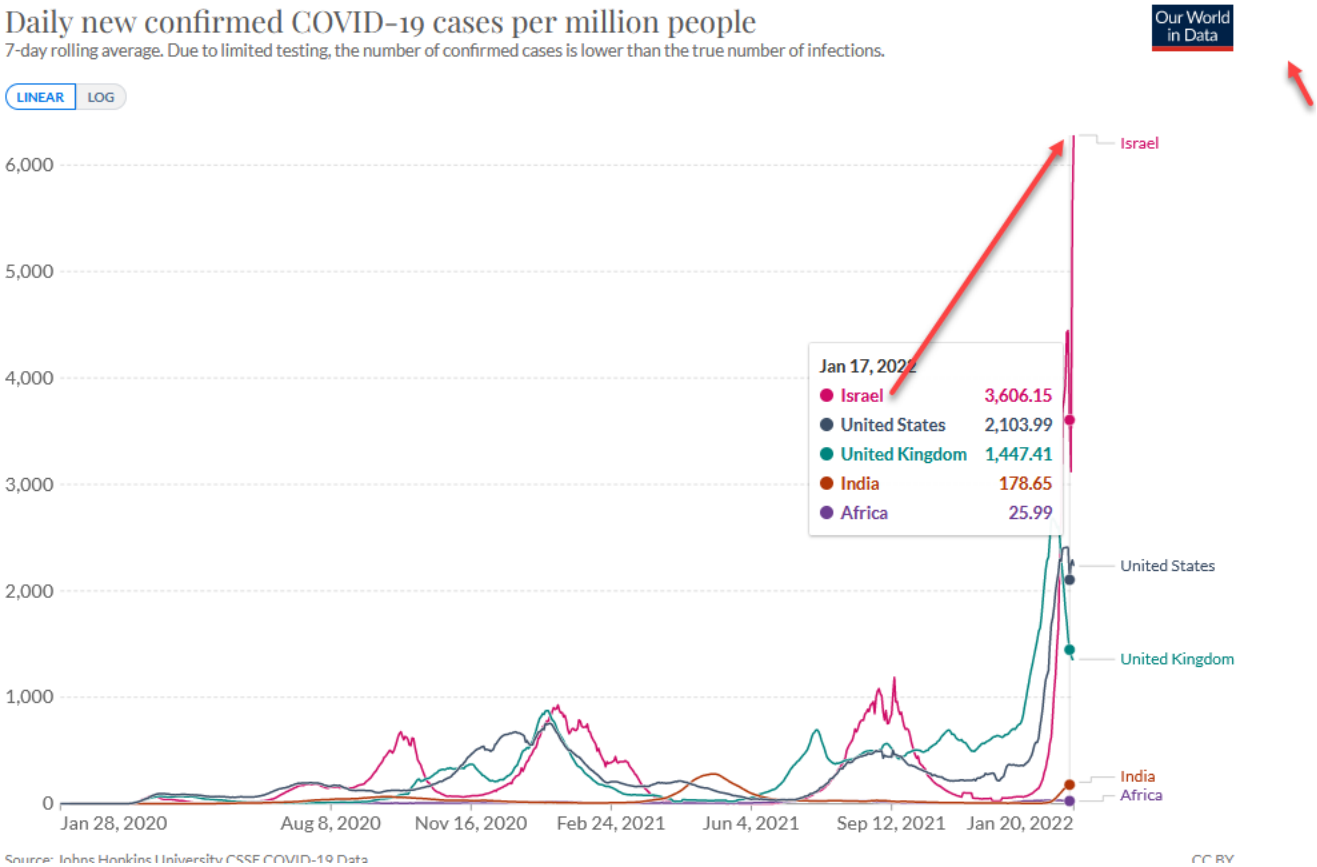


Total Coronavirus Deaths in Iceland



Let's check in on Israel. 4-shots and the highest case rates in the world on January 17th, 2022.

A picture is worth a thousand words…



This graph dramatically shows that the vaccines offered little protection against omicron.

Israel like most of the countries of the world has dropped off from this peak a little over a month ago. But that is due to the build-up of natural immunity, the waning of the virus and seasonality.

Three ways the CDC skews the "unvaccinated" numbers

The first way

The CDC doesn't consider a person fully vaccinated until a minimum of 6-weeks after their first dose. That is if the person gets their second dose on time 30 days after the first dose. Of course, many people do not. They procrastinate, get busy, have second thoughts and for many other reasons don't follow through on time. That means for large numbers of the population who may not get that second dose until a couple months after the first, means that they may be 10-weeks or more after their first dose until they get their second dose and are considered "fully vaccinated" 2-weeks later. How does that impact the numbers? Millions of people have contracted the infection and developed COVID-19 within that 6-week to 12-week window and are then classified as "unvaccinated" by the CDC for purposes of their statistics. So, whether that person is hospitalized or dies, they go into the unvaccinated column. Since these people are not fully vaccinated, but also are not truly UNvaccinated, they should have their own column "partially vaccinated." If we did that, the disparity

between the fully vaccinated and the unvaccinated would be much smaller if different at all. But then again if you don't parse out that large subgroup, that's how you effectively lie with numbers.

The second way

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)

The third way

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.

And with Omicron, the vaxxed have seen less and less benefit.

According to the data, which is submitted to the CDC by health departments across the country, the COVID-19 case rate in fully vaccinated people rose by more than 1,000 percent between Dec. 11, 2021, and Jan. 8, 2022.

The case rate among those who also received a booster dose skyrocketed as well, rising some 2,400 percent between the same dates.

While cases also rose among the unvaccinated, the jump in infections among the vaccinated closed the gap between the populations. As a result, people who haven't received a vaccine were just 3.2 times more likely to test positive for COVID-19 in January.

COVID-19-associated hospitalizations also increased among the vaccinated, from 1.4 per 100,000 for the fully vaccinated for the week ending Dec. 18, 2021, to 35.2 per 100,000 in the week ending Jan. 8, according to data from the CDC.

New evidence supporting that the genetically engineered spike protein from the shots can rapidly integrate into the DNA of the person who is injected

A study released February 25th, 2022 in the Journal ***Current Issues in Molecular Biology*** titled, **Intracellular Reverse Transcription of Pfizer BioNTech COVID-19 mRNA Vaccine BNT162b2 In Vitro in Human Liver Cell Line**, raises alarming concerns about what many top doctors and scientists have feared about the ability of the lab derived spike protein in the mRNA shots to integrate into the recipient's DNA.

The abstract

Preclinical studies of COVID-19 mRNA vaccine BNT162b2, developed by Pfizer and BioNTech, showed reversible hepatic effects in animals that received the BNT162b2 injection. Furthermore, a recent study showed that SARS-CoV-2 RNA can be reverse-transcribed and integrated into the genome of human cells. In this study, we investigated the effect of BNT162b2 on the human liver cell line Huh7 in vitro. Huh7 cells were exposed to BNT162b2, and quantitative PCR was performed on RNA extracted from the cells. We detected high levels of BNT162b2 in Huh7 cells and changes in gene expression of long interspersed nuclear element-1 (LINE-1), which is an endogenous reverse transcriptase. Immunohistochemistry using antibody binding to LINE-1 open reading frame-1 RNA-binding protein (ORFp1) on Huh7 cells treated with BNT162b2 indicated increased nucleus distribution of LINE-1. PCR on genomic DNA of Huh7 cells exposed to BNT162b2 amplified the DNA sequence unique to BNT162b2. Our results indicate a fast up-take of BNT162b2 into human liver cell line Huh7, leading to changes in LINE-1 expression and distribution. We also show that BNT162b2 mRNA is reverse transcribed intracellularly into DNA in as fast as 6 h upon BNT162b2 exposure.

Discussion

In this study we present evidence that COVID-19 mRNA vaccine BNT162b2 is able to enter the human liver cell line Huh7 in vitro. BNT162b2 mRNA is reverse transcribed intracellularly into DNA as fast as 6 h after BNT162b2 exposure. A possible mechanism for reverse transcription is through endogenous reverse transcriptase LINE-1, and the nucleus protein distribution of LINE-1 is elevated by BNT162b2.

A previous study on mRNA vaccines against H10N8mand H7N9 influenza viruses using a similar LNP delivery system showed that the mRNA vaccine can distribute rather nonspecifically to several organs such as liver, spleen, heart, kidney, lung, and brain…

In the BNT162b2 toxicity report, no genotoxicity nor carcinogenicity studies have been provided [26]. Our study shows that BNT162b2 can be reverse transcribed to DNA in liver cell line Huh7, and this may give rise to the concern if BNT162b2-derived DNA may be integrated into the host genome and affect the integrity of genomic DNA, which may potentially mediate genotoxic side effects. At this stage, we do not know if DNA reverse transcribed from BNT162b2 is integrated into the cell genome. Further studies are needed to demonstrate the effect of BNT162b2 on genomic integrity, including whole genome sequencing of cells exposed to BNT162b2, as well as tissues from human subjects who received BNT162b2 vaccination.

Conclusions

Our study is the first in vitro study on the effect of COVID-19 mRNA vaccine BNT162b2 on human liver cell line. We present evidence on fast entry of BNT162b2 into the cells and subsequent intracellular reverse transcription of BNT162b2 mRNA into DNA.

https://www.mdpi.com/1467-3045/44/3/73/htm

Toxicologist warns about the COVID jabs having the potential to affect fertility

This content is from a Mercola article titled, **Toxicologist Warns Against COVID Jabs** and is an interview of Dr Janci Chunn Lindsay, Ph.D., a molecular biologist and toxicologist.

Some key points from the article:

- April 23, 2021, Janci Chunn Lindsay, Ph.D., a molecular biologist and toxicologist, has called for an immediate halt to COVID-19 mRNA and DNA vaccines due to multiple safety concerns
- There's credible concern that the COVID jabs will cross-react with syncytin (a retroviral envelope protein) and reproductive genes in sperm, ova and placenta in ways that may impair fertility and reproductive outcomes
- In the case of the COVID shots, important animal studies that help ascertain toxic and systemic effects were not done. We're now seeing danger signals that are not being heeded. Preliminary safety results of mRNA COVID shots used in pregnant women,

published in April 2021, revealed an 82% miscarriage rate when the jab was administered during the first 20 weeks of pregnancy. *(I reported on this in a previous issue of my newsletter).*

- CDC data reveal more than 300 children between the ages of 12 and 18 have died from myocarditis, a now-recognized side effect of the COVID jab, yet the shot is now authorized for children as young as 5
- Since the COVID gene therapies do not prevent infection, but only lessen symptoms, they are actually a treatment, not a prevention. And there are far safer and more effective treatment available, including nebulized peroxide, ozone therapy, and hydroxychloroquine and ivermectin regimens

Janci Chunn Lindsay, Ph.D., is a molecular biologist and toxicologist and director of toxicology and molecular biology for Toxicology Support Services LLC. April 23, 2021, she delivered a three-minute public comment to the U.S. Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP).

Her expertise is analysis of pharmacological dose-responses, mechanistic biology and complex toxicity dynamics. In her ACIP comment (see video below), Lindsay described how she aided the development of a contraceptive vaccine in the 1990s that ended up causing unintended autoimmune destruction and sterility in animals which, despite careful pre-analysis, had not been predicted.

She explains:

"We were developing what was meant to be a temporary contraceptive vaccine, which was very attractive because it prevented fertilization rather than preventing implantation — or it should have; that was the idea.

Unfortunately, even though quite a bit of analysis was done in different animal models to make sure that it did not have an autoimmune action, it did end up having an autoimmune action and caused complete ovarian destruction.

Now it's used in that manner [for permanent sterilization] in dogs, cats and other animals. So, that's a cautionary tale of how animal studies can help us avoid mistakes in humans when they're used properly, and when proper animal studies are done."

Are COVID Jabs a Population-Wide Immunocontraceptive?

When asked what she thinks the motive behind this mass injection campaign might be, considering the clear danger signals, she replies:

"I certainly think that to discount that it is a form of population-wide contraceptive would be naïve. There's a paper that came out in 2005. It's called ***'Evaluation of Fusogenic Trophoblast Surface Epitopes as Targets for Immune Contraception****.'* See below

This paper tried to find *contraceptive peptides in persons that had infertility problems already that were isolated to placentation. So, it was taking a backwards approach, getting the sera from people who had fertility problems and trying to see what they had antibodies to that was causing the fertility problems …*

This work was sponsored by the WHO and the Rockefeller Foundation [and the National Institutes of Health]. No surprise there. It was then picked up by a company called AplaGen that took it to patent in 2007.

These are 12-mer peptides, and there's a series of eight of them that can be used to induce sterility. When they patented it, they also said that it could be used to ameliorate sterility. Interestingly, it was also associated with

all of the things that we know syncytin is associated with, — lupus, skeletal muscle disorders, bipolar depression [and] a number of other things.

Even though they don't name syncytin proteins as the proteins that are targeted, they worked backwards from these peptides, and then said they were a series of other proteins. Sometimes we know that proteins can be called the same thing in different discovery realms. So, that's going to take more research, but it was certainly interesting to me.

What it really points out is that there were efforts to use peptides or immune-contraceptive means at the placental trophoblast interface to cause sterilization … So, it would be naïve to think that this was not on the plate for future use."

Evaluation of fusogenic trophoblast surface epitopes as targets for immune contraception

Contraception. 2005 Apr;71(4):282-93. doi: 10.1016/j.contraception.2004.12.022.

- PMID: **15792647**
- DOI: 10.1016/j.contraception.2004.12.022

The Abstract (red highlights are mine)

Syncytial trophoblast fusion is an essential step in the process of implantation. This project is aimed at the immunological inhibition of syncytial trophoblast fusion as a novel approach to contraception. Fusion-inhibiting recombinant antibodies were generated and used together with autoantibodies from patients with repetitive in vitro fertilization (IVF) failure that were shown to inhibit syncytial fusion and are expected to inhibit implantation, to generate anti-idiotypic peptides. These peptides mimic trophoblast epitopes essential for syncytial fusion and are, therefore, considered specific immunogens for the generation of antibodies that will inhibit implantation. To verify their physiological role in humans, 300 anti-idiotypic peptides were tested for their binding capacity to patient autoantibodies associated with repetitive IVF failure, habitual abortion and preeclampsia. Of these, only three peptides were found to selectively bind to autoantibodies of patients with repetitive IVF failure and were considered safe and efficient enough for evaluation in preclinical and clinical studies required for the development of immune contraceptives. **When used as immunogens, these peptides are expected to elicit an antibody response inhibiting syncytial fusion and thus implantation.** Furthermore, the action of these antibodies needs to be restricted to the stage of syncytium formation at the time of implantation so as not to cause complications of pregnancy in those cases where they fail to have a contraceptive effect. To exclude potential side effects on other systems, toxicological experiments in animals are in progress.

https://www.contraceptionjournal.org/article/S0010-7824(05)00018-1/fulltext

This next study raises concerns about the effects of the shots, although the authors downplay it.

This 2022 study published in ***Obstetrics and Gynecology*** titled, **Association Between Menstrual Cycle Length and Coronavirus Disease 2019 (COVID-19) Vaccination**, found that women who had the shots saw a change in the length of their menstrual cycle of one day as compared to no change in the unvaxxed women in the study.

From the study

We evaluated 23,754 menstrual cycles prospectively reported by 3,959 U.S. individuals to evaluate whether COVID-19 vaccination is associated with menstrual cycle disturbances during cycles when vaccination occurs.

Statistically significant differences existed between vaccination status groups, but the change in cycle length was less than 1 day, which is below the reportable difference in the menstrual cycle tracking application and is not clinically significant. A subset of individuals who received both vaccine doses in a single cycle had, on average, an adjusted 2-day increase in their vaccination cycle length compared with unvaccinated individuals. Although approximately 10% of these individuals experienced a clinically notable change in cycle length of 8 days or more, this change attenuated quickly within two postvaccine cycles.

https://pubmed.ncbi.nlm.nih.gov/34991109/

My comment

To me this is a disturbing signal that any change in the normal cycle was seen. Couple that with the Japanese biodistribution study I reported on where there was a large accumulation of the mRNA lipid nanoparticles from the injections in the ovaries. 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.

And, then consider the previous story and then the next one I have for you and like me I think you would say, "Houston, we have a problem."

Department of Defense data shows a significantly higher rate of miscarriages in female personnel who received the COVID-19 injections.

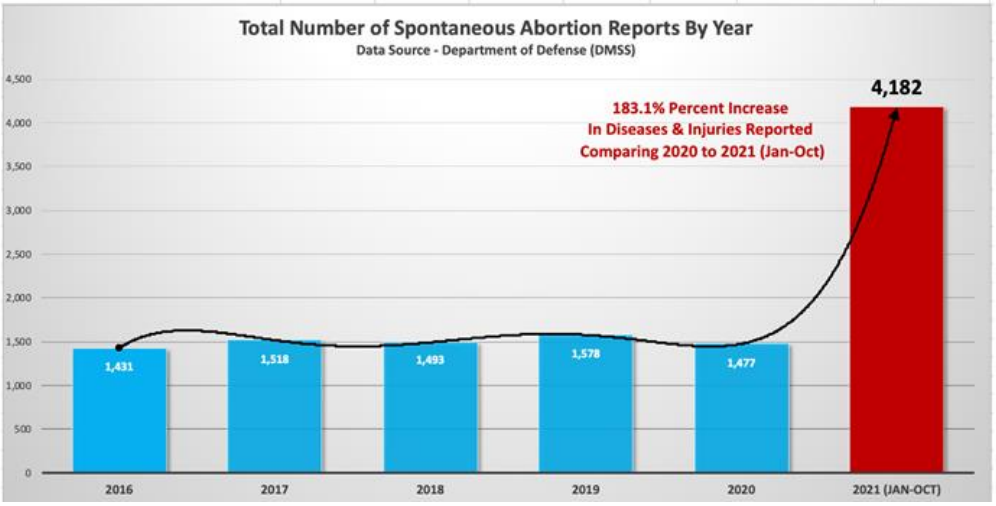
This story is from a Substack article by Jessica Rose

I am going to hit on spontaneous abortions in this article, since I have already written up an estimate of the Under Reporting Factor (URF) using the DMED data in a previous Substack article. I will use the exact same protocol as before, but I will substitute in the 'updated' numbers for 2016-2020 to calculate the URF.
This is a screenshot of the original DoD analysis of spontaneous abortions from 2016-2021 (until October).

See graphics on the next page…

This is a screenshot of the original DoD analysis of spontaneous abortions from 2016-2021 (until October).

Diagnosis	2016	2017	2018	2019	2020	Total 2016 to 2020	2021 (Jan-Oct)
Spontaneous Abortion	1,431	1,518	1,493	1,578	1,477	7,497	4,182

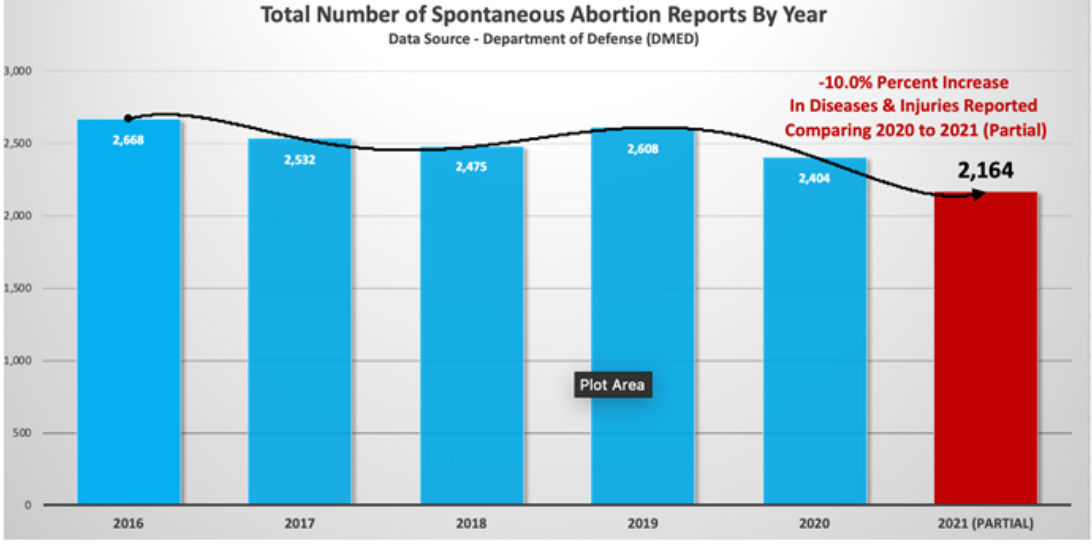


According to the data, the total number of spontaneous abortions (miscarriages) ***each year*** for the past 5 years (2016-2020) was 1,499.[3] According to VAERS data, in 2021 the number of reports of spontaneous abortions was 3,527.[4]

Let's calculate the background rate of spontaneous abortions using the DMED data. The total number of women enlisted and on active duty in the U.S. military in 2020 was 226,417 (this represents the 17.2% female population enrolled + active in 2020 (N = 1,333,822)). Therefore, the background rate based on the pre-COVID injection roll-out DMED data is 662 spontaneous abortions per 100,000 women (~1/151). This includes all women including women 41 years and older.

And this is a screenshot of the 'updated' analyzed data for spontaneous abortions. You cannot make this shit up. This arrived a few days later.

Diagnosis	2016	2017	2018	2019	2020	Total 2016 to 2020	2021 (Partial)
Spontaneous abortion (First Occurrence)	2,668	2,532	2,475	2,608	2,404	12,687	2,164



So, let's amend the calculations with their 'updated' data.

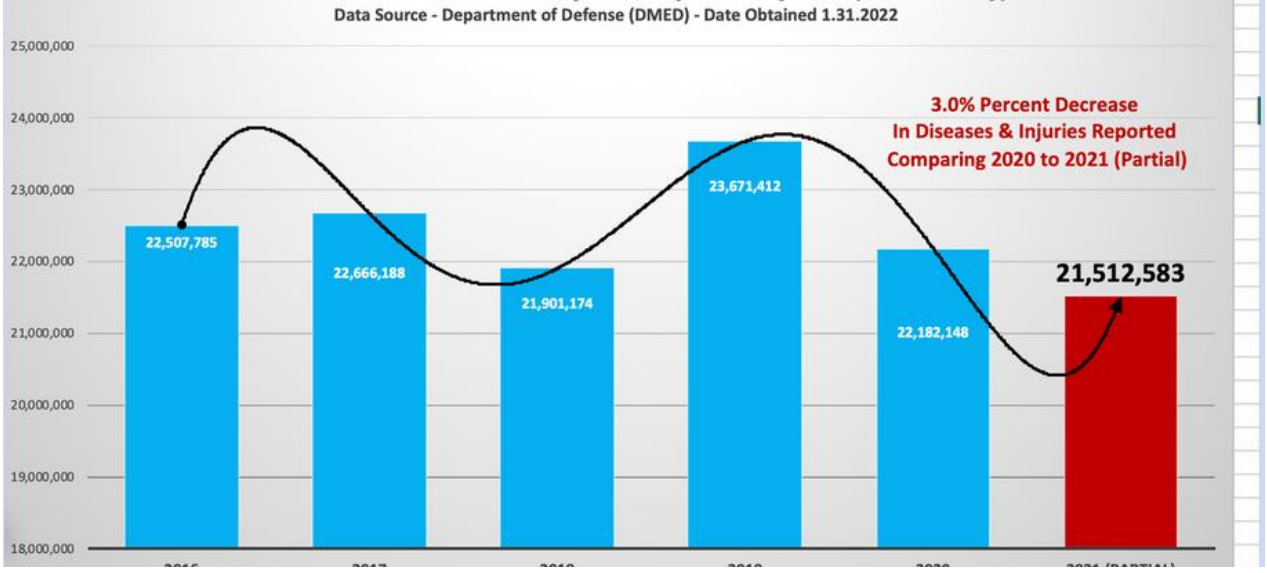
According to the data, the total number of spontaneous abortions (miscarriages) ***each year*** for the past 5 years (2016-2020) was 2,537. According to VAERS data, in 2021 the number of reports of spontaneous abortions was 3,527.

Let's calculate the background rate of spontaneous abortions using the DMED data. The total number of women enlisted and on active duty in the U.S. military in 2020 was 226,417 (this represents the 17.2% female population enrolled + active in 2020 (N = 1,333,822)). Therefore, the background rate based on the pre-COVID injection roll-out DMED data is 1,120 spontaneous abortions per 100,000 women (~1/89). This includes all women including women 41 years and older.

The number of females of child-bearing age (CDC: women ages 12-49) injected in the U.S. with at least one dose of COVID-19 product is 63,384,802 according to the CDC.6 Considering the 3,527 reports of spontaneous abortions to VAERS in 2021, the rate of reporting of spontaneous abortions in VAERS is 5.6/100,000 women. To get to the estimated rate in the DMED, we need to multiply our VAERS rate by 200. This means, the URF for spontaneous abortion in VAERS is 200. When we apply this URF we get 705,400 spontaneous abortions.
So what's going on here? It's not that I don't buy that the 'real' numbers are these updated ones for the spontaneous abortion rates but if they are, then our URF is way higher.

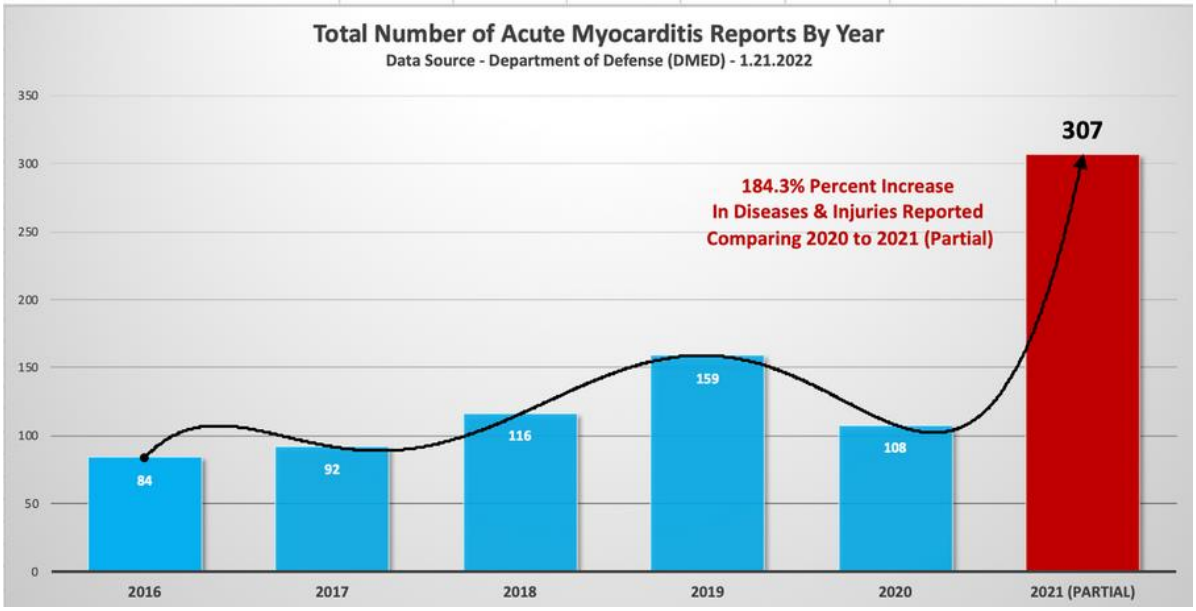
If there are 22,585,741 reports of diseases and injuries as a 5-year average in the U.S. military, and these are not regular check-ups, then you guys might have a serious problem on your hands. It is possible that these ambulatory visits are normal check-ups. Time will tell.

Diagnosis	2016	2017	2018	2019	2020	Total 2016 to 2020	2021 (Partial)
All disease and injuries (Amb)	22,507,785	22,666,188	21,901,174	23,671,412	22,182,148	112,928,707	21,512,583

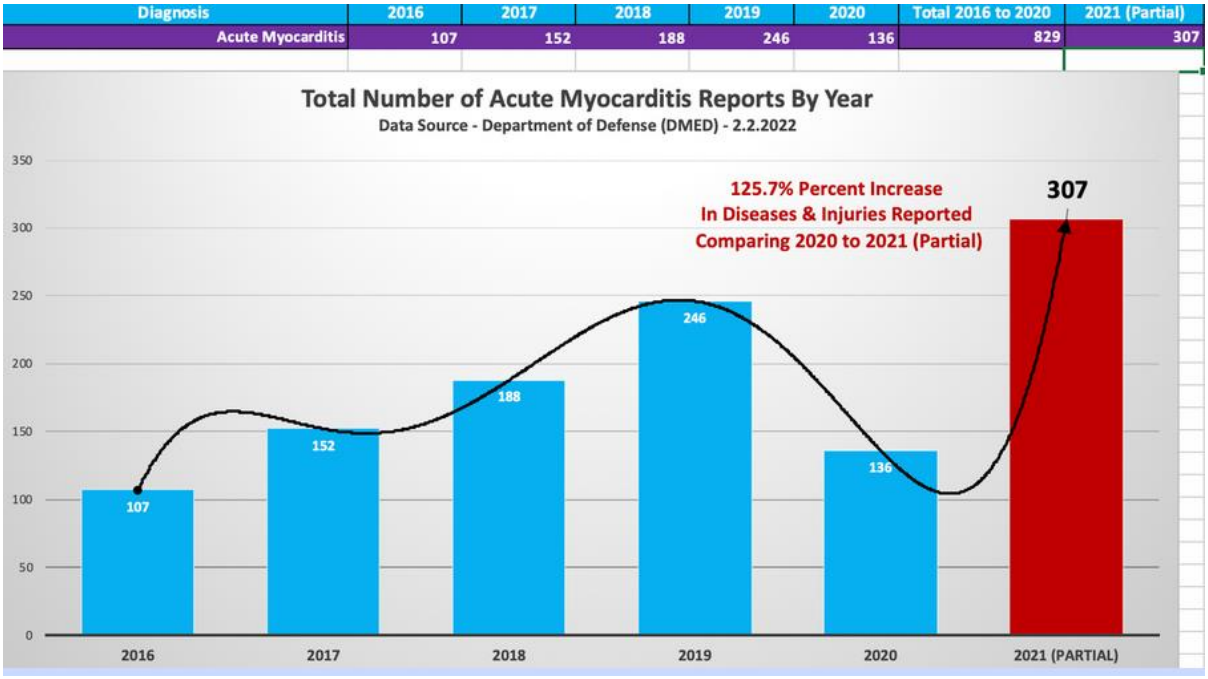


Also, seriously suspicious is that only some categories or reported adverse events were 'updated'. The ones that have been reported on, for example, and also myocarditis. Those numbers actually rose just slightly in the adjusted 'updated' data.

Diagnosis	2016	2017	2018	2019	2020	Total 2016 to 2020	2021 (Partial)
Acute Myocarditis	84	92	116	159	108	559	307



Diagnosis	2016	2017	2018	2019	2020	Total 2016 to 2020	2021 (Partial)
Acute Myocarditis	107	152	188	246	136	829	307



I find this highly disturbing. I don't even care why it's happening. I care ***that*** it's happening. THIS SHOULDN'T HAPPEN IN A GOVERNMENT DATABASE. Even if we buy their own story that the previous 5 years of data were simply not updated, then we can ask the simple question: why the hell not? And how the hell do you expect anyone to think your 'updated' data is fine? It's not fine.

The next step would be to check out what these numbers would mean per person. If we include the non-active military members in our military personnel count, the total number of military personnel would be 3.5 million, including DoD Active Duty military personnel (1,333,822) for 2020. In 2020, according to their 'updated' data, 22,182,148 ambulatory (not confined to bed) reports were made. So this would mean that every single person would have had to have made 6 reports each in that year. If we only use the active duty personnel, each active member would had to have filed 16 ambulatory reports each.

I think someone is rigging this data. I just don't buy that this kind of floopiness could be possibly be going on in a U.S. military database. So the question becomes, who's doing this and why? And how the hell is this our reality? Why the hell is so much energy wasted in this kind of crap? Why can't everyone just be like Buckminster Fuller?

https://jessicar.substack.com/p/spontaneous-abortion-urf-in-department

This is a link to a recent interview/presentation that Dr. Jessica Rose did on the VAERS reporting system and what is being seen related to adverse events from the COVID jabs.
https://www.voiceforscienceandsolidarity.org/videos-and-interviews/jessica-rose-on-vaers-at-the-covid-health-symposium

Now for a more in-depth assessment of some of the other changes that have appeared on the DOD database since the alarming figures were first released.

Widespread and significant data changes appear on the DOD database after questions were raised about spikes in reports of adverse events after COVID injections to military personnel

This story is a bombshell! Not just what the original data showed, but what has happened to the alteration of the data after it was discovered.

The story comes from an article on ***The Blaze*** by Michael Horowitz February 7th, 2022 and is titled, **Horowitz: The Pentagon's RESPONSE to the explosive DOD medical data is an even bigger story than the data .**

The article

One thing is clear about the revelation of the 2021 military epidemiological data and the military's response to it: There is undoubtedly a public health and national security crisis in the military, and the Pentagon's reaction only seems to be concerned with exonerating the vaccine, not fixing its own alleged problem.

It's now certain that the military's health surveillance system — DMED — showed a massive increase in sickness and injury diagnoses in 2021 over previous years, particularly in the neurological, cardiovascular, oncological, and reproductive health categories. The military, in a very terse and cryptic statement to PolitiFact last week, admitted as much, but claimed without any further explanation that the data in the system accessed by several military doctors working with attorney Thomas Renz was only a "fraction" of the true numbers that existed. In the words of the Pentagon spokesman, it was a "glitch in the database." Where those true numbers existed, why they weren't in the system for five years, what exactly was in the system, and why the 2021 numbers were accurate according to the DOD account remain a mystery.

However, one by one, the military public health officials have been adding back random numbers to the 2016 through 2020 codes. I'm told by Renz and two of the whistleblowers that throughout the past week, they have queried the same data again, and in most of the ICD categories, they have found that the numbers from 2016

through 2020 were “increased” exponentially to look as though 2021 was not an abnormal year. This has been done without any transparency, any press release, any statement of narrative, and sloppily in a way that makes the already unbelievable narrative simply impossible to believe.

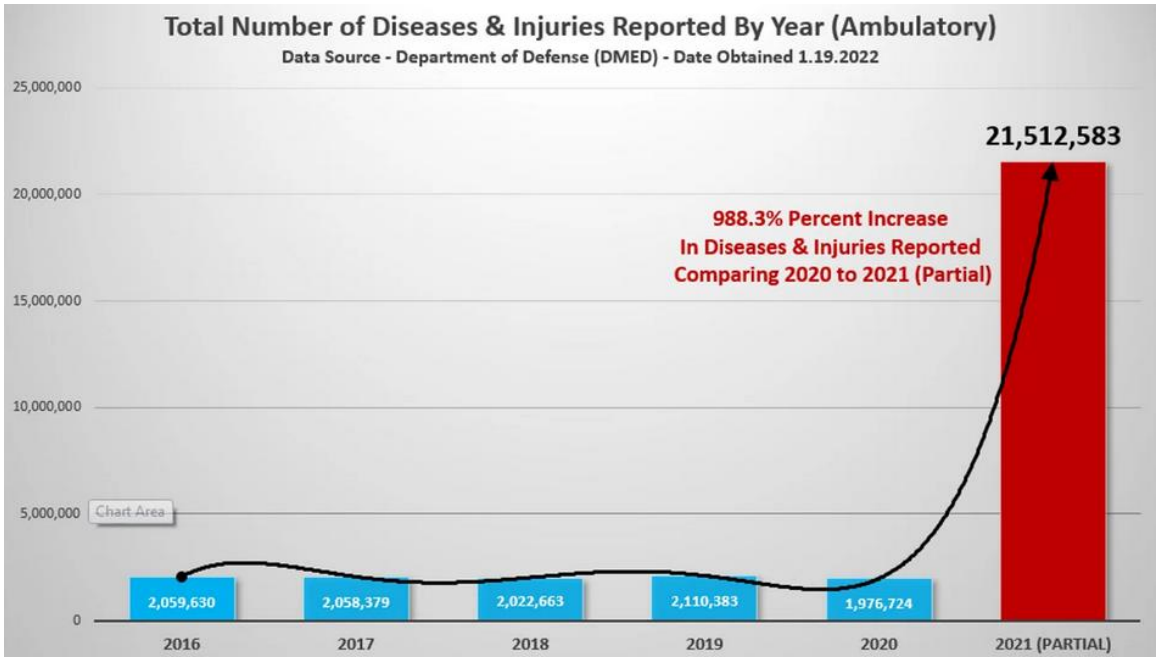
In addition to believing that every epidemiological report for five years was somehow completely tainted with false data — including during the first year of the pandemic itself — we would have to believe that the minute they discovered this from Renz, they suddenly discovered the exact numbers. A five-year mistake fixed overnight!

Just take a look at the following statement given to the Epoch Times, the only other public comment delivered by an authorized Pentagon spokesman: “Comparing the DMED database to the source data contained in DMSS, AFHSD discovered that the total number of medical diagnoses from 2016-2020 that were accessible in DMED represented only a small fraction of actual medical diagnoses for those years. In contrast, the 2021 total number of medical diagnoses were up to date in DMED. Comparison of 2021 to 2016-2020 resulted in the appearance of significant increased occurrence of all medical diagnoses in 2021 because of the under-reported data for 2016-2020. AFHSD has taken DMED offline to identify and correct the root-cause of the data corruption,” said Maj. Charlie Dietz.

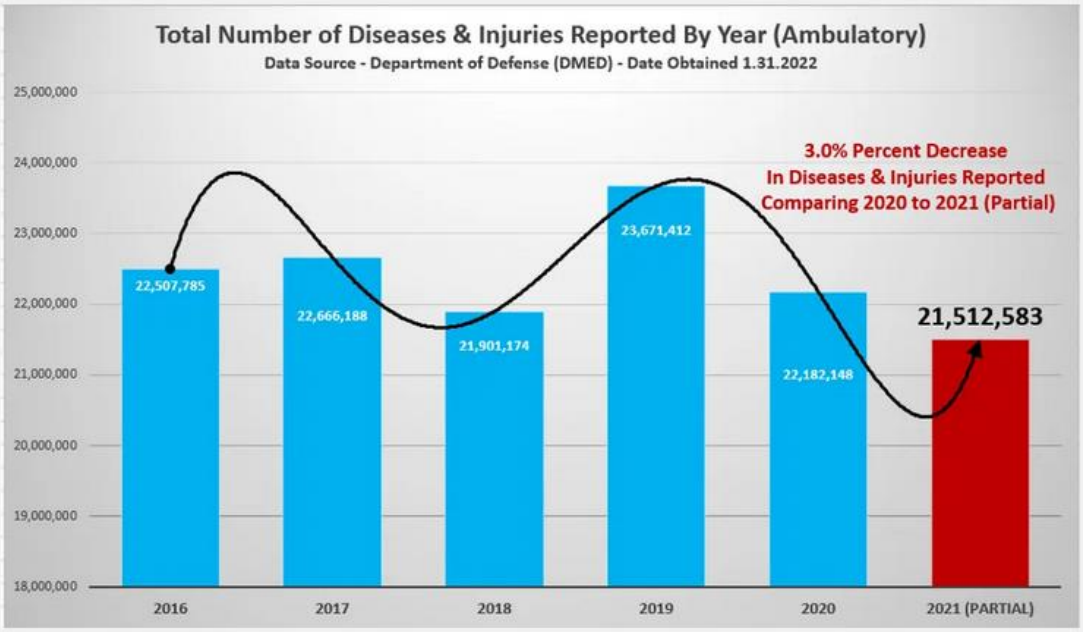
That’s it! They are only concerned with downplaying any potential culpability of the vaccine, not explaining how they were flying blind, according to their official narrative, on such an important endeavor for so many years. Just consider the fact that at last week’s meeting of the CDC's Advisory Committee on Immunization Practices (ACIP), officials revealed that they have been monitoring vaccine safety data from the DOD, among other places.

You know what that means? The CDC was looking at data for months that showed insane safety signals and did nothing about it, and somehow nobody in HHS or the DOD all along thought the data was a “glitch.” Moreover, the DOD’s new data (as presented on Renz’s website) that was somehow updated so quickly is impossible to believe for a number of other reasons. Take a look at the top-line number of ICD codes in 2016-2020, as reflected in the data before the DOD tampered with it to input the new updated numbers.

Here is the original data of total annual outpatient diagnoses in DMED before the Pentagon changed it:



And here is the top-line tally for 2016-2020 based on the new numbers added:



This is a bar graph presentation from Thomas Renz contrasting the 2016-2020 total outpatient ICD diagnosis codes in the military before the DOD change and after the change. As you can see, during a typical year, there were about 2 million diagnosis codes, jumping almost tenfold in 2021. However, based on the changes made last week, 2021 is exactly in line with every other year (even though 2021 remains slightly lower; the data does not include numbers from December).

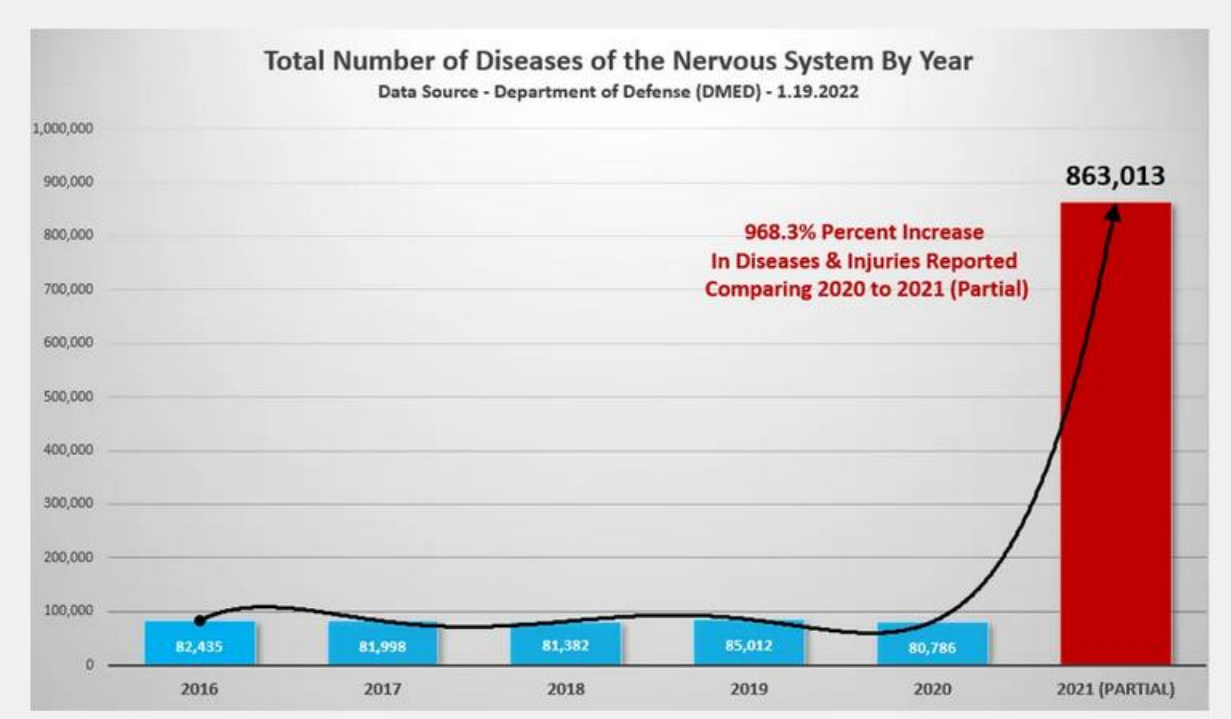
Here's the problem with such an alleged presentation of the data. Putting the vaccines aside, the DOD's "new" model would literally erase the existence of COVID off the face of the planet as if we never had the biggest pandemic of our lifetime. Even if the vaccine never caused a single doctor's visit, COVID alone had to increase the codes. Yes, the military is generally very young, and deaths and hospitalizations were relatively low, but it's impossible to believe that especially during the vicious Delta outbreak since the summer, there was no increase in COVID-related doctor's visits. Just long COVID alone had to register a meaningful increase. Ironically, the Biden administration is forcing a vaccine mandate for a virus that, according to this alleged new data, didn't cause even a 1% increase in baseline outpatient doctor's visits this year!

The data originally reflected on DMED that was downloaded by the whistleblowers a few weeks ago makes much more sense because it accommodates both COVID and vaccine injury, which would explain the unprecedented increase. Now, obviously, COVID alone can't explain all the increases, because some of the specific data points presented have already been associated with the vaccine injury, per VAERS and other studies, as opposed to the virus.

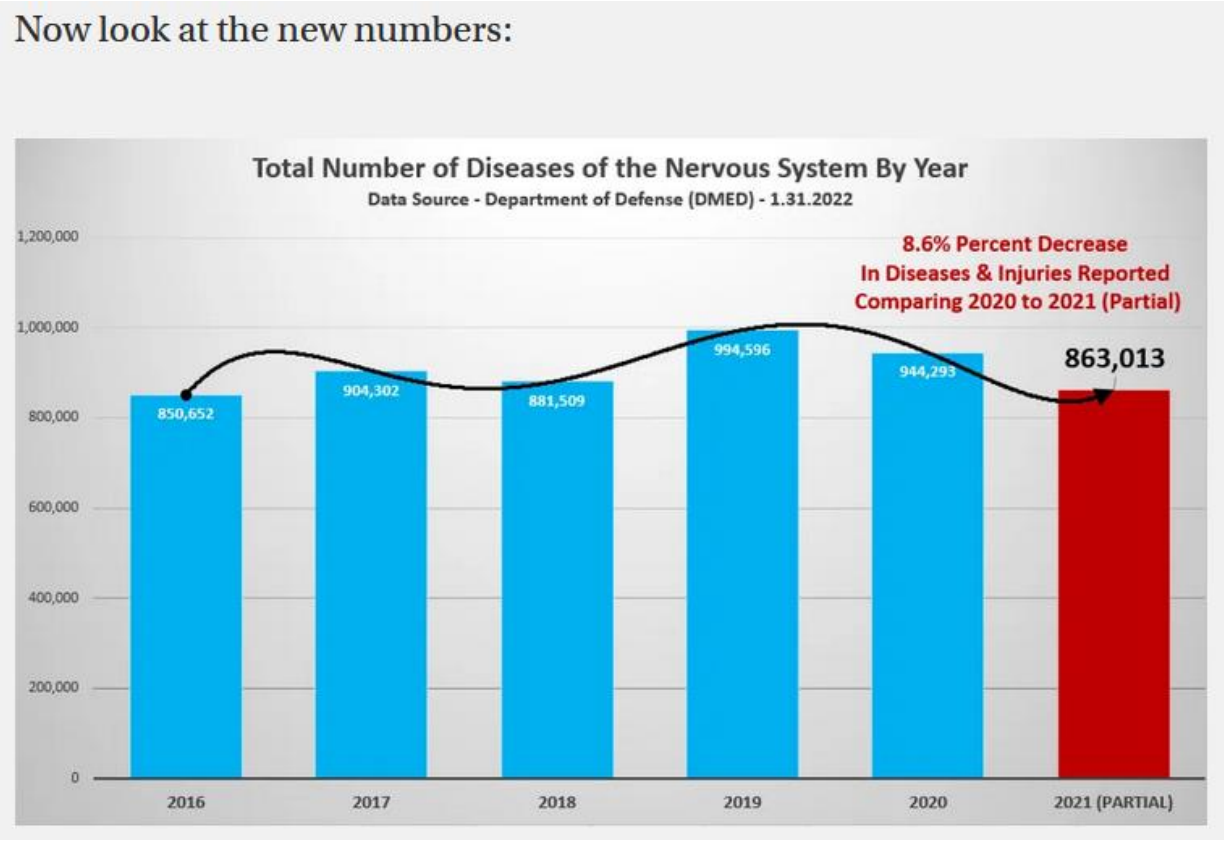
More fundamentally, it is simply ludicrous to suggest that there are this many diagnoses in the military in a given year. All active-duty soldiers have to be medically screened. Obesity, diabetes, and heart conditions are very rare, and the population is generally very young. If we really have over 20 million diagnoses every year in the military (consisting of about 1.4 million active-duty personnel), there is something seriously wrong, and that in itself is a huge story.

Let's drill down to some specific ICD codes to drive home this point.

Take a look at the data for nervous system diagnoses before the numbers were altered:



Now look at the new numbers:

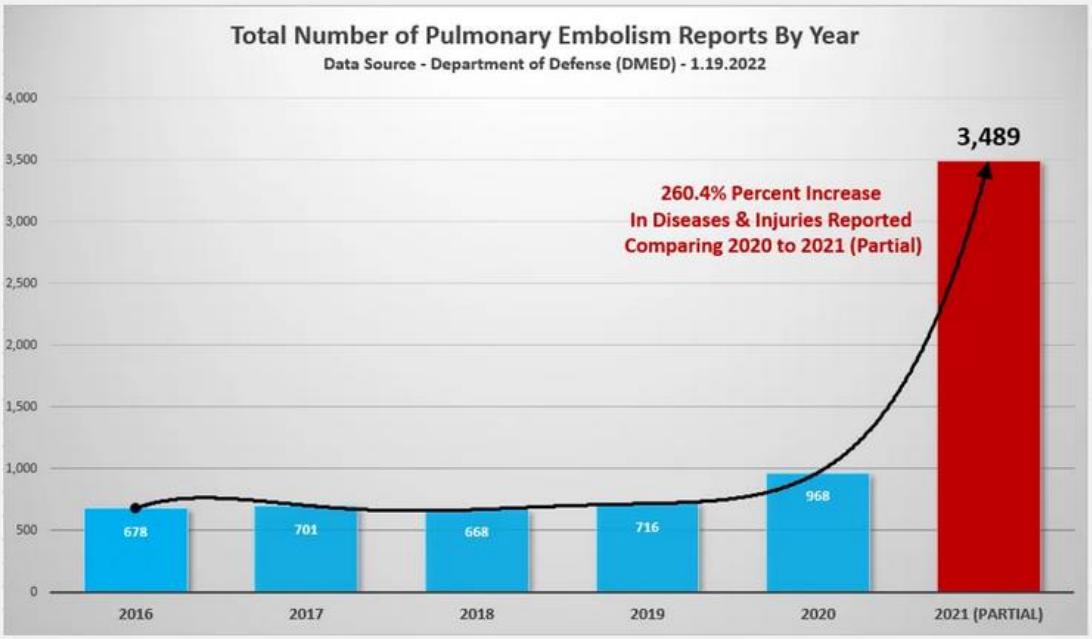


We are to believe that there was ZERO increase in the year of the Delta pandemic as well as what we already know from the civilian world about vertigo and migraines following the shots? We were all shocked by the percentage increase, but to say there was no increase whatsoever defies any expectation. Moreover, we are to believe that there are nearly 1 million nervous system diagnoses in the military every year in a fighting force of 1.4 million?

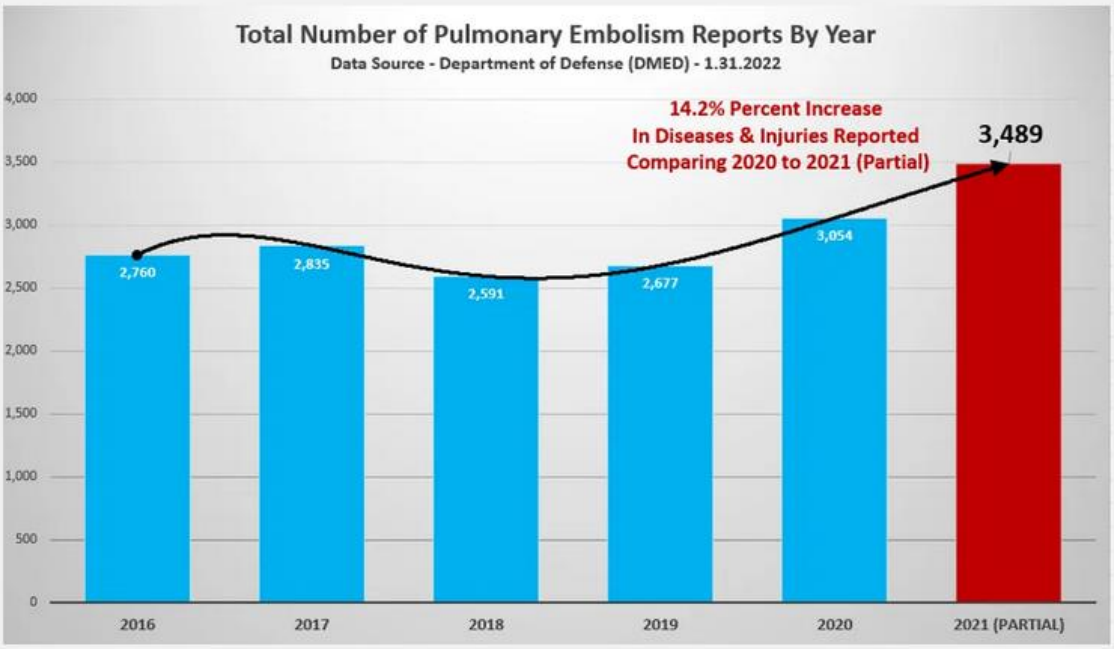
To further explore this point, let's look at the number of pulmonary embolism diagnoses before and after the DOD "fixed" the data. Blood clotting in the longs is a clear consequence of the spike protein, which sticks to CD-147 receptors on blood vessels.

See next page…

Here are the numbers before:



And here are the numbers after the DOD alteration:

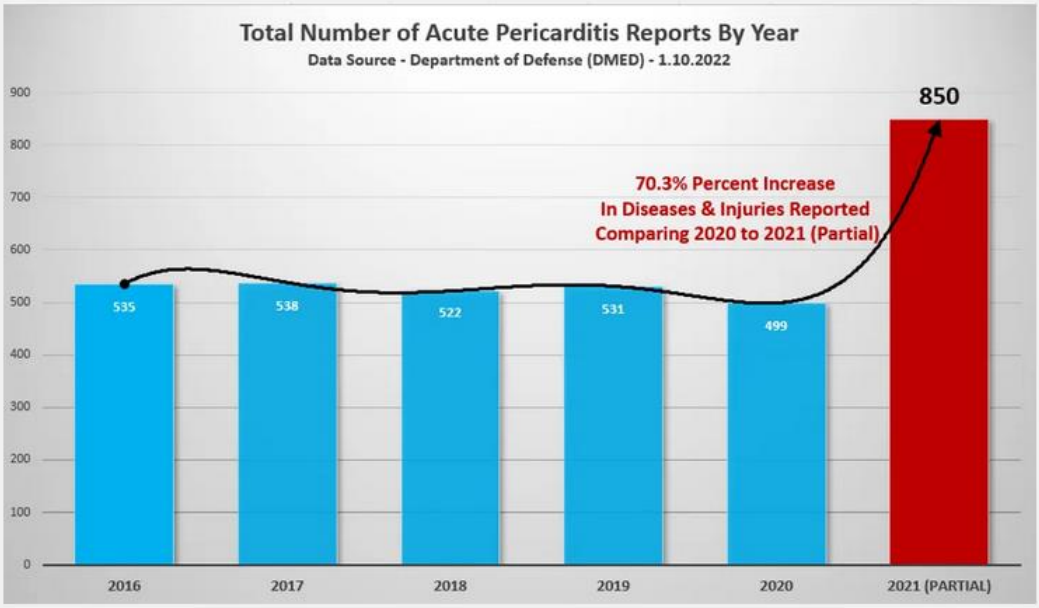


While even the “revised” numbers do show some degree of increase, it is not enough to account for the unprecedented nature of both COVID and the COVID vaccines. But the more serious issue is how can a military of healthy young people have such a high baseline of pulmonary embolisms every year? One estimate of pulmonary embolism prevalence in the U.S. is between 60 and 70 per 100,000 per year. But that is almost exclusively in the elderly and sicker population. Soldiers 20 to 25 years old don’t exactly get pulmonary

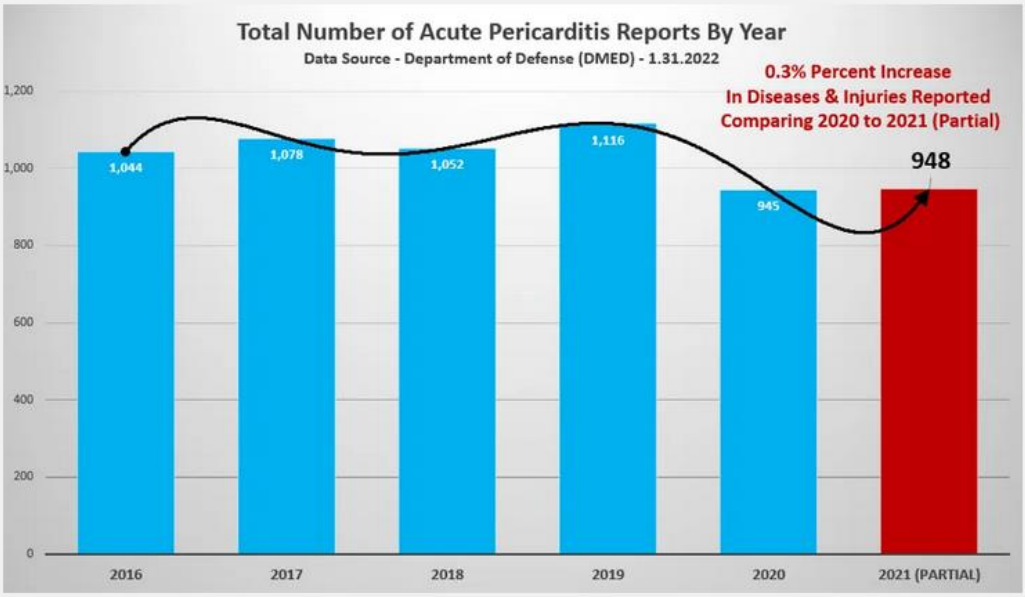
embolisms. So even accounting for the fact that these are diagnosis codes and not unique individuals (some might have had a few visits in a year), the numbers are way too high.

Finally, it's important to note that the DOD is so overprotective of the vaccine that it revised numbers to show zero increase in ailments that are universally understood to have increased – at least to some extent – because of the vaccine. Although they were smart enough to still show a baseline increase in myocarditis (everyone knows that), the new numbers would indicate zero increase for pericarditis. (emphasis mine)

Here is the original data queried by the whistleblowers:



And here is the new data, which seem to indicate no unusual increase, even if we add in the missing month for 2021:



The silence both from the media and congressional members of the House and Senate Armed Services Committees is astounding. One of two things is true: Either there was mass vaccine injury in the military, or our military has been very unhealthy and the Pentagon completely lost control over epidemiological surveillance of these health issues for years. Either way, this is the story of the year.

End of story

https://www.theblaze.com/op-ed/horowitz-the-pentagons-response-to-the-explosive-dod-medical-data-is-an-even-bigger-story-than-the-data

This may be one of the triggers that caused the ***Department of Defense*** to "recalculate" the previous 5-year's data. It is a letter from Senator Ron Johnson of Wisconsin sent on February 1st, 2022, to the Secretary of Defense Lloyd J. Austin III.

United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510-6250

February 1, 2022

The Honorable Lloyd J. Austin III
Secretary
Department of Defense

Dear Secretary Austin:

On January 24, 2022, I held a roundtable featuring world renowned doctors and medical experts who shared their perspectives on COVID-19 vaccine efficacy and safety and the overall response to the pandemic.[1] At that roundtable, I heard testimony from Thomas Renz, an attorney who is representing three Department of Defense (DoD) whistleblowers, who revealed disturbing information regarding dramatic increases in medical diagnoses among military personnel. The concern is that these increases may be related to the COVID-19 vaccines that our servicemen and women have been mandated to take.

Based on data from the Defense Medical Epidemiology Database (DMED), Renz reported that these whistleblowers found a significant increase in registered diagnoses on DMED for miscarriages, cancer, and many other medical conditions in 2021 compared to a five-year average from 2016-2020.[2] For example, at the roundtable Renz stated that registered diagnoses for neurological issues increased 10 times from a five-year average of 82,000 to 863,000 in 2021.[3] There were also increases in registered diagnoses in 2021 for the following medical conditions:[4]

- Hypertension – 2,181% increase
- Diseases of the nervous system – 1,048% increase
- Malignant neoplasms of esophagus – 894% increase
- Multiple sclerosis – 680% increase
- Malignant neoplasms of digestive organs – 624% increase
- Guillain-Barre syndrome – 551% increase
- Breast cancer – 487% increase
- Demyelinating – 487% increase
- Malignant neoplasms of thyroid and other endocrine glands – 474% increase

[1] Press Release, *VIDEO RELEASE Sen. Ron Johnson COVID-19: A Second Opinion Panel Garners Over 800,000 Views in 24 Hours*, Jan. 25, 2022, https://www.ronjohnson.senate.gov/2022/1/video-release-sen-ron-johnson-covid-19-a-second-opinion-panel-garners-over-800-000-views-in-24-hours.
[2] *COVID-19: A Second Opinion*, Rumble, Jan. 22, 2022, https://rumble.com/vt62y6-covid-19-a-second-opinion.html

A new Lancet Journal article documents cases of Multisystem Inflammatory Syndrome in teens after receiving the COVID-19 shots

A new article published February 22nd, 2022 in the ***Lancet*** titled, **Reported cases of multisystem inflammatory syndrome in children aged 12–20 years in the USA who received a COVID-19 vaccine, December, 2020, through August, 2021: a surveillance investigation**, reports on "rare" cases of this serious illness in children after receiving the COVID-19 shots. Multisystem Inflammatory Syndrome is a condition that was reported in rare instances after illness from the SARS-CoV-2 virus. Now it appears that it can occur from the injections themselves. Not surprising considering that the target portion of the virus selected for use in the vaccines was the most dangerous part of the virus itself.

Introduction

Multisystem inflammatory syndrome in children (MIS-C), also known as paediatric inflammatory multisystem syndrome temporally associated with SARS-CoV-2, is a rare but serious complication of SARS-CoV-2 infection in children and adolescents that generally occurs 2–6 weeks after SARS-CoV-2 infection.1 MIS-C, first recognised in April, 2020, is characterised by fever, systemic inflammation, and multisystem organ involvement.1–4 From May 14, 2020, to Nov 30, 2021, 5973 cases were reported to the MIS-C national surveillance system of the US Centers for Disease Control and Prevention (CDC).5 The pathogenesis of MIS-C is hypothesised to involve a dysregulated immune response to SARS-CoV-2 infection, and host genetics might alter susceptibility to developing MIS-C.

Findings

Using surveillance results from Dec 14, 2020, to Aug 31, 2021, we identified 21 individuals with MIS-C after COVID-19 vaccination. Of these 21 individuals, median age was 16 years (range 12–20); 13 (62%) were male and eight (38%) were female. All 21 were hospitalised: 12 (57%) were admitted to an intensive care unit and all were discharged home. 15 (71%) of 21 individuals had laboratory evidence of past or recent SARS-CoV-2 infection, and six (29%) did not. As of Aug 31, 2021, 21 335 331 individuals aged 12–20 years had received one or more doses of a COVID-19 vaccine, making the overall reporting rate for MIS-C after vaccination 1·0 case per million individuals receiving one or more doses in this age group. The reporting rate in only those without evidence of SARS-CoV-2 infection was 0·3 cases per million vaccinated individuals.

Interpretation

Here, we describe a small number of individuals with MIS-C who had received one or more doses of a COVID-19 vaccine before illness onset; the contribution of vaccination to these illnesses is unknown. Our findings suggest that MIS-C after COVID-19 vaccination is rare. Continued reporting of potential cases and surveillance for MIS-C illnesses after COVID-19 vaccination is warranted.

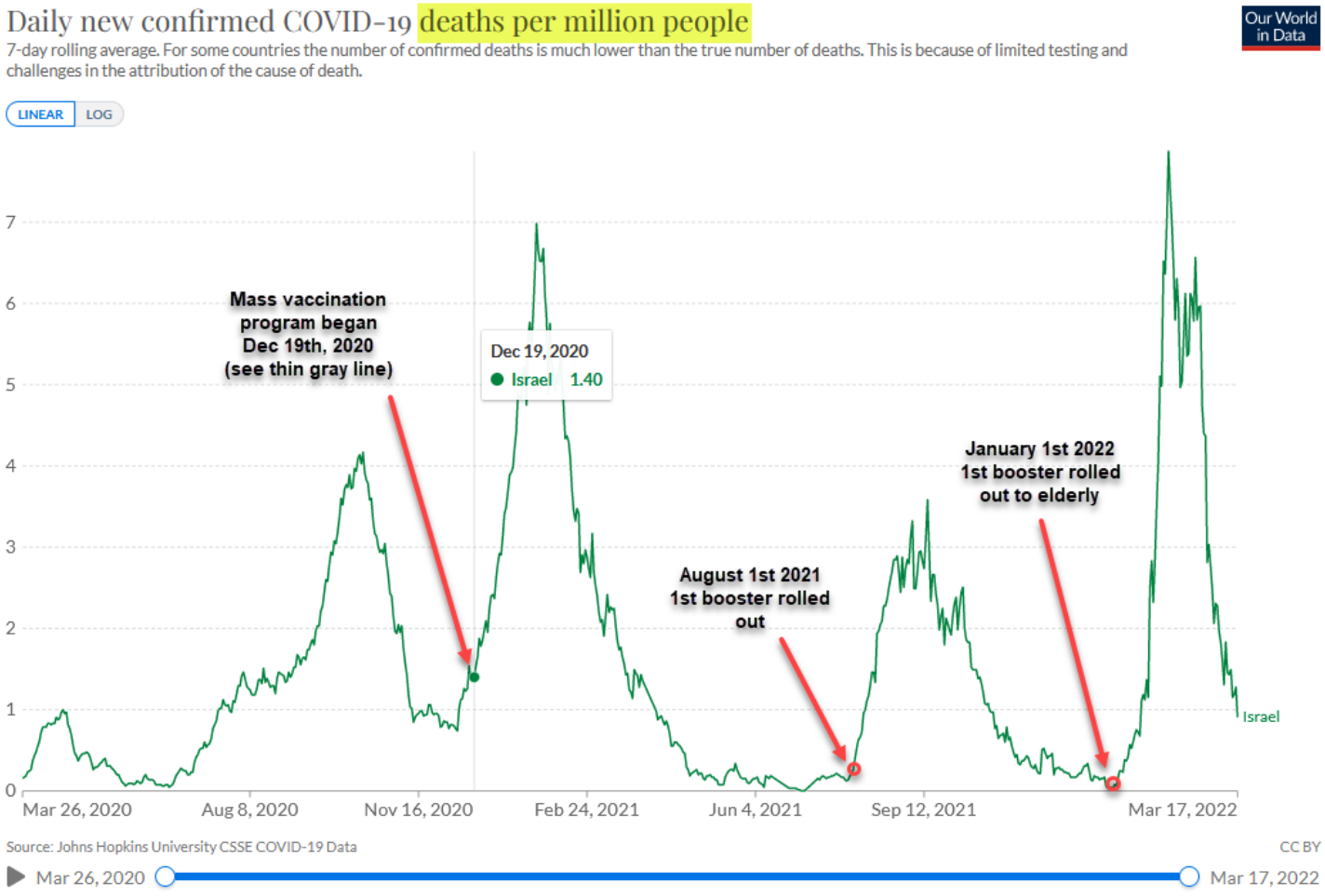
From the discussion

This investigation highlights the challenges of diagnosing MIS-C and importance of a thorough clinical evaluation. **My comment:** Since MIS-C can have a complex and confusing range of clinical signs and symptoms and most physicians may not recognize it for what it truly is, it is very likely that the majority of these cases are missed or not being reported.

Our data are subject to additional limitations. The national MIS-C and VAERS surveillance platforms are both passive reporting systems and probably not all cases are reported, particularly since receipt of vaccine is not part of the MIS-C case definition; therefore, our calculated reporting rates are probably underestimated. Vaccinated individuals being evaluated who have negative SARS-CoV-2 NAAT and anti-nucleocapsid serology tests (and do not have an anti-spike antibody test done) might not be reported because they do not satisfy the CDC case definition and might not be suspected of having MIS-C.
https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(22)00028-1/fulltext

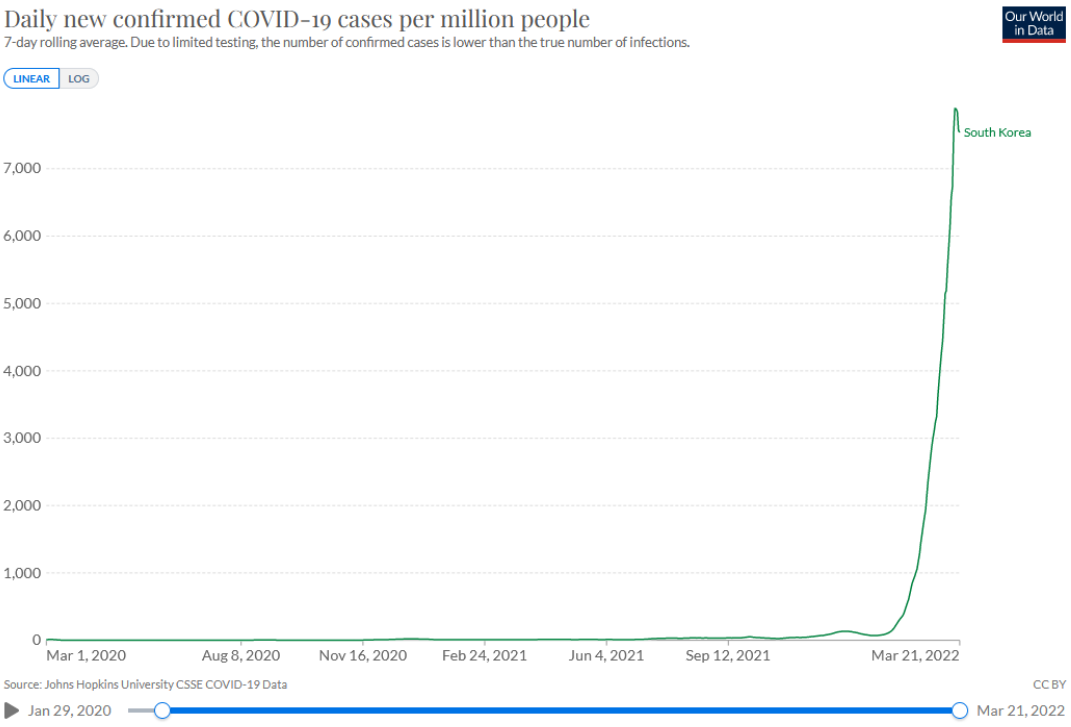
Updates April 1st, 2022

How has each new vaccine campaign impacted deaths in Israel?

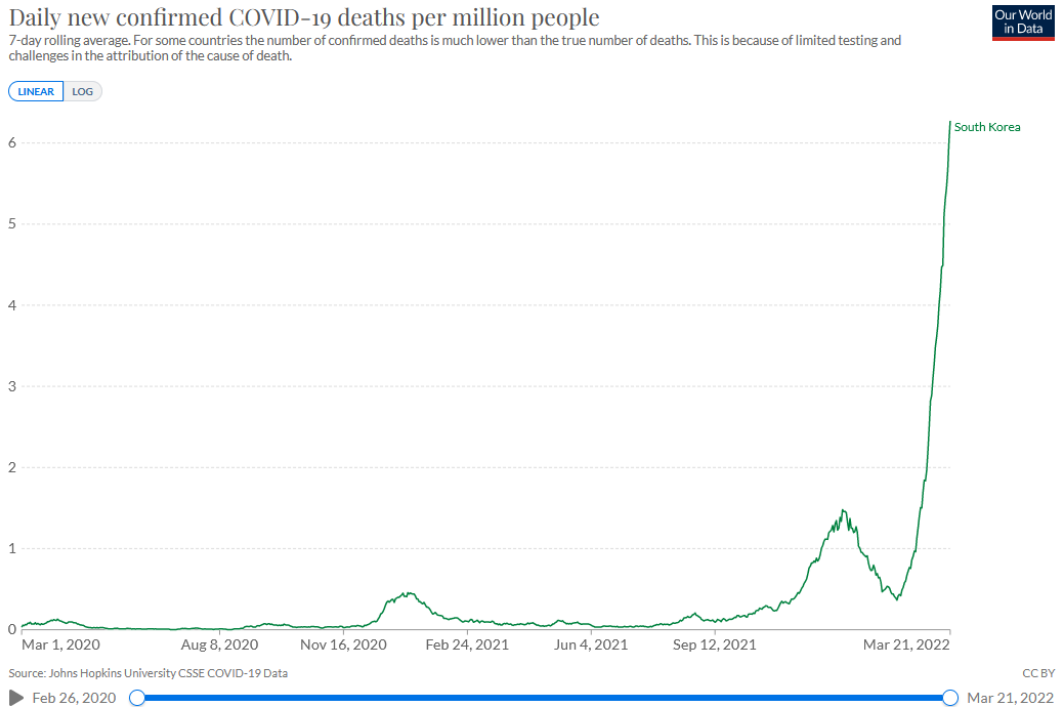


South Korea is making the headlines for their explosion of cases and deaths, in a population that is 87% fully vaccinated, nearly 100% masked, distanced and contact traced

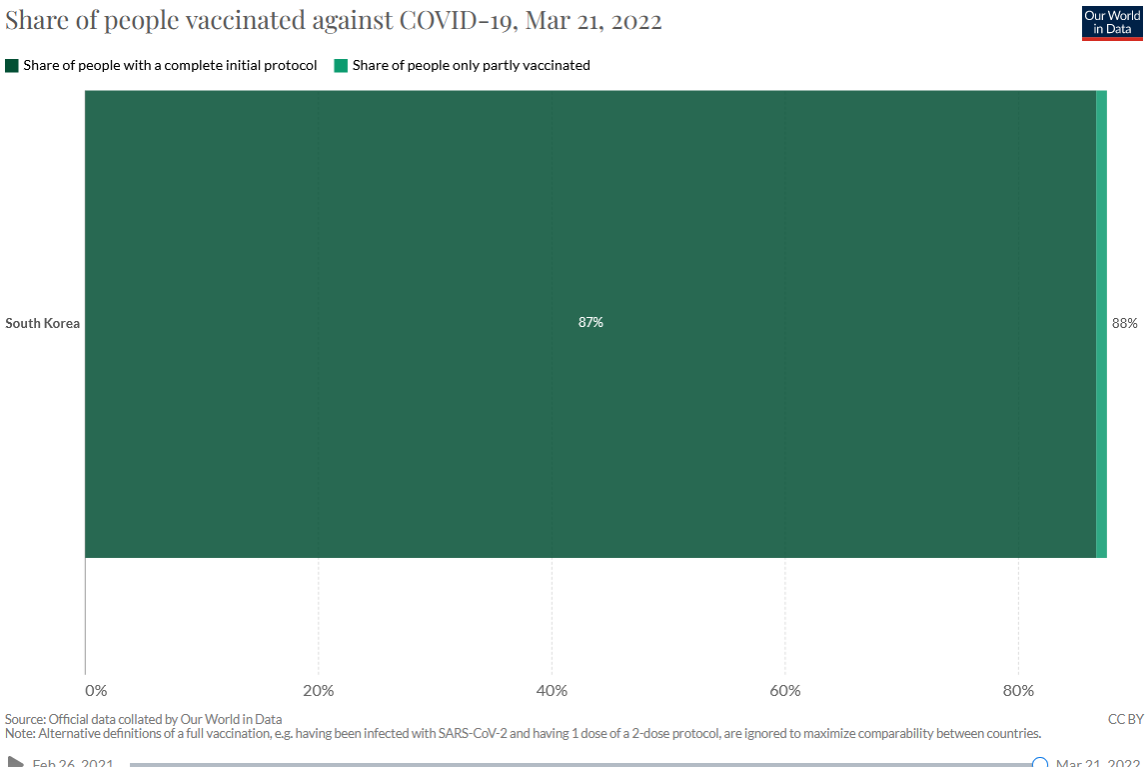
Cases



Deaths

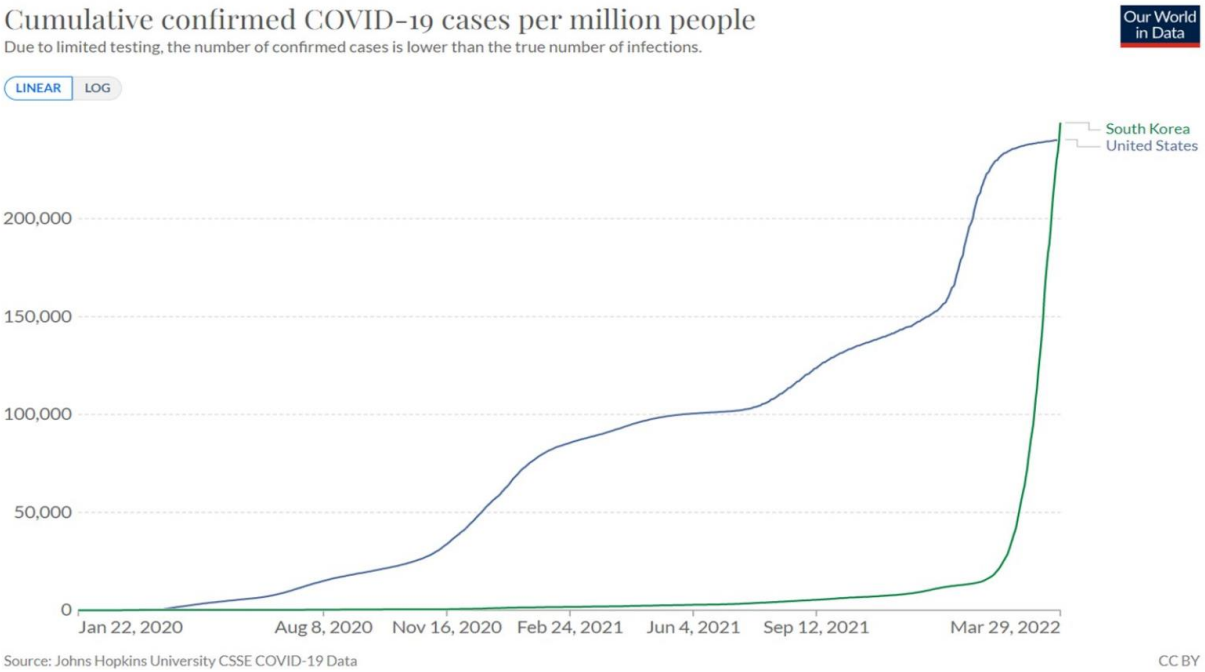


Vaccine compliance



Now let's compare the course of the pandemic in South Korea with that in the United States

South Korea has touted the success of their testing, contact tracing, isolation, masking and vaccine compliance. What this next graph proves is that you can't hide from a virus, you can't "outsmart" a virus and you can't defeat a virus. You may delay the inevitable, but the inevitable will come.



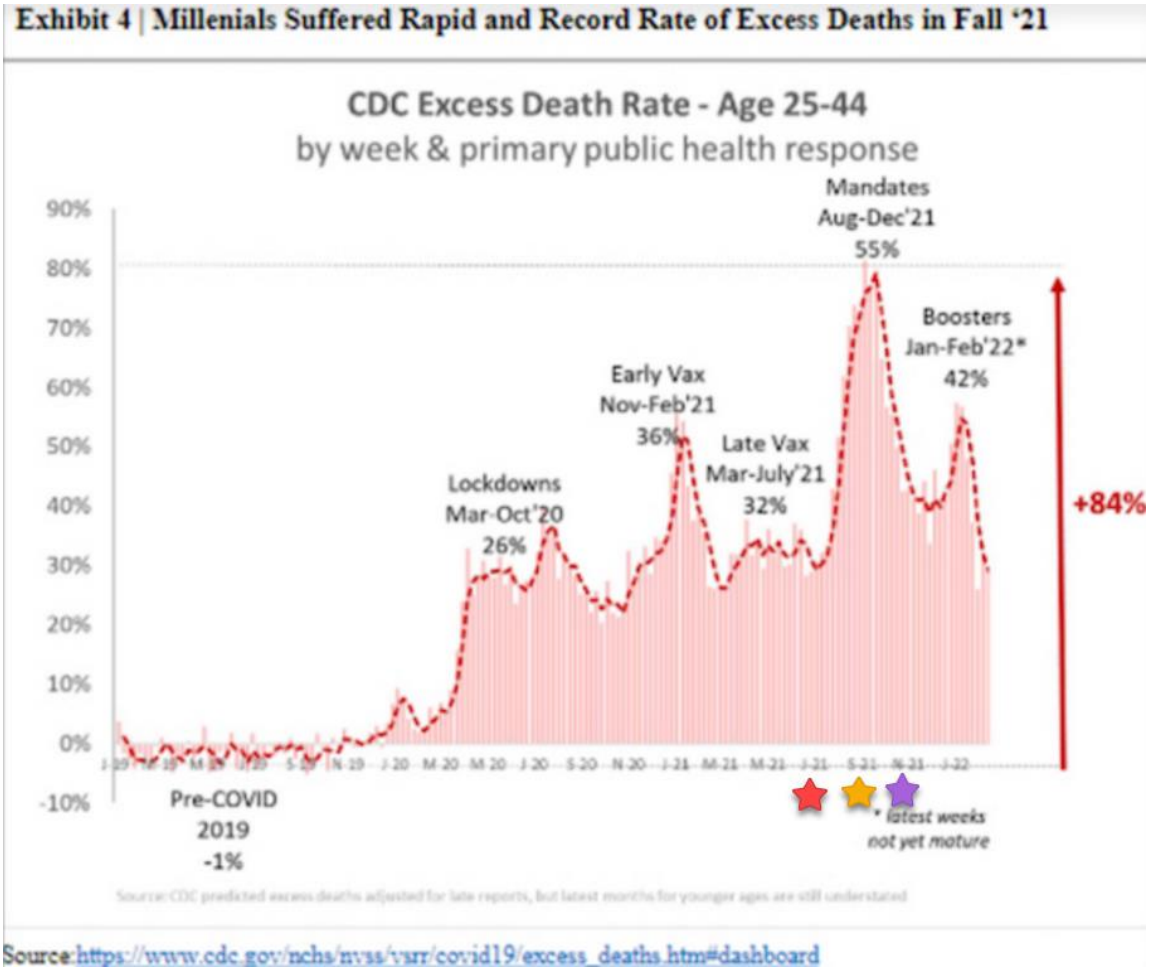
U.S. Millennials aged 25-40 saw a historic spike in excess deaths in the fall of 2021 coinciding with governmental vaccine mandates and the booster campaign. What is the real cause?

A March 16th, 2022 **Substack** by data analyst Jessica Rose titled, **What is killing the millenials? - Drugs? Suicide? Injections? Cancer?**, presents disturbing data showing an 84% increase in deaths in this age category, a group of people that generally are not greatly affected by COVID-19. To put things into perspective, it is an increase that is seven times the rate of excess deaths in people over the age of 85 last year.

Jessica Rose has been all over alt media giving interviews, testifying at Senator Ron Johnson of Wisconsin's hearings and was interviewed by Del Bigtree on Episode 260 of ***The Highwire*** discussing the Bradford-Hill Criteria as it relates to the VAERS deaths being caused by the injections and not just correlation, or coincidence. You can watch her interview here: https://thehighwire.com/watch/

According to Wikipedia, the Bradford Hill criteria, otherwise known as Hill's criteria for causation, are a group of nine principles that can be useful in establishing epidemiologic evidence of a causal relationship between a presumed cause and an observed effect and have been widely used in public health research.

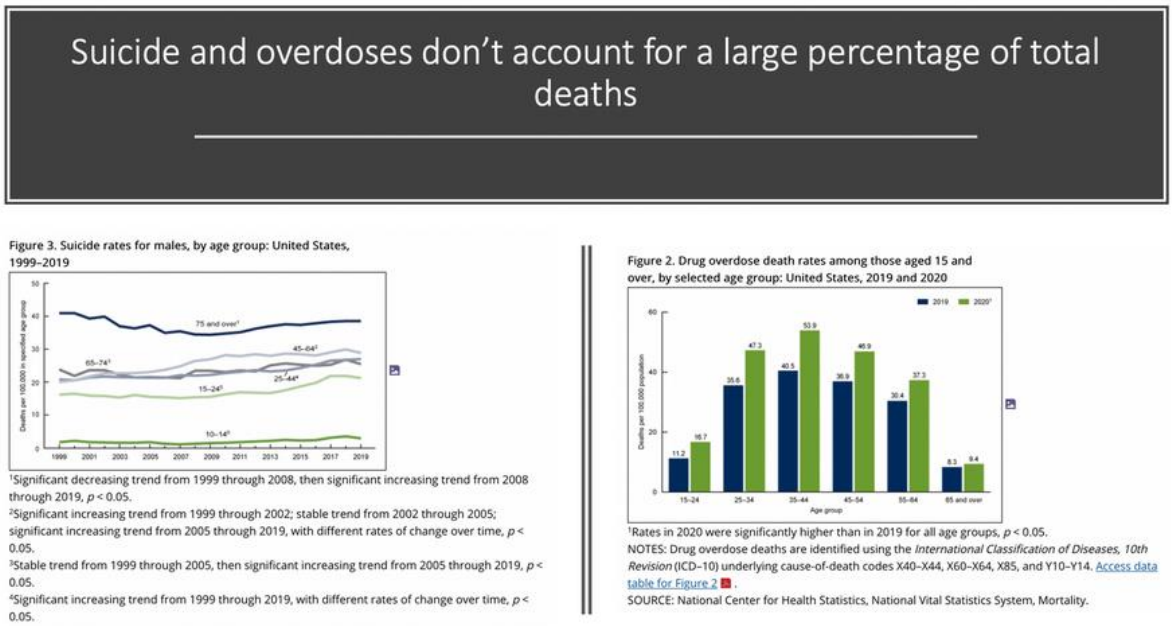
I will first show a couple of charts from the article which are a very graphic visual of this unprecedented spike.

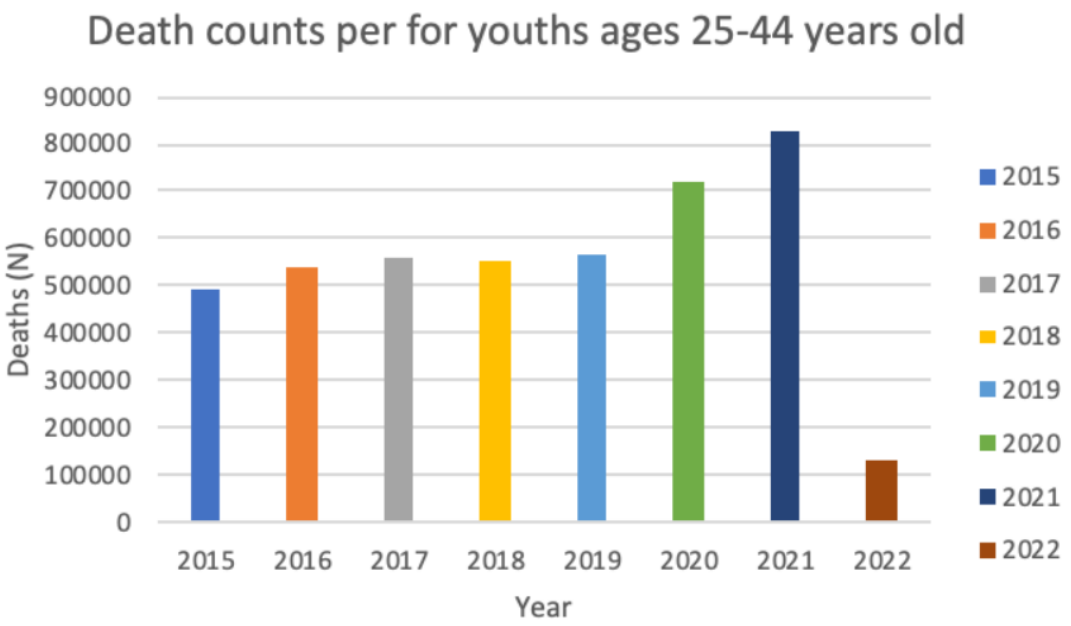


Source: https://www.cdc.gov/nchs/nvss/vsrr/covid19/excess_deaths.htm#dashboard

* I have added color stars to identify dates since the text is so small and blurry.
Red at the July vertical, Gold at September and Purple at November

There has been speculation that opioid overdoses or suicides have greatly contributed to this spike. But the data just doesn't bear that out.



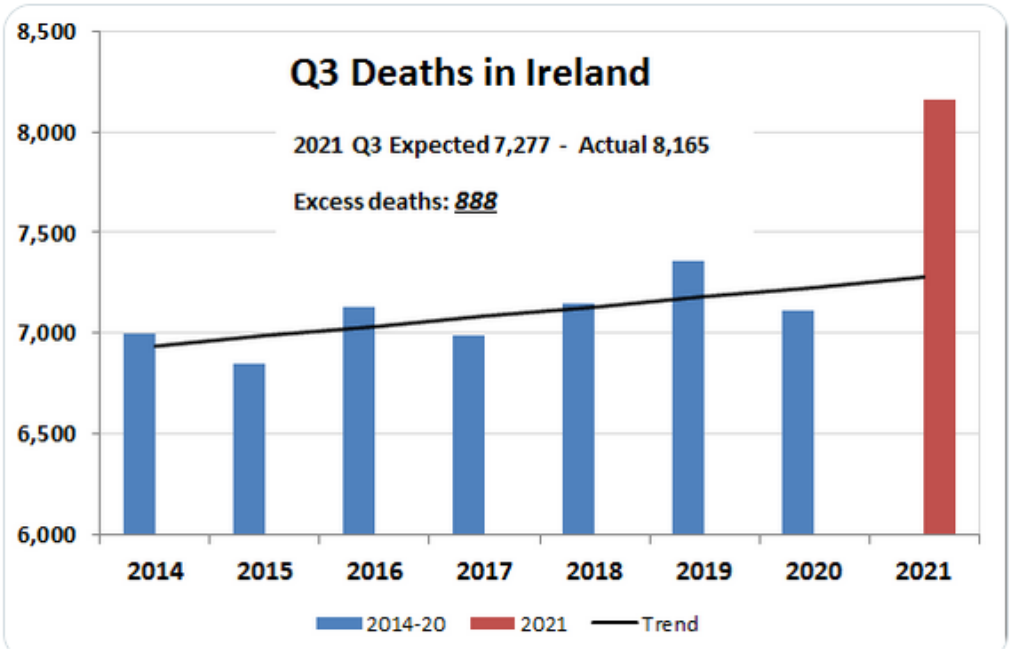


You can read the entire article here… https://jessicar.substack.com/p/what-is-killing-the-millenials?s=r

References

1 https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC8689980/
2 https://www.cdc.gov/nchs/products/databriefs/db428.htm
3 https://www.cdc.gov/nchs/fastats/suicide.htm
4 https://www.cdc.gov/nchs/products/databriefs/db398.htm#fig5

And this next graph looks at a similar phenomenon in Ireland during the mandate/booster period…



Adverse events from the Pfizer document data dump are off the charts

According to the FDA's guidelines, adverse events of special interest should have been tracked, reported and investigated. Instead, these adverse events were hidden from the public. It is not possible to perform data safety monitoring when the AE is a secret… Thanks to the Informed Consent Action Network (ICAN), the FDA has been forced to release the Pfizer clinical trial data in about a year rather than the 75 years that the FDA was seeking. See all the Pfizer documents to date here: https://www.icandecide.org/pfizer/

The FDA defines an adverse event of special interest as follows:

"An adverse event of special interest (serious or nonserious) is one of scientific and medical concern specific to the sponsor's product or program, for which ongoing monitoring and rapid communication by the investigator to the sponsor can be appropriate. Such an event might warrant further investigation in order to characterize and understand it. Depending on the nature of the event, rapid communication by the trial sponsor to other parties (e.g., regulators) might also be warranted. (Based on CIOMS VI)"

Source: https://www.fda.gov/media/71255/download

The document this data came from is titled, **5.3.6 CUMULATIVE ANALYSIS OF POST-AUTHORIZATION ADVERSE EVENT REPORTS OF PF-07302048 (BNT162B2) RECEIVED THROUGH 28-FEB-2021**
https://www.icandecide.org/pfizer-documents/

The complete list of adverse events shown in very small font on the next page. (See Appendix 1 on Page 30 of the full document)

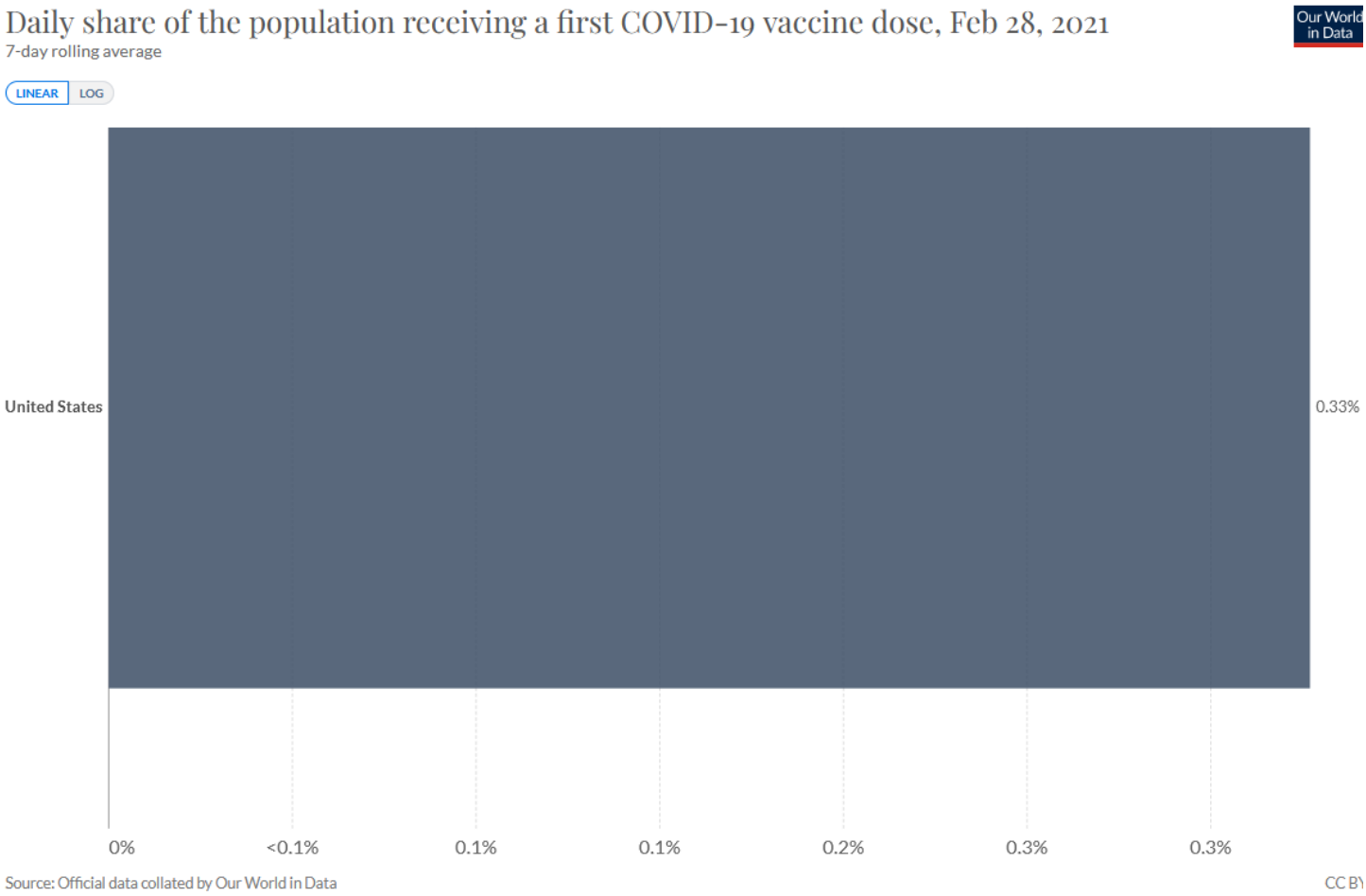
APPENDIX 1. LIST OF ADVERSE EVENTS OF SPECIAL INTEREST

1p36 deletion syndrome;2-Hydroxyglutaric aciduria;5'nucleotidase increased;Acoustic neuritis;Acquired C1 inhibitor deficiency;Acquired epidermolysis bullosa;Acquired epileptic aphasia;Acute cutaneous lupus erythematosus;Acute disseminated encephalomyelitis;Acute encephalitis with refractory, repetitive partial seizures;Acute febrile neutrophilic dermatosis;Acute flaccid myelitis;Acute haemorrhagic leukoencephalitis;Acute haemorrhagic oedema of infancy;Acute kidney injury;Acute macular outer retinopathy;Acute motor axonal neuropathy;Acute motor-sensory axonal neuropathy;Acute myocardial infarction;Acute respiratory distress syndrome;Acute respiratory failure;Addison's disease;Administration site thrombosis;Administration site vasculitis;Adrenal thrombosis;Adverse event following immunisation;Ageusia;Agranulocytosis;Air embolism;Alanine aminotransferase abnormal;Alanine aminotransferase increased;Alcoholic seizure;Allergic bronchopulmonary mycosis;Allergic oedema;Alloimmune hepatitis;Alopecia areata;Alpers disease;Alveolar proteinosis;Ammonia abnormal;Ammonia increased;Amniotic cavity infection;Amygdalohippocampectomy;Amyloid arthropathy;Amyloidosis;Amyloidosis senile;Anaphylactic reaction;Anaphylactic shock;Anaphylactic transfusion reaction;Anaphylactoid reaction;Anaphylactoid shock;Anaphylactoid syndrome of pregnancy;Angioedema;Angiopathic neuropathy;Ankylosing spondylitis;Anosmia;Antiacetylcholine receptor antibody positive;Anti-actin antibody positive;Anti-aquaporin-4 antibody positive;Anti-basal ganglia antibody positive;Anti-cyclic citrullinated peptide antibody positive;Anti-epithelial antibody positive;Anti-erythrocyte antibody positive;Anti-exosome complex antibody positive;Anti-GAD antibody negative;Anti-GAD antibody positive;Anti-ganglioside antibody positive;Antigliadin antibody positive;Anti-glomerular basement membrane antibody positive;Anti-glomerular basement membrane disease;Anti-glycyl-tRNA synthetase antibody positive;Anti-HLA antibody test positive;Anti-IA2 antibody positive;Anti-insulin antibody increased;Anti-insulin antibody positive;Anti-insulin receptor antibody increased;Anti-insulin receptor antibody positive;Anti-interferon antibody negative;Anti-interferon antibody positive;Anti-islet cell antibody positive;Antimitochondrial antibody positive;Anti-muscle specific kinase antibody positive;Anti-myelin-associated glycoprotein antibodies positive;Anti-myelin-associated glycoprotein associated polyneuropathy;Antimyocardial antibody positive;Anti-neuronal antibody positive;Antineutrophil cytoplasmic antibody increased;Antineutrophil cytoplasmic antibody positive;Anti-neutrophil cytoplasmic antibody positive vasculitis;Anti-NMDA antibody positive;Antinuclear antibody increased;Antinuclear antibody positive;Antiphospholipid antibodies positive;Antiphospholipid syndrome;Anti-platelet antibody positive;Anti-prothrombin antibody positive;Antiribosomal P antibody positive;Anti-RNA polymerase III antibody positive;Anti-saccharomyces cerevisiae antibody test positive;Anti-sperm antibody positive;Anti-SRP antibody positive;Antisynthetase syndrome;Anti-thyroid antibody positive;Anti-transglutaminase antibody increased;Anti-VGCC antibody positive;Anti-VGKC antibody positive;Anti-vimentin antibody positive;Antiviral prophylaxis;Antiviral treatment;Anti-zinc transporter 8 antibody positive;Aortic embolus;Aortic thrombosis;Aortitis;Aplasia pure red cell;Aplastic anaemia;Application site thrombosis;Application site vasculitis;Arrhythmia;Arterial bypass occlusion;Arterial bypass thrombosis;Arterial thrombosis;Arteriovenous fistula thrombosis;Arteriovenous graft site stenosis;Arteriovenous graft thrombosis;Arteritis;Arteritis fasciitis;Eosinophilic granulomatosis with polyangiitis;Eosinophilic oesophagitis;Epidermolysis;Epilepsy;Epilepsy surgery;Epilepsy with myoclonic-atonic seizures;Epileptic aura;Epileptic psychosis;Erythema;Erythema induratum;Erythema multiforme;Erythema nodosum;Evans syndrome;Exanthema subitum;Expanded disability status scale score decreased;Expanded disability status scale score increased;Exposure to communicable disease;Exposure to SARS-CoV-2;Eye oedema;Eye pruritus;Eye swelling;Eyelid oedema;Face oedema;Facial paralysis;Facial paresis;Faciobrachial dystonic seizure;Fat embolism;Febrile convulsion;Febrile infection-related epilepsy syndrome;Febrile neutropenia;Felty's syndrome;Femoral artery embolism;Fibrillary glomerulonephritis;Fibromyalgia;Flushing;Foaming at mouth;Focal cortical resection;Focal dyscognitive seizures;Foetal distress syndrome;Foetal placental thrombosis;Foetor hepaticus;Foreign body embolism;Frontal lobe epilepsy;Fulminant type 1 diabetes mellitus;Galactose elimination capacity test abnormal;Galactose elimination capacity test decreased;Gamma-glutamyltransferase abnormal;Gamma-glutamyltransferase increased;Gastritis herpes;Gastrointestinal amyloidosis;Gelastic seizure;Generalised onset non-motor seizure;Generalised tonic-clonic seizure;Genital herpes;Genital herpes simplex;Genital herpes zoster;Giant cell arteritis;Glomerulonephritis;Glomerulonephritis membranoproliferative;Glomerulonephritis membranous;Glomerulonephritis rapidly progressive;Glossopharyngeal nerve paralysis;Glucose transporter type 1 deficiency syndrome;Glutamate dehydrogenase increased;Glycocholic acid increased;GM2 gangliosidosis;Goodpasture's syndrome;Graft thrombosis;Granulocytopenia;Granulocytopenia neonatal;Granulomatosis with polyangiitis;Granulomatous dermatitis;Grey matter heterotopia;Guanase increased;Guillain-Barre syndrome;Haemolytic anaemia;Haemophagocytic lymphohistiocytosis;Haemorrhage;Haemorrhagic ascites;Haemorrhagic disorder;Haemorrhagic pneumonia;Haemorrhagic varicella syndrome;Haemorrhagic vasculitis;Hantavirus pulmonary infection;Hashimoto's encephalopathy;Hashitoxicosis;Hemimegalencephaly;Henoch-Schonlein purpura;Henoch-Schonlein purpura nephritis;Hepaplastin abnormal;Hepaplastin decreased;Heparin-induced thrombocytopenia;Hepatic amyloidosis;Hepatic artery embolism;Hepatic artery flow decreased;Hepatic artery thrombosis;Hepatic enzyme abnormal;Hepatic enzyme decreased;Hepatic enzyme increased;Hepatic fibrosis marker abnormal;Hepatic fibrosis marker increased;Hepatic function abnormal;Hepatic hydrothorax;Hepatic hypertrophy;Hepatic hypoperfusion;Hepatic lymphocytic infiltration;Hepatic mass;Hepatic pain;Hepatic sequestration;Hepatic vascular resistance increased;Hepatic vascular thrombosis;Hepatic vein embolism;Hepatic vein thrombosis;Hepatic venous pressure gradient abnormal;Hepatic venous pressure gradient increased;Hepatitis;Hepatobiliary scan abnormal;Hepatomegaly;Hepatosplenomegaly;Hereditary angioedema with C1 esterase inhibitor deficiency;Herpes dermatitis;Herpes gestationis;Herpes oesophagitis;Herpes ophthalmic;Herpes pharyngitis;Herpes sepsis;Herpes simplex;Herpes simplex cervicitis;Herpes simplex colitis;Herpes simplex encephalitis;Herpes simplex gastritis;Herpes simplex hepatitis;Herpes simplex meningitis;Herpes simplex meningoencephalitis;Herpes simplex meningomyelitis;Herpes simplex necrotising retinopathy;Herpes simplex oesophagitis;Herpes simplex otitis externa;Herpes simplex pharyngitis;Herpes simplex pneumonia;Herpes simplex reactivation;Herpes simplex sepsis;Herpes simplex viraemia;Herpes simplex virus conjunctivitis neonatal;Herpes simplex visceral;Herpes virus neuropathy;Optic perineuritis;Oral herpes;Oral lichen planus;Oropharyngeal oedema;Oropharyngeal spasm;Oropharyngeal swelling;Osmotic demyelination syndrome;Ovarian vein thrombosis;Overlap syndrome;Paediatric autoimmune neuropsychiatric disorders associated with streptococcal infection;Paget-Schroetter syndrome;Palindromic rheumatism;Palisaded neutrophilic granulomatous dermatitis;Palmoplantar keratoderma;Palpable purpura;Pancreatitis;Panencephalitis;Papillophlebitis;Paracancerous pneumonia;Paradoxical embolism;Parainfluenzae viral laryngotracheobronchitis;Paraneoplastic dermatomyositis;Paraneoplastic pemphigus;Paraneoplastic thrombosis;Paresis cranial nerve;Parietal cell antibody positive;Paroxysmal nocturnal haemoglobinuria;Partial seizures;Partial seizures with secondary generalisation;Patient isolation;Pelvic venous thrombosis;Pemphigoid;Pemphigus;Penile vein thrombosis;Pericarditis;Pericarditis lupus;Perihepatic discomfort;Periorbital oedema;Periorbital swelling;Peripheral artery thrombosis;Peripheral embolism;Peripheral ischaemia;Peripheral vein thrombus extension;Periportal oedema;Peritoneal fluid protein abnormal;Peritoneal fluid protein decreased;Peritoneal fluid protein increased;Peritonitis lupus;Pernicious anaemia;Petit mal epilepsy;Pharyngeal oedema;Pharyngeal swelling;Pityriasis lichenoides et varioliformis acuta;Placenta praevia;Pleuroparenchymal fibroelastosis;Pneumobilia;Pneumonia;Pneumonia adenoviral;Pneumonia cytomegaloviral;Pneumonia herpes viral;Pneumonia influenzal;Pneumonia measles;Pneumonia mycoplasmal;Pneumonia necrotising;Pneumonia parainfluenzae viral;Pneumonia respiratory syncytial viral;Pneumonia viral;POEMS syndrome;Polyarteritis nodosa;Polyarthritis;Polychondritis;Polyglandular autoimmune syndrome type I;Polyglandular autoimmune syndrome type II;Polyglandular autoimmune syndrome type III;Polyglandular disorder;Polymicrogyria;Polymyalgia rheumatica;Polymyositis;Polyneuropathy;Polyneuropathy idiopathic progressive;Portal pyaemia;Portal vein embolism;Portal vein flow decreased;Portal vein pressure increased;Portal vein thrombosis;Portosplenomesenteric venous thrombosis;Post procedural hypotension;Post procedural pneumonia;Post procedural pulmonary embolism;Post stroke epilepsy;Post stroke seizure;Post thrombotic retinopathy;Post thrombotic syndrome;Post viral fatigue syndrome;Postictal headache;Postictal paralysis;Postictal psychosis;Postictal state;Postoperative respiratory distress;Postoperative respiratory failure;Postoperative thrombosis;Postpartum thrombosis;Postpartum venous thrombosis;Postpericardiotomy syndrome;Post-traumatic epilepsy;Postural orthostatic tachycardia syndrome;Precerebral artery thrombosis;Pre-eclampsia;Preictal state;Premature labour;Premature menopause;Primary amyloidosis;Primary biliary cholangitis;Primary progressive multiple sclerosis;Procedural shock;Proctitis herpes;Proctitis ulcerative;Product availability issue;Product distribution issue;Product supply issue;Progressive facial hemiatrophy;Progressive multifocal leukoencephalopathy;Progressive multiple sclerosis;Progressive relapsing multiple sclerosis;Prosthetic cardiac valve thrombosis;Pruritus;Pruritus allergic;Pseudovasculitis;Psoriasis;Psoriatic arthropathy;Pulmonary amyloidosis;Pulmonary artery thrombosis;Pulmonary embolism;Pulmonary fibrosis;Pulmonary haemorrhage;Pulmonary microemboli;Pulmonary oil microembolism;Pulmonary renal syndrome;Pulmonary sarcoidosis;Pulmonary sepsis;Pulmonary thrombosis;Pulmonary tumour thrombotic microangiopathy;Pulmonary vasculitis;Pulmonary veno-occlusive disease;Pulmonary venous thrombosis;Pyoderma gangrenosum;Pyostomatitis vegetans;Pyrexia;Quarantine;Radiation leukopenia;Radiculitis coronary;Arthralgia;Arthritis;Arthritis enteropathic;Ascites;Aseptic cavernous sinus thrombosis;Aspartate aminotransferase abnormal;Aspartate aminotransferase increased;Aspartate-glutamate-transporter deficiency;AST to platelet ratio index increased;AST/ALT ratio abnormal;Asthma;Asymptomatic COVID-19;Ataxia;Atheroembolism;Atonic seizures;Atrial thrombosis;Atrophic thyroiditis;Atypical benign partial epilepsy;Atypical pneumonia;Aura;Autoantibody positive;Autoimmune anaemia;Autoimmune aplastic anaemia;Autoimmune arthritis;Autoimmune blistering disease;Autoimmune cholangitis;Autoimmune colitis;Autoimmune demyelinating disease;Autoimmune dermatitis;Autoimmune disorder;Autoimmune encephalopathy;Autoimmune endocrine disorder;Autoimmune enteropathy;Autoimmune eye disorder;Autoimmune haemolytic anaemia;Autoimmune heparin-induced thrombocytopenia;Autoimmune hepatitis;Autoimmune hyperlipidaemia;Autoimmune hypothyroidism;Autoimmune inner ear disease;Autoimmune lung disease;Autoimmune lymphoproliferative syndrome;Autoimmune myocarditis;Autoimmune myositis;Autoimmune nephritis;Autoimmune neuropathy;Autoimmune neutropenia;Autoimmune pancreatitis;Autoimmune pancytopenia;Autoimmune pericarditis;Autoimmune retinopathy;Autoimmune thyroid disorder;Autoimmune thyroiditis;Autoimmune uveitis;Autoinflammation with infantile enterocolitis;Autoinflammatory disease;Automatism epileptic;Autonomic nervous system imbalance;Autonomic seizure;Axial spondyloarthritis;Axillary vein thrombosis;Axonal and demyelinating polyneuropathy;Axonal neuropathy;Bacterascites;Baltic myoclonic epilepsy;Band sensation;Basedow's disease;Basilar artery thrombosis;Basophilopenia;B-cell aplasia;Behcet's syndrome;Benign ethnic neutropenia;Benign familial neonatal convulsions;Benign familial pemphigus;Benign rolandic epilepsy;Beta-2 glycoprotein antibody positive;Bickerstaff's encephalitis;Bile output abnormal;Bile output decreased;Biliary ascites;Bilirubin conjugated abnormal;Bilirubin conjugated increased;Bilirubin urine present;Biopsy liver abnormal;Biotinidase deficiency;Birdshot chorioretinopathy;Blood alkaline phosphatase abnormal;Blood alkaline phosphatase increased;Blood bilirubin abnormal;Blood bilirubin increased;Blood bilirubin unconjugated increased;Blood cholinesterase abnormal;Blood cholinesterase decreased;Blood pressure decreased;Blood pressure diastolic decreased;Blood pressure systolic decreased;Blue toe syndrome;Brachiocephalic vein thrombosis;Brain stem embolism;Brain stem thrombosis;Bromosulphthalein test abnormal;Bronchial oedema;Bronchitis;Bronchitis mycoplasmal;Bronchitis viral;Bronchopulmonary aspergillosis allergic;Bronchospasm;Budd-Chiari syndrome;Bulbar palsy;Butterfly rash;C1q nephropathy;Caesarean section;Calcium embolism;Capillaritis;Caplan's syndrome;Cardiac amyloidosis;Cardiac arrest;Cardiac failure;Cardiac failure acute;Cardiac sarcoidosis;Cardiac ventricular thrombosis;Cardiogenic shock;Cardiolipin antibody positive;Cardiopulmonary failure;Cardio-respiratory arrest;Cardio-respiratory distress;Cardiovascular insufficiency;Carotid arterial embolus;Carotid artery thrombosis;Cataplexy;Catheter site thrombosis;Catheter site vasculitis;Cavernous sinus thrombosis;CDKL5 deficiency disorder;CEC syndrome;Cement embolism;Central nervous system lupus;Central nervous system vasculitis;Cerebellar artery thrombosis;Cerebellar embolism;Cerebral amyloid angiopathy;Cerebral arteritis;Cerebral artery embolism;Cerebral artery thrombosis;Cerebral gas embolism;Cerebral microembolism;Cerebral septic infarct;Cerebral thrombosis;Cerebral venous sinus thrombosis;Cerebral venous thrombosis;Cerebrospinal thrombotic infection;Herpes zoster;Herpes zoster cutaneous disseminated;Herpes zoster infection neurological;Herpes zoster meningitis;Herpes zoster meningoencephalitis;Herpes zoster meningomyelitis;Herpes zoster meningoradiculitis;Herpes zoster necrotising retinopathy;Herpes zoster oticus;Herpes zoster pharyngitis;Herpes zoster reactivation;Herpetic radiculopathy;Histone antibody positive;Hoigne's syndrome;Human herpesvirus 6 encephalitis;Human herpesvirus 6 infection;Human herpesvirus 6 infection reactivation;Human herpesvirus 7 infection;Human herpesvirus 8 infection;Hyperammonaemia;Hyperbilirubinaemia;Hypercholia;Hypergammaglobulinaemia benign monoclonal;Hyperglycaemic seizure;Hypersensitivity;Hypersensitivity vasculitis;Hyperthyroidism;Hypertransaminasaemia;Hyperventilation;Hypoalbuminaemia;Hypocalcaemic seizure;Hypogammaglobulinaemia;Hypoglossal nerve paralysis;Hypoglossal nerve paresis;Hypoglycaemic seizure;Hyponatraemic seizure;Hypotension;Hypotensive crisis;Hypothenar hammer syndrome;Hypothyroidism;Hypoxia;Idiopathic CD4 lymphocytopenia;Idiopathic generalised epilepsy;Idiopathic interstitial pneumonia;Idiopathic neutropenia;Idiopathic pulmonary fibrosis;IgA nephropathy;IgM nephropathy;IIIrd nerve paralysis;IIIrd nerve paresis;Iliac artery embolism;Immune thrombocytopenia;Immune-mediated adverse reaction;Immune-mediated cholangitis;Immune-mediated cholestasis;Immune-mediated cytopenia;Immune-mediated encephalitis;Immune-mediated encephalopathy;Immune-mediated endocrinopathy;Immune-mediated enterocolitis;Immune-mediated gastritis;Immune-mediated hepatic disorder;Immune-mediated hepatitis;Immune-mediated hyperthyroidism;Immune-mediated hypothyroidism;Immune-mediated myocarditis;Immune-mediated myositis;Immune-mediated nephritis;Immune-mediated neuropathy;Immune-mediated pancreatitis;Immune-mediated pneumonitis;Immune-mediated renal disorder;Immune-mediated thyroiditis;Immune-mediated uveitis;Immunoglobulin G4 related disease;Immunoglobulins abnormal;Implant site thrombosis;Inclusion body myositis;Infantile genetic agranulocytosis;Infantile spasms;Infected vasculitis;Infective thrombosis;Inflammation;Inflammatory bowel disease;Infusion site thrombosis;Infusion site vasculitis;Injection site thrombosis;Injection site urticaria;Injection site vasculitis;Instillation site thrombosis;Insulin autoimmune syndrome;Interstitial granulomatous dermatitis;Interstitial lung disease;Intracardiac mass;Intracardiac thrombus;Intracranial pressure increased;Intrapericardial thrombosis;Intrinsic factor antibody abnormal;Intrinsic factor antibody positive;IPEX syndrome;Irregular breathing;IRVAN syndrome;IVth nerve paralysis;IVth nerve paresis;JC polyomavirus test positive;JC virus CSF test positive;Jeavons syndrome;Jugular vein embolism;Jugular vein thrombosis;Juvenile idiopathic arthritis;Juvenile myoclonic epilepsy;Juvenile polymyositis;Juvenile psoriatic arthritis;Juvenile spondyloarthritis;Kaposi sarcoma inflammatory cytokine syndrome;Kawasaki's disease;Kayser-Fleischer ring;Keratoderma blenorrhagica;Ketosis-prone diabetes mellitus;Kounis syndrome;Lafora's myoclonic epilepsy;Lambl's excrescences;Laryngeal dysplasia;Laryngeal oedema;Laryngeal rheumatoid arthritis;Laryngospasm;Laryngotracheal oedema;Latent autoimmune diabetes in adults;LE cells present;Lemierre syndrome;Lennox-Gastaut syndrome;Leucine aminopeptidase increased;Leukoencephalomyelitis;Leukoencephalopathy;Leukopenia;Leukopenia neonatal;Lewis-Sumner syndrome;Lhermitte's sign;Lichen planopilaris;Lichen planus;Lichen sclerosus;Limbic encephalitis;Linear IgA disease;Lip oedema;Lip swelling;Liver function test abnormal;Liver function test decreased;Liver function test increased;Liver induration;Liver injury;Liver iron concentration abnormal;Liver iron concentration brachial;Radiologically isolated syndrome;Rash;Rash erythematous;Rash pruritic;Rasmussen encephalitis;Raynaud's phenomenon;Reactive capillary endothelial proliferation;Relapsing multiple sclerosis;Relapsing-remitting multiple sclerosis;Renal amyloidosis;Renal arteritis;Renal artery thrombosis;Renal embolism;Renal failure;Renal vascular thrombosis;Renal vasculitis;Renal vein embolism;Renal vein thrombosis;Respiratory arrest;Respiratory disorder;Respiratory distress;Respiratory failure;Respiratory paralysis;Respiratory syncytial virus bronchiolitis;Respiratory syncytial virus bronchitis;Retinal artery embolism;Retinal artery occlusion;Retinal artery thrombosis;Retinal vascular thrombosis;Retinal vasculitis;Retinal vein occlusion;Retinal vein thrombosis;Retinol binding protein decreased;Retinopathy;Retrograde portal vein flow;Retroperitoneal fibrosis;Reversible airways obstruction;Reynold's syndrome;Rheumatic brain disease;Rheumatic disorder;Rheumatoid arthritis;Rheumatoid factor increased;Rheumatoid factor positive;Rheumatoid factor quantitative increased;Rheumatoid lung;Rheumatoid neutrophilic dermatosis;Rheumatoid nodule;Rheumatoid nodule removal;Rheumatoid scleritis;Rheumatoid vasculitis;Saccadic eye movement;SAPHO syndrome;Sarcoidosis;SARS-CoV-1 test;SARS-CoV-1 test negative;SARS-CoV-1 test positive;SARS-CoV-2 antibody test;SARS-CoV-2 antibody test negative;SARS-CoV-2 antibody test positive;SARS-CoV-2 carrier;SARS-CoV-2 sepsis;SARS-CoV-2 test;SARS-CoV-2 test false negative;SARS-CoV-2 test false positive;SARS-CoV-2 test negative;SARS-CoV-2 test positive;SARS-CoV-2 viraemia;Satoyoshi syndrome;Schizencephaly;Scleritis;Scleredactylia;Scleroderma;Scleroderma associated digital ulcer;Scleroderma renal crisis;Scleroderma-like reaction;Secondary amyloidosis;Secondary cerebellar degeneration;Secondary progressive multiple sclerosis;Segmented hyalinising vasculitis;Seizure;Seizure anoxic;Seizure cluster;Seizure like phenomena;Seizure prophylaxis;Sensation of foreign body;Septic embolus;Septic pulmonary embolism;Severe acute respiratory syndrome;Severe myoclonic epilepsy of infancy;Shock;Shock symptom;Shrinking lung syndrome;Shunt thrombosis;Silent thyroiditis;Simple partial seizures;Sjogren's syndrome;Skin swelling;SLE arthritis;Smooth muscle antibody positive;Sneezing;Spinal artery embolism;Spinal artery thrombosis;Splenic artery thrombosis;Splenic embolism;Splenic thrombosis;Splenic vein thrombosis;Spondylitis;Spondyloarthropathy;Spontaneous heparin-induced thrombocytopenia syndrome;Status epilepticus;Stevens-Johnson syndrome;Stiff leg syndrome;Stiff person syndrome;Stillbirth;Still's disease;Stoma site thrombosis;Stoma site vasculitis;Stress cardiomyopathy;Stridor;Subacute cutaneous lupus erythematosus;Subacute endocarditis;Subacute inflammatory demyelinating polyneuropathy;Subclavian artery embolism;Subclavian artery thrombosis;Subclavian vein thrombosis;Sudden unexplained death in epilepsy;Superior sagittal sinus thrombosis;Susac's syndrome;Suspected COVID-19;Swelling;Swelling face;Swelling of eyelid;Swollen tongue;Sympathetic ophthalmia;Systemic lupus erythematosus;Systemic lupus erythematosus disease activity index abnormal;Systemic lupus erythematosus disease activity index decreased;Systemic lupus erythematosus disease activity index increased;Systemic lupus erythematosus rash;Systemic scleroderma;Systemic sclerosis pulmonary;Tachycardia;Tachypnoea;Takayasu's arteritis;Temporal lobe epilepsy;Terminal ileitis;Testicular autoimmunity;Throat tightness;Thromboangiitis obliterans;Thrombocytopenia;Thrombocytopenic purpura;Thrombophlebitis;Thrombophlebitis migrans;Thrombophlebitis tamponade;Cerebrovascular accident;Change in seizure presentation;Chest discomfort;Child-Pugh-Turcotte score abnormal;Child-Pugh-Turcotte score increased;Chillblains;Choking;Choking sensation;Cholangitis sclerosing;Chronic autoimmune glomerulonephritis;Chronic cutaneous lupus erythematosus;Chronic fatigue syndrome;Chronic gastritis;Chronic inflammatory demyelinating polyradiculoneuropathy;Chronic lymphocytic inflammation with pontine perivascular enhancement responsive to steroids;Chronic recurrent multifocal osteomyelitis;Chronic respiratory failure;Chronic spontaneous urticaria;Circulatory collapse;Circumoral oedema;Circumoral swelling;Clinically isolated syndrome;Clonic convulsion;Coeliac disease;Cogan's syndrome;Cold agglutinins positive;Cold type haemolytic anaemia;Colitis;Colitis erosive;Colitis herpes;Colitis microscopic;Colitis ulcerative;Collagen disorder;Collagen-vascular disease;Complement factor abnormal;Complement factor C1 decreased;Complement factor C2 decreased;Complement factor C3 decreased;Complement factor C4 decreased;Complement factor decreased;Computerised tomogram liver abnormal;Concentric sclerosis;Congenital anomaly;Congenital bilateral perisylvian syndrome;Congenital herpes simplex infection;Congenital myasthenic syndrome;Congenital varicella infection;Congestive hepatopathy;Convulsion in childhood;Convulsions local;Convulsive threshold lowered;Coombs positive haemolytic anaemia;Coronary artery disease;Coronary artery embolism;Coronary artery thrombosis;Coronary bypass thrombosis;Coronavirus infection;Coronavirus test;Coronavirus test negative;Coronavirus test positive;Corpus callosotomy;Cough;Cough variant asthma;COVID-19;COVID-19 immunisation;COVID-19 pneumonia;COVID-19 prophylaxis;COVID-19 treatment;Cranial nerve disorder;Cranial nerve palsies multiple;Cranial nerve paralysis;CREST syndrome;Crohn's disease;Cryofibrinogenaemia;Cryoglobulinaemia;CSF oligoclonal band present;CSWS syndrome;Cutaneous amyloidosis;Cutaneous lupus erythematosus;Cutaneous sarcoidosis;Cutaneous vasculitis;Cyanosis;Cyclic neutropenia;Cystitis interstitial;Cytokine release syndrome;Cytokine storm;De novo purine synthesis inhibitors associated acute inflammatory syndrome;Death neonatal;Deep vein thrombosis;Deep vein thrombosis postoperative;Deficiency of bile secretion;Deja vu;Demyelinating polyneuropathy;Demyelination;Dermatitis;Dermatitis bullous;Dermatitis herpetiformis;Dermatomyositis;Device embolisation;Device related thrombosis;Diabetes mellitus;Diabetic ketoacidosis;Diabetic mastopathy;Dialysis amyloidosis;Dialysis membrane reaction;Diastolic hypotension;Diffuse vasculitis;Digital pitting scar;Disseminated intravascular coagulation;Disseminated intravascular coagulation in newborn;Disseminated neonatal herpes simplex;Disseminated varicella;Disseminated varicella zoster vaccine virus infection;Disseminated varicella zoster virus infection;DNA antibody positive;Double cortex syndrome;Double stranded DNA antibody positive;Dreamy state;Dressler's syndrome;Drop attacks;Drug withdrawal convulsions;Dyspnoea;Early infantile epileptic encephalopathy with burst-suppression;Eclampsia;Eczema herpeticum;Embolia cutis medicamentosa;Embolic cerebellar infarction;Embolic cerebral infarction;Embolic pneumonia;Embolic stroke;Embolism;Embolism arterial;Embolism venous;Encephalitis;Encephalitis allergic;Encephalitis autoimmune;Encephalitis brain stem;Encephalitis haemorrhagic;Encephalitis periaxialis diffusa;Encephalitis post immunisation;Encephalomyelitis;Encephalopathy;Endocrine disorder;Endocrine ophthalmopathy;Endotracheal intubation;Enteritis;Enteritis leukopenic;Enterobacter pneumonia;Enterocolitis;Enteropathic spondylitis;Eosinophilia;Eosinophilic increased;Liver opacity;Liver palpable;Liver sarcoidosis;Liver scan abnormal;Liver tenderness;Low birth weight baby;Lower respiratory tract herpes infection;Lower respiratory tract infection;Lower respiratory tract infection viral;Lung abscess;Lupoid hepatic cirrhosis;Lupus cystitis;Lupus encephalitis;Lupus endocarditis;Lupus enteritis;Lupus hepatitis;Lupus myocarditis;Lupus myositis;Lupus nephritis;Lupus pancreatitis;Lupus pleurisy;Lupus pneumonitis;Lupus vasculitis;Lupus-like syndrome;Lymphocytic hypophysitis;Lymphocytopenia neonatal;Lymphopenia;MAGIC syndrome;Magnetic resonance imaging liver abnormal;Magnetic resonance proton density fat fraction measurement;Mahler sign;Manufacturing laboratory analytical testing issue;Manufacturing materials issue;Manufacturing production issue;Marburg's variant multiple sclerosis;Marchiafava-Bignami disease;Marine Lenhart syndrome;Mastocytic enterocolitis;Maternal exposure during pregnancy;Medical device site thrombosis;Medical device site vasculitis;MELAS syndrome;Meningitis;Meningitis aseptic;Meningitis herpes;Meningoencephalitis herpes simplex neonatal;Meningoencephalitis herpetic;Meningomyelitis herpes;MERS-CoV test;MERS-CoV test negative;MERS-CoV test positive;Mesangioproliferative glomerulonephritis;Mesenteric artery embolism;Mesenteric artery thrombosis;Mesenteric vein thrombosis;Metapneumovirus infection;Metastatic cutaneous Crohn's disease;Metastatic pulmonary embolism;Microangiopathy;Microembolism;Microscopic polyangiitis;Middle East respiratory syndrome;Migraine-triggered seizure;Miliary pneumonia;Miller Fisher syndrome;Mitochondrial aspartate aminotransferase increased;Mixed connective tissue disease;Model for end stage liver disease score abnormal;Model for end stage liver disease score increased;Molar ratio of total branched-chain amino acid to tyrosine;Molybdenum cofactor deficiency;Monocytopenia;Mononeuritis;Mononeuropathy multiplex;Morphoea;Morvan syndrome;Mouth swelling;Moyamoya disease;Multifocal motor neuropathy;Multiple organ dysfunction syndrome;Multiple sclerosis;Multiple sclerosis relapse;Multiple sclerosis relapse prophylaxis;Multiple subpial transection;Multisystem inflammatory syndrome in children;Muscular sarcoidosis;Myasthenia gravis;Myasthenia gravis crisis;Myasthenia gravis neonatal;Myasthenic syndrome;Myelitis;Myelitis transverse;Myocardial infarction;Myocarditis;Myocarditis post infection;Myoclonic epilepsy;Myoclonic epilepsy and ragged-red fibres;Myokymia;Myositis;Narcolepsy;Nasal herpes;Nasal obstruction;Necrotising herpetic retinopathy;Neonatal Crohn's disease;Neonatal epileptic seizure;Neonatal lupus erythematosus;Neonatal mucocutaneous herpes simplex;Neonatal pneumonia;Neonatal seizure;Nephritis;Nephrogenic systemic fibrosis;Neuralgic amyotrophy;Neuritis;Neuritis cranial;Neuromyelitis optica pseudo relapse;Neuromyelitis optica spectrum disorder;Neuromyotonia;Neuronal neuropathy;Neuropathy peripheral;Neuropathy, ataxia, retinitis pigmentosa syndrome;Neuropsychiatric lupus;Neurosarcoidosis;Neutropenia;Neutropenia neonatal;Neutropenic colitis;Neutropenic infection;Neutropenic sepsis;Nodular rash;Nodular vasculitis;Noninfectious myelitis;Noninfective encephalitis;Noninfective encephalomyelitis;Noninfective oophoritis;Obstetrical pulmonary embolism;Occupational exposure to communicable disease;Occupational exposure to SARS-CoV-2;Ocular hyperaemia;Ocular myasthenia;Ocular pemphigoid;Ocular sarcoidosis;Ocular vasculitis;Oculofacial paralysis;Oedema;Oedema blister;Oedema due to hepatic disease;Oedema mouth;Oesophageal achalasia;Ophthalmic artery thrombosis;Ophthalmic herpes simplex;Ophthalmic herpes zoster;Ophthalmic vein thrombosis;Optic neuritis;Optic neonatal;Thrombophlebitis septic;Thrombophlebitis superficial;Thromboplastin antibody positive;Thrombosis;Thrombosis corpora cavernosa;Thrombosis in device;Thrombosis mesenteric vessel;Thrombotic cerebral infarction;Thrombotic microangiopathy;Thrombotic stroke;Thrombotic thrombocytopenic purpura;Thyroid disorder;Thyroid stimulating immunoglobulin increased;Thyroiditis;Tongue amyloidosis;Tongue biting;Tongue oedema;Tonic clonic movements;Tonic convulsion;Tonic posturing;Topectomy;Total bile acids increased;Toxic epidermal necrolysis;Toxic leukoencephalopathy;Toxic oil syndrome;Tracheal obstruction;Tracheal oedema;Tracheobronchitis;Tracheobronchitis mycoplasmal;Tracheobronchitis viral;Transaminases abnormal;Transaminases increased;Transfusion-related alloimmune neutropenia;Transient epileptic amnesia;Transverse sinus thrombosis;Trigeminal nerve paresis;Trigeminal neuralgia;Trigeminal palsy;Truncus coeliacus thrombosis;Tuberous sclerosis complex;Tubulointerstitial nephritis and uveitis syndrome;Tumefactive multiple sclerosis;Tumour embolism;Tumour thrombosis;Type 1 diabetes mellitus;Type I hypersensitivity;Type III immune complex mediated reaction;Uhthoff's phenomenon;Ulcerative keratitis;Ultrasound liver abnormal;Umbilical cord thrombosis;Uncinate fits;Undifferentiated connective tissue disease;Upper airway obstruction;Urine bilirubin increased;Urobilinogen urine decreased;Urobilinogen urine increased;Urticaria;Urticaria papular;Urticarial vasculitis;Uterine rupture;Uveitis;Vaccination site thrombosis;Vaccination site vasculitis;Vagus nerve paralysis;Varicella;Varicella keratitis;Varicella post vaccine;Varicella zoster gastritis;Varicella zoster oesophagitis;Varicella zoster pneumonia;Varicella zoster sepsis;Varicella zoster virus infection;Vasa praevia;Vascular graft thrombosis;Vascular pseudoaneurysm thrombosis;Vascular purpura;Vascular stent thrombosis;Vasculitic rash;Vasculitic ulcer;Vasculitis;Vasculitis gastrointestinal;Vasculitis necrotising;Vena cava embolism;Vena cava thrombosis;Venous intravasation;Venous recanalisation;Venous thrombosis;Venous thrombosis in pregnancy;Venous thrombosis limb;Venous thrombosis neonatal;Vertebral artery thrombosis;Vessel puncture site thrombosis;Visceral venous thrombosis;VIth nerve paralysis;VIth nerve paresis;Vitiligo;Vocal cord paralysis;Vocal cord paresis;Vogt-Koyanagi-Harada disease;Warm type haemolytic anaemia;Wheezing;White nipple sign;XIth nerve paralysis;X-ray hepatobiliary abnormal;Young's syndrome;Zika virus associated Guillain Barre syndrome.

Pfizer documents reveal an extraordinarily high number of deaths compared to the number of people vaccinated

From the start of the program through Feb 28th, 2021 when the data contained in this document was terminated, there was approx. 1,100,000 people in the US vaccinated.

According to their documents, there were 1,223 fatalities from Dec. 11th, through Feb 28th. With 1,100,000 people having been vaccinated, that means that there was one death per 899 people vaccinated (unless I'll admit is possible. Please feel free to check my work).



Continued next page…

"This document provides an integrated analysis of the cumulative post-authorization safety data, including U.S. and foreign post-authorization adverse event reports received through 28 February 2021."

Table 1 below presents the main characteristics of the overall cases.

Table 1. General Overview: Selected Characteristics of All Cases Received During the Reporting Interval

Characteristics		Relevant cases (N=42086)
Gender:	Female	29914
	Male	9182
	No Data	2990
Age range (years): 0.01 -107 years Mean = 50.9 years n = 34952	≤ 17 18-30 31-50 51-64 65-74 ≥ 75 Unknown	175[a] 4953 13886 7884 3098 5214 6876
Case outcome:	Recovered/Recovering	19582
	Recovered with sequelae	520
	Not recovered at the time of report	11361
	Fatal	1223
	Unknown	9400

a. in 46 cases reported age was <16-year-old and in 34 cases <12-year-old.

As shown in Figure 1, the System Organ Classes (SOCs) that contained the greatest number (≥2%) of events, in the overall dataset, were General disorders and administration site conditions (51,335 AEs), Nervous system disorders (25,957), Musculoskeletal and connective tissue disorders (17,283), Gastrointestinal disorders (14,096), Skin and subcutaneous tissue disorders (8,476), Respiratory, thoracic and mediastinal disorders (8,848), Infections and infestations (4,610), Injury, poisoning and procedural complications (5,590), and Investigations (3,693).

BNT162b2
5.3.6 Cumulative Analysis of Post-authorization Adverse Event Reports

Figure 1. Total Number of BNT162b2 AEs by System Organ Classes and Event Seriousness

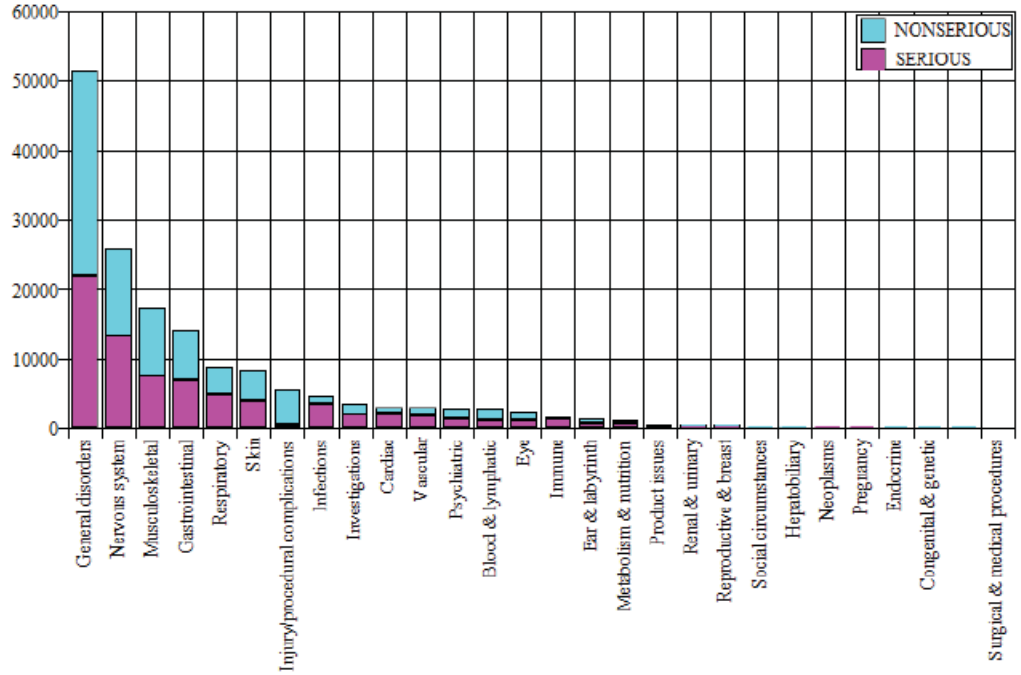


Table 2 shows the most commonly (≥2%) reported MedDRA (v. 23.1) PTs in the overall dataset (through 28 February 2021),

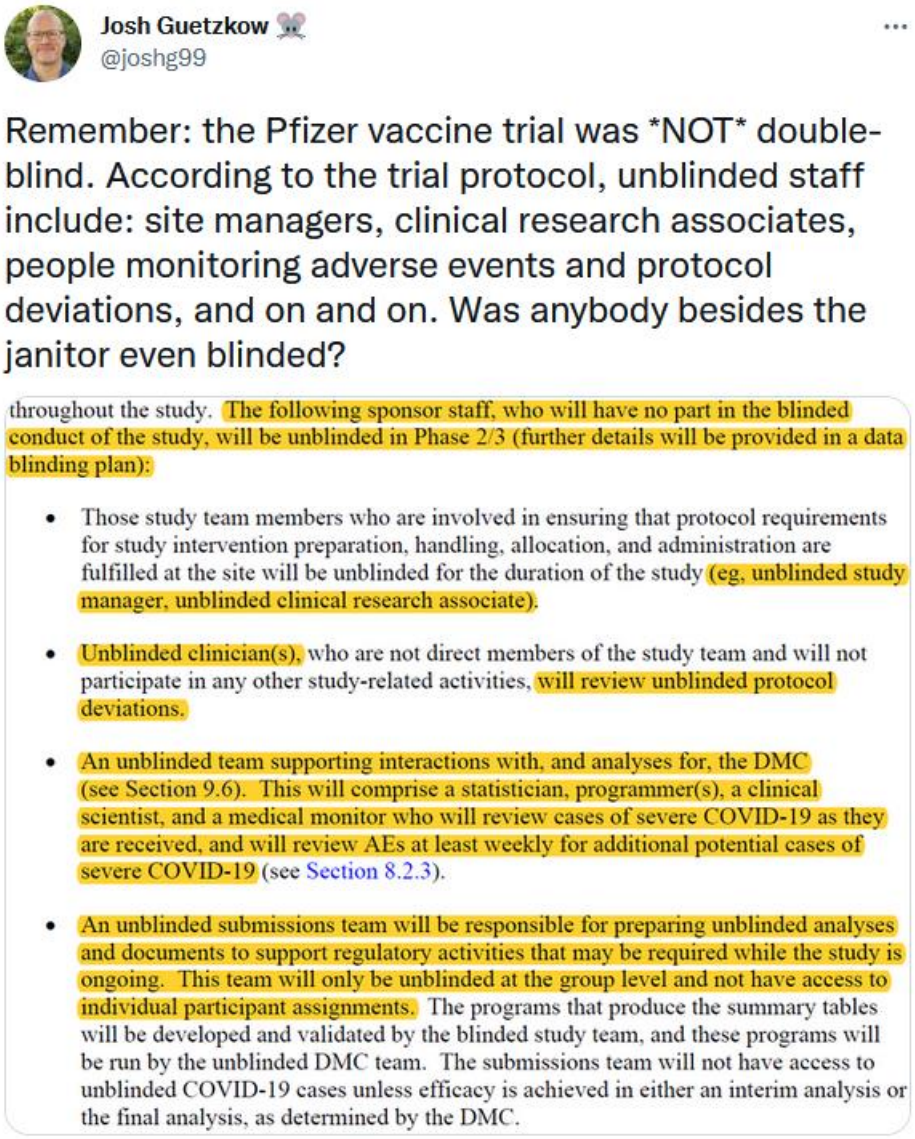
Table 2. Events Reported in ≥2% Cases

MedDRA SOC	MedDRA PT	Cumulatively Through 28 February 2021 AEs (AERP%) N = 42086
Blood and lymphatic system disorders		
	Lymphadenopathy	1972 (4.7%)
Cardiac disorders		
	Tachycardia	1098 (2.6%)
Gastrointestinal disorders		
	Nausea	5182 (12.3%)
	Diarrhoea	1880 (4.5%)
	Vomiting	1698 (4.0%)
General disorders and administration site conditions		
	Pyrexia	7666 (18.2%)
	Fatigue	7338 (17.4%)
	Chills	5514 (13.1%)
	Vaccination site pain	5181 (12.3%)

Table 2. Events Reported in ≥2% Cases Continued

MedDRA SOC	MedDRA PT	Cumulatively Through 28 February 2021 AEs (AERP%) N = 42086
	Pain	3691 (8.8%)
	Malaise	2897 (6.9%)
	Asthenia	2285 (5.4%)
	Drug ineffective	2201 (5.2%)
	Vaccination site erythema	930 (2.2%)
	Vaccination site swelling	913 (2.2%)
	Influenza like illness	835 (2%)
Infections and infestations		
	COVID-19	1927 (4.6%)
Injury, poisoning and procedural complications		
	Off label use	880 (2.1%)
	Product use issue	828 (2.0%)
Musculoskeletal and connective tissue disorders		
	Myalgia	4915 (11.7%)
	Pain in extremity	3959 (9.4%)
	Arthralgia	3525 (8.4%)
Nervous system disorders		
	Headache	10131 (24.1%)
	Dizziness	3720 (8.8%)
	Paraesthesia	1500 (3.6%)
	Hypoaesthesia	999 (2.4%)
Respiratory, thoracic and mediastinal disorders		
	Dyspnoea	2057 (4.9%)
	Cough	1146 (2.7%)
	Oropharyngeal pain	948 (2.3%)
Skin and subcutaneous tissue disorders		
	Pruritus	1447 (3.4%)
	Rash	1404 (3.3%)
	Erythema	1044 (2.5%)
	Hyperhidrosis	900 (2.1%)
	Urticaria	862 (2.1%)
Total number of events		**93473**

The Pfizer clinical trial was not double-blinded as is the gold-standard leading to biased and potentially manipulated results



Whistleblower reveals numerous instances of deviation from trial protocols and in her words “fraud” that occurred right under her nose.

The following is from a website created by the whistleblower whose name is Brooke Jackson. She has documents and evidence backing up her allegations. I've covered this story in the past and it's really quite astounding. But I just came across her website and thought it may be of interest to anybody who has not seen the evidence or details of her allegations.

From her home page…

My name is Brook Jackson. In September 2020, I was hired as a Regional Director for two of the three clinical trial sites in Texas that were participating in Pfizer's pivotal, Phase III, mRNA ("vaccine") clinical trial. Although my time with this company was brief, the misconduct that I witnessed was so blatant and so widespread that I documented numerous violations of the U.S. Food and Drug Administration (FDA) Code of Federal Regulations every, single day. After repeatedly bringing these concerns to Ventavia's management and to Pfizer directly (although anonymously), I watched in disbelief as they began their efforts to conceal the fraud.

On September 25, 2020, I filed a formal complaint with the FDA and was fired hours later.

Starting October 9, 2020, efforts by Big Pharma and Big Tech have been used to intimidate me and keep me from bringing information forward to the public. I was misled by a team of former attorneys and pressured into filing a legal action that I believe was used to keep me silenced. That action was filed on January 8, 2021, under seal and ordered me to refrain from disclosing any information about the case.

As I watched the roll out of Pfizer's product to millions, the mandates that ensued, the reports of injury and death, I could not be silent anymore. The weight on my heart was just too heavy. Even after being warned by a former lawyer that, "if you break the seal the Government will come after you", I just couldn't hold their secret any longer and took the evidence to The BMJ and retained new council.

Earlier this month the case was finally unsealed after the Government declined to intervene in support of the lawsuit. There was never an investigation by the FDA, the Department of Justice, or any other agency. All have refused to investigate the allegations of fraud and misbranding of Pfizer's Covid-19 "vaccine" for nearly a year and a half now.

Since being fired, there have been other former and current employees of Ventavia that have reached out to me. Ventavia continues to be rewarded with additional contracts, new Sponsors, and opportunity to give Big Pharma favorable data no matter the cost.

The information that I have belongs to the entire world. Those involved in this evil, massive, fraudulent scheme to censor and cover up the truth must be held accountable.

I created this website so that I can share this information and to catalogue related documents.

To see the website and documentation go here: https://www.iambrookjackson.com/

Pfizer study results on children shows rapidly declining efficacy and are determined ineffective after two shots

A ***medRxiv*** pre-print February 28th, 2022, titled, **Effectiveness of the BNT162b2 vaccine among children 5-11 and 12-17 years in New York after the Emergence of the Omicron Variant**, should alert everyone including people that want to vaccinate their children that the risk is not worth the "reward."

This was a large-scale study from New York. In the age 5-11 age group there was data on 365,502 children. In the 12-17 age group there were 852,384 individuals.

The data looked at two groups, those previously vaccinated and those newly vaccinated. The efficacy in newly vaccinated 12-year-olds dropped from 65% to 12% within 28-34 days after full vaccination! If it drops that much after one month, what happens after 2-months and beyond?

Efficacy against hospitalization in 12-year-olds vaccinated a median time of 51-days dropped to 48% in approximately 1-month.

In the 12-17 year old previously vaccinated group, the case efficacy dropped from 66% to 51% in 48 days. Efficacy against hospitalization dropped from 85% to 73%. In the newly vaccinated group, the case efficacy dropped from 76% to 56% in one month.

My comments:

Missing from this data was the…

- Co-morbidity data
- Death (mortality) data
- Adverse event data

If the results showed such rapid decline in one month, in a population in which healthy children have a statistically ZERO chance of death and an extremely low chance of severe outcomes, then what is the possible reason to risk vaccine injury for such a paltry benefit if any? Of course, that should be up to each parent to calculate the risk vs. the reward ratio for their particular child. But what do the authors of the study suggest? They suggest either a 3-dose vaccine regimen or vaccinating the children more frequently. Really? How about leaving healthy children alone and giving their parents the ability to provide a healthy environment, a good diet, nutritional supplementation, and healthy lifestyle habits for their children, without pressure or coercion to comply with these injections.

Staunch vaccine advocate/proponent suffers tinnitus from COVID-19 shots

A ***Medpage Today*** article titled, **Vaccine Researcher Who Developed Tinnitus After COVID Shot Calls for Further Study**

— Gregory Poland, MD, advocates both vaccination and better understanding of possible side effect
by Jennifer Henderson, Enterprise & Investigative Writer, MedPage Today March 9, 2022

Gregory Poland, MD, director of the Mayo Clinic's Vaccine Research Group in Rochester, Minnesota, remains a steadfast vaccination advocate -- even though he developed tinnitus soon after receiving his second dose of COVID vaccine.

A little more than a year ago, Poland was driving back from the hospital after receiving his second shot when he nearly veered out of his lane.

"It was like someone suddenly blew a dog whistle in my ear," Poland told *MedPage Today*. "It has been pretty much unrelenting."

Since then, Poland said he has been experiencing what he describes as life-altering tinnitus, or ringing in the ear. It occurs in both ears, but is worse in the left than in the right.

He remains steadfast that opting to receive his booster -- after which his tinnitus briefly disappeared but then returned at a slightly higher pitch that made it just a bit less bothersome -- was the right move. After all, it would be "way too ironic" for a prominent vaccinologist to die of COVID, he said. He also worried about the possibility of contracting COVID and spreading it to his patients.

Yet Poland realizes his life may never be the same, and that many others may be grappling with the same reality. He continues to receive emails from other individuals across the country and around the world who say they have also developed tinnitus after COVID vaccination.

Poland believes there may be tens of thousands of people affected in the U.S. and potentially millions worldwide. He feels strongly that more research should be done to determine what caused these symptoms and what can be done to help people desperate for relief.

"What has been heartbreaking about this, as a seasoned physician, are the emails I get from people that, this has affected their life so badly, they have told me they are going to take their own life," Poland said.

Troubling Symptoms

Poland said of his own symptoms that he "can only begin to estimate the number of times I just want to scream because I can't get rid of the noise or how many hours of sleep I've lost," he said. The noise he hears is "particularly loud at night when there are no masking sounds."

On a recent evening, he had an especially difficult moment. Poland, a self-described lover of nature and the outdoors, realized that he may never be able to hear the silence of nature again, which brought tears to his eyes.

He said that he finds some comfort in his 14- to 16-hour work days that have helped him to not focus on the noise that won't cease.

"It's something that deserves attention," Poland said, pointing to the effort that has gone into defining the risk of myocarditis post-vaccination, and rightfully so, he said.

Thankfully, myocarditis often resolves within a few days of treatment, Poland noted. But with tinnitus, symptoms can persist.

My comment: *Not so fast Dr. Poland. See the next story covering a study from the* ***Journal of Pediatrics*** *showing that the majority of participants ages 12 through 17 we're still suffering myocarditis related structural and functional heart problems eight months after their injections.*

The American Tinnitus Association describes the condition as audiological and neurological. Tinnitus can be acute or chronic, and many cases can be extreme and debilitating. Currently, there is no cure for most types of the condition, though there are treatment options to help patients live more comfortable and productive lives, according to the association.

Is There a Link?

Elliott Kozin, MD, a neurotologist at Massachusetts Eye and Ear in Boston, told *MedPage Today* in an email that there are "ongoing research efforts to understand if COVID-19 vaccines may be related to various auditory complaints, including hearing loss and tinnitus."

Kozin said there are "no definitive studies on the subject." Still, some research has shown evidence of neurological complications following COVID vaccination. For instance, the CDC has acknowledged rare reports of and the FDA warned about the risk of Guillain-Barre syndrome (GBS) following vaccination with the Johnson & Johnson vaccine.

And in a recent Vaccine Adverse Event Reporting System (VAERS) analysis reported in the *Annals of Neurology*, tinnitus was among the most commonly reported adverse neurological events following vaccination. But its authors noted that rates of neurological adverse events were far higher following SARS-CoV-2 infection than after vaccination.

A *MedPage Today* search of the VAERS database yielded more than 13,000 results for tinnitus following COVID vaccination with mRNA vaccines. However, the database specifies that, for any reported event, cause-and-effect relationship has not been established.

A spokesperson for CDC told *MedPage Today* in an email that the agency is "aware of reports of tinnitus occurring in temporal association with mRNA COVID-19 vaccination."

"Tinnitus is a common condition, heterogenous in nature, and has many causes and risk factors," the spokesperson added. "Hundreds of millions of people have received mRNA COVID-19 vaccination under the most intensive monitoring in U.S. history. Currently, the data from safety monitoring are not sufficient to conclude that a causal relationship exists between vaccination and tinnitus."

Kozin said two lines of research are needed: prospective human studies and well-designed animal studies. "Without studying symptomatic and asymptomatic individuals, it is challenging to understand the overall risk," Kozin said regarding the need for prospective studies. "Animal studies may allow us to better understand causation as one can readily control administration of vaccine versus a placebo, as well as study auditory changes that occur on behavioral, physiologic, and cellular levels."

Poland also believes more research is needed, though he, too, cautioned against rushing to conclusions. "Temporality is not causality," Poland said. "Rather, it forms a hypothesis, and then what you do is carefully collect information to determine [whether] this potential syndrome or side effect [is] above and beyond the background rate before there was COVID or a COVID vaccine, and is the rate different in people who got the vaccine and people who didn't."

"My own best guess is that this may be an off-target inflammatory response, inflammation of the temporal lobe area of the brain where sounds are generated or made sense of," Poland said.

What Can Be Done

Kozin said that, following the administration of any new medication, including the COVID-19 vaccine, "individuals should pay attention to symptoms of hearing loss, tinnitus, ear 'fullness,' and dizziness," and seek "prompt evaluation by a primary care provider, otolaryngologist, and/or audiologist."

"Sometimes hearing symptoms are subtle," Kozin said. "For example, an individual may primarily experience

tinnitus and not realize that it is also accompanied by hearing loss."

"The first step is to visit a medical provider and obtain a formal hearing test," he added. "In some circumstances, such as sudden hearing loss, steroids may be given if a diagnosis is made soon after the onset of symptoms."

For Poland, he believes that ongoing transparency is essential to continuing to build trust and confidence in vaccines.

He stressed that his story is not meant to frighten others or discourage them from getting vaccinated. Nearly 1 million Americans have died of COVID, which can be prevented by a free vaccine and a 25-cent mask, he said. And there have also been reports of tinnitus following COVID itself.

Poland added that he would absolutely receive the COVID vaccine again because a wise person makes decisions on the balance of risks and benefits, not on fear.

Moving Forward
With the possibility that Americans could be advised to receive a fourth shot in the near future, or that COVID vaccines could become recommended on an annual basis or even more frequently, Poland said he is hopeful for more options.

Given his personal situation, he will look to protein subunit vaccines that are in development but not yet authorized by the FDA, such as those from Novavax, Medicago, and Sanofi.

A spokesperson for Pfizer, one of the makers of mRNA vaccines, said the following in a statement provided to *MedPage Today*: "We take adverse events, that are voluntarily reported by HCPs and individuals following vaccination with our COVID-19 vaccine, very seriously. Tinnitus cases have been reviewed and no causal association to the Covid-19 vaccine has been established."

"To date, about 3 billion of our COVID-19 vaccines have been delivered globally," the spokesperson added. "It is important to note that serious adverse events that are unrelated to the vaccine are unfortunately likely to occur at a similar rate as they would in the general population."
Moderna, which also makes an mRNA vaccine, did not immediately respond to a request for comment.
Though tinnitus can sometimes resolve within several months or a year, that hasn't yet happened for Poland. But he tries to keep things in perspective.

"Tinnitus is often associated with hearing loss, and I have my first grandchild and I want to hear him, all the things he thinks about as he grows up," Poland said. "I'd encourage him to get the vaccine. But I don't want this to happen to him."

https://www.medpagetoday.com/special-reports/exclusives/97592

A couple of anonymous sources I trust relayed the following about Dr. Poland

First source
Dr. Poland of the Mayo Clinic in Minnesota is something else. He was quoted in September 2021 personally guaranteeing that no one has died from the COVID-19 vaccines.

But his corrupt history runs much deeper.

In 2013 he started to look at why Somali kids in Minnesota were having severe reactions to the MMR vax. His research concluded that a possible link between the Rubella component and East African descent. Then his research stopped. His testimony in Minnesota state legislature stated that MMR is safe for all kids.

Second source
I went toe to toe with him in 1998 or 9 when DOD paid him to go to multiple military bases and give talks about anthrax vaccine. I was doing the same thing. All lies. Once I pointed out ten or twenty lies in what he said, they stopped using him.

He is single-handedly responsible for pushing through the flu vaccine program in the US

He used to have on his website that he had a "take no prisoner" approach and he cared about the ends not the means. Later he removed this.

Ironically, Dr. Poland published *Personalized vaccines: the emerging field of vaccinomics* in 2008.

His abstract:

"*The next 'golden age' in vaccinology will be ushered in by the new science of vaccinomics. In turn, this will inform and allow the development of personalized vaccines, based on our increasing understanding of immune response phenotype: genotype information. Rapid advances in developing such data are already occurring for hepatitis B, influenza, measles, mumps, rubella, anthrax and smallpox vaccines. In addition, newly available data suggest that some vaccine-related adverse events may also be genetically determined and, therefore, predictable. This paper reviews the basis and logic of personalized vaccines, and describes recent advances in the field.*"

Yet the government is still pushing one-composition/size-fits-all vaccines regardless of gender, weight, or ethnic heritage (not to mention other known susceptibilities to adverse reaction).

Journal of Pediatrics posts a study showing that the majority of participants ages 12-17 suffering from myocarditis after their COVID-19 injections were still having structural and functional adverse effects of their hearts 8 months later

The study was accepted as a pre-print by the ***Journal of Pediatrics*** March 23rd, 2022 and is titled, **Persistent cardiac MRI findings in a cohort of adolescents with post COVID-19 mRNA vaccine myocarditis.**

From the study

We previously reported 15 patients with clinically suspected SARS-CoV-2 mRNA vaccine induced myopericarditis. All patients had an abnormal CMR, with edema and or LGE in addition to clinical symptoms and troponin elevation, and some had abnormal ECG or echocardiogram…

In a cohort of adolescents with COVID-19 mRNA vaccine-related myopericarditis, a large portion have persistent LGE abnormalities, raising concerns for potential longer-term effects. Despite these persistent abnormalities, all patients had rapid clinical improvement and normalization of echocardiographic measures of systolic function. For patients with short acute illness, no dysfunction demonstrated by echocardiogram at presentation and resolution of symptoms at follow up, return to sports was guided by normalization of CMR alone. In patients with persistent CMR abnormalities we performed exercise stress testing prior to sports clearance per myocarditis recommendations. We plan to repeat CMR at 1 year post-vaccine for our cohort to assess for resolution or continued CMR changes.
My preface to this next section: **Myocarditis can have severe long-term ramifications**

The presence of LGE is an indicator of cardiac injury and fibrosis and has been strongly associated with worse prognosis in patients with classical acute myocarditis. In a meta-analysis including 8 studies, Yang et al found that presence of LGE is a predictor of all cause death, cardiovascular death, cardiac transplant, rehospitalization, recurrent acute myocarditis and requirement for mechanical circulatory support. Similarly, Georgiopoulos et al found presence and extent of LGE to be a significant predictor of adverse cardiac outcomes in an 11 study meta-analysis. The persistence of LGE over time and its prognostic value is less well established. Malek et al found that in a cohort of 18 patients with myocarditis, nearly 70% had persistent CMR changes at a median follow-up time of 7 months. Dubey et al found similar findings in their cohort of 12 pediatric patients, with persistence of LGE in all patients despite resolution of edema. Prognostic meaning of LGE in vaccine associated myopericarditis requires further study.

https://www.jpeds.com/article/S0022-3476(22)00282-7/fulltext

Study looks at spike protein in the blood from infection compared to that from COVID-19 injections

A ***Stanford Department of Pathology*** study published in ***Cell*** March 17th, 2022 titled, **Immune imprinting, breadth of variant recognition, and germinal center response in human SARS-CoV-2 infection and vaccination**, found interesting and somewhat surprising reasons for variable levels of spike in the blood and how these fluctuations can cause short and long-term reactions in the body.

Interestingly, this study was funded in part by the NIH and The Bill and Melinda Gates Foundation.

From the study

At least some portion of spike antigen generated after administration of BNT162b2 becomes distributed into the blood.

We detected spike antigen in 96% of vaccinees in plasma collected 1–2 days after the prime injection, with antigen levels reaching as high as 174 pg/mL.

The range of spike antigen concentrations in the blood of vaccinees at this early time point largely overlaps with the range of spike antigen concentrations reported in plasma in a study of acute infection (Ogata et al., 2020) although a small number of infected individuals had higher concentrations in the ng/mL range. At later time points after vaccination, the concentrations of spike antigen in blood quickly decrease although spike is still detectable in plasma in 63% of vaccinees 1 week after the first dose.

A practical finding in our study is that the detection of spike antigen in plasma samples is impeded after second dose BNT162b2 vaccination, likely due to the formation of circulating immune complexes of anti-spike antibodies and spike protein, masking the antigen epitopes of the capture and detection antibodies that form the basis of antigen detection assays, similar to assay interference that has been reported for other diseases.

Study highlights for the spike protein in the blood

Important points:

This study is to understand the effect of the booster dose. Authors concluded that the immunity generated by the vaccine is better than the infection. It is an interesting and a thorough study where researchers observed antibodies to vaccine or infection and their levels in plasma and saliva. Authors noted the levels of IgM, IgG, and IgA. In this process, they observed and documented something that is of interest to me. It is the spike proteins from vaccine in the blood, and the duration it remains in the blood.

Spike protein in the blood and lymph nodes:

In the lymph nodes the Spike Proteins are found up to 8 weeks after the vaccination.

At least some portion of the antigen produced by the vaccine is distributed in the blood. What proportion from the whole volume is not known. However, the amount distributed to the blood is very similar to the amount observed after an acute COVID infection. As a reminder a study showed the amount of spike in the blood of acute COVID patients to be 70 pg/mL.

Days 1-2 after vaccine:

96% of the vaccinees had spike proteins in the plasma. Median spike concentration was 47 pg/mL. Levels reached as high as 174 pg/mL in some vaccinees. And, a small number of individuals had the spike protein levels in the blood in ng/mL. (Thousands of times more than the acute COVID)

Day 7 after vaccine:

63% of vaccinees had spike proteins in the plasma. Median spike concentration was 1.7 pg/mL.

21 Days after the booster:

Spike concentration was reduced in the plasma. Reason was that the previously trained immune system produced antibodies. These antibodies attached to the new spike in the blood. Forming complexes. This binding eliminated the chances of the spikes to bind with the test kit. Hence, the test kit showed no spikes. This is called a window period, where antibodies and the antigens are not found because they are bound as circulating immune complexes. This phenomenon is also responsible for impeded detection of spike protein in the plasma after the second shot.…**However**, these complexes can be dangerous as well. They can cause Type II & III hypersensitivity reactions. They can lay on the surface of tissues attracting macrophages which stimulate cytokine and chemokine release leading to inflammatory reactions like vasculitis, arthritis and glomerulonephritis and numerous other tissue surfaces. Authors proved this hypothesis by adding spike

proteins in the plasma in high concentrations and observe their levels. And, this may explain in part why adverse reactions after the second injections are more prevalent than after the first.

Due to the antigen-antibody complex formations, the spike detection in the plasma is impeded after the second dose.

Authors found that the Pfizer-BionTech vaccine generates IgG in as high levels as acute COVID disease, with a similar time course.

https://www.sciencedirect.com/science/article/pii/S0092867422000769

An interesting and informative discussion on this study can be found done by Dr. Mobeen Syed here: https://www.youtube.com/watch?v=-Y7dTMzn9B8&t=1630s

The Washington Times publishes an opinion piece that asks tough questions about excess deaths that spike after COVID-19 shots

The piece titled, **Excess deaths raise questions about COVID-19 vaccines - Correlation or coincidence?**, reveals some very uncomfortable correlations that demand independent investigation.

By Editorial Board - The Washington Times - Sunday, March 20, 2022

OPINION:

Americans are hearing they need another dose of the COVID-19 vaccine. The news is as unwelcome as an annoying jingle that keeps repeating unbidden in the brain. It is also puzzling since the pandemic and its attendant panic are subsiding. Before submitting for another jab — and another and another — the nation's medical establishment should come clean on what it knows about troubling spikes in death that have followed recurring waves of frightened citizens crowding pharmacies for their turn to get vaccinated.

Pfizer CEO Albert Bourla told CBS' "Face the Nation" a week ago the three-dose vaccine his company has manufactured "is good enough — actually quite good for hospitalizations and deaths." Protection against variants like omicron is short-lived, though, and "it is necessary, a fourth [dose] for right now," he said.

There are certain effects associated with the Pfizer shot and the similarly formulated Moderna injection that raise questions — sometimes described darkly as "vaccine hesitancy" — among reasonable individuals.

One anomaly that fairly shouts for attention arises from a graphic published by the U.S. Centers for Disease Control and Prevention showing dramatic surges in the excess death rate among Americans of the 25-44 age group during the pandemic.

Concerned citizens with analytical skills have observed a fluctuating pattern to these coronavirus deaths and have searched for clues to explain it. Former BlackRock portfolio manager Edward Dowd noticed a 36% death rate rise between November 2020 and February 2021 when the vaccines debuted, a much sharper spike between August and December 2021 when government-ordered vaccine mandates mushroomed and, most recently, a 42% hike during the first two months of 2022 when Americans were urged to get the third-dose boosters.

“The millennial generation experienced 61k excess death in the second half of 2021,” wrote Mr. Dowd in a March 10 tweet clearly crafted to roil vaccine orthodoxy. “That is a Vietnam War event. Death by government mandates … we call this democide.”

Correlation is not necessarily causation, but a seemingly recurrent interrelationship between inoculation and death within a relatively robust age cohort suggests that Mr. Dowd is eying a statistical nugget that requires a full accounting.

Feminist author Naomi Wolf has pointed out another uncomfortable finding that requires explanation. On Steve Bannon’s “War Room” Tuesday, Ms. Wolf described a “pretty terrifying” discovery among 55,000 documents related to the COVID-19 vaccines that the U.S. Food and Drug Administration tried unsuccessfully to shield from public scrutiny for 75 years: a chart showing vaccine batches formulated with varying concentrations of ingredients.

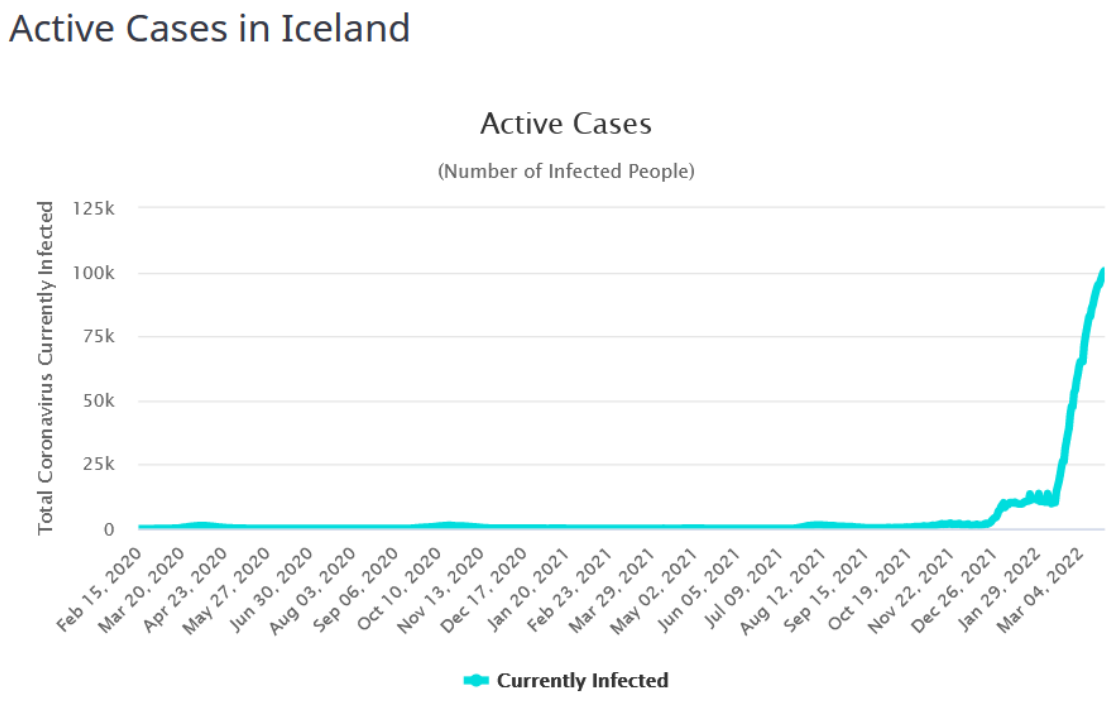
“If you look at this table, it would appear that some batches have more of the spike protein … than others,” she said. The implication is that strong doses of the critical immune-response-triggering ingredient administered without regard for a patient’s physical size and medical history could result in deadly side effects.

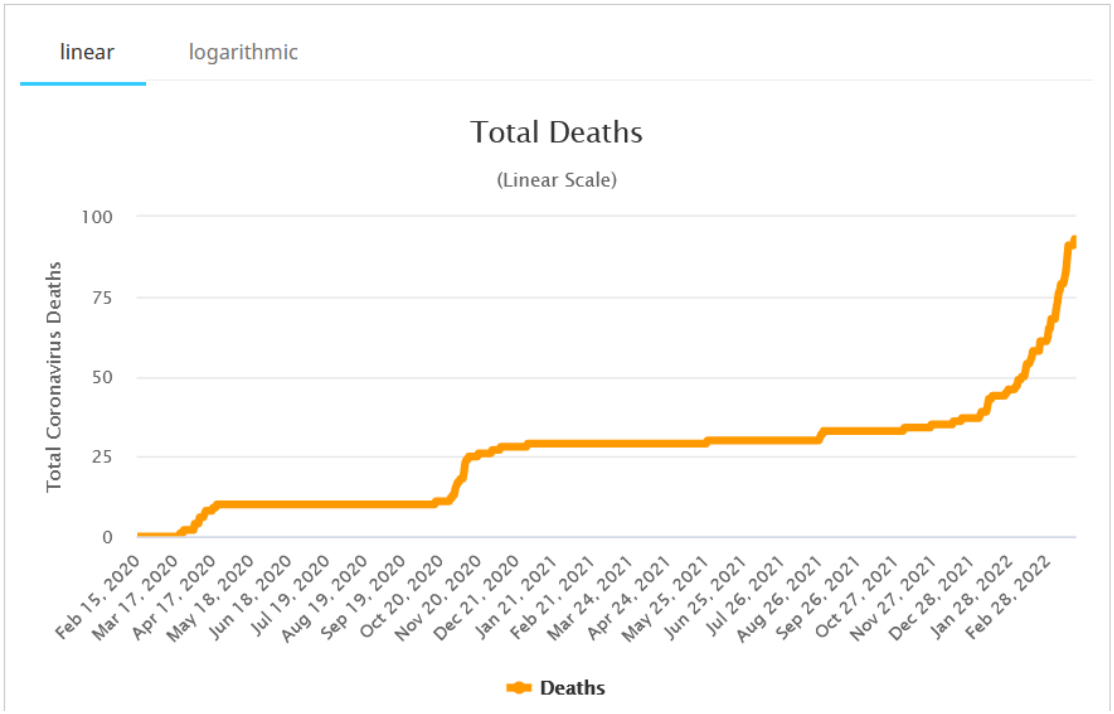
Americans deserve to know whether excess deaths that surge in tandem with the repetitive rush for the next vaccine dose are coincidence or correlation.

End of opinion piece

https://m.washingtontimes.com/news/2022/mar/20/editorial-excess-deaths-raise-questions-about-covi/

Iceland, 79% fully vaccinated and in the top 10 most vaccinated countries in the world seeing huge uptick in COVID cases and deaths since the boosters rolled out

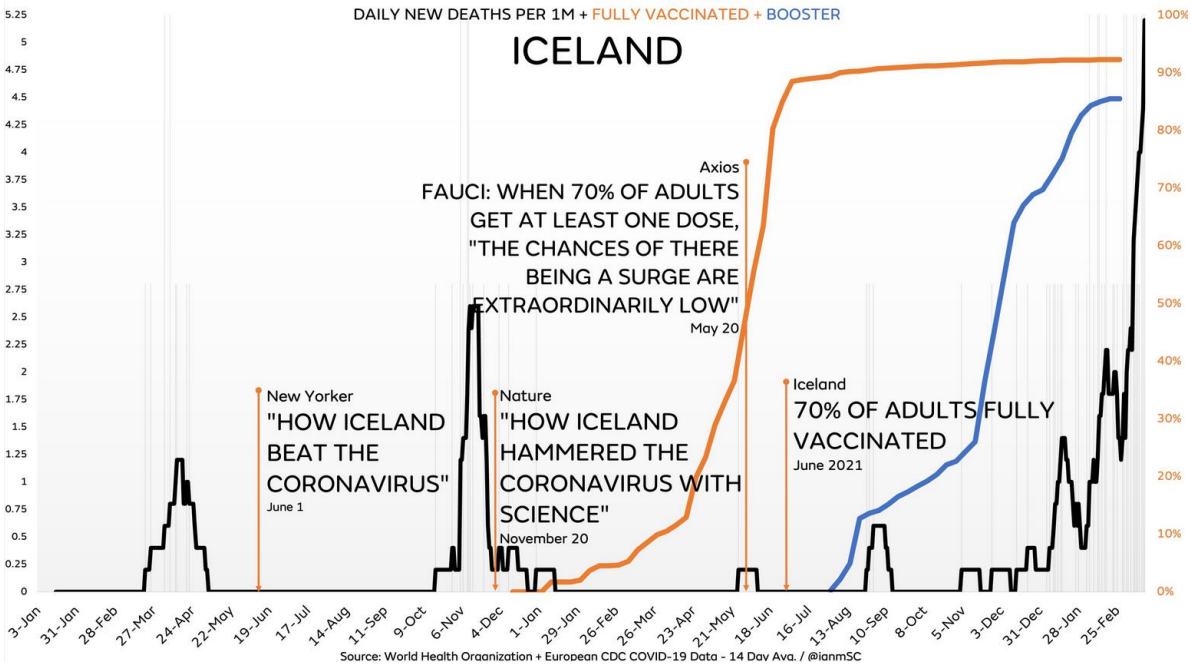




As you look at the point where the steepest incline occurs in both graphs, realize that the 3rd shot boosters were rolled out the end of November and peaked at approximately 65% of the population boosted by the beginning of February. If boosters prevented infections and deaths, you would never know it from the data.

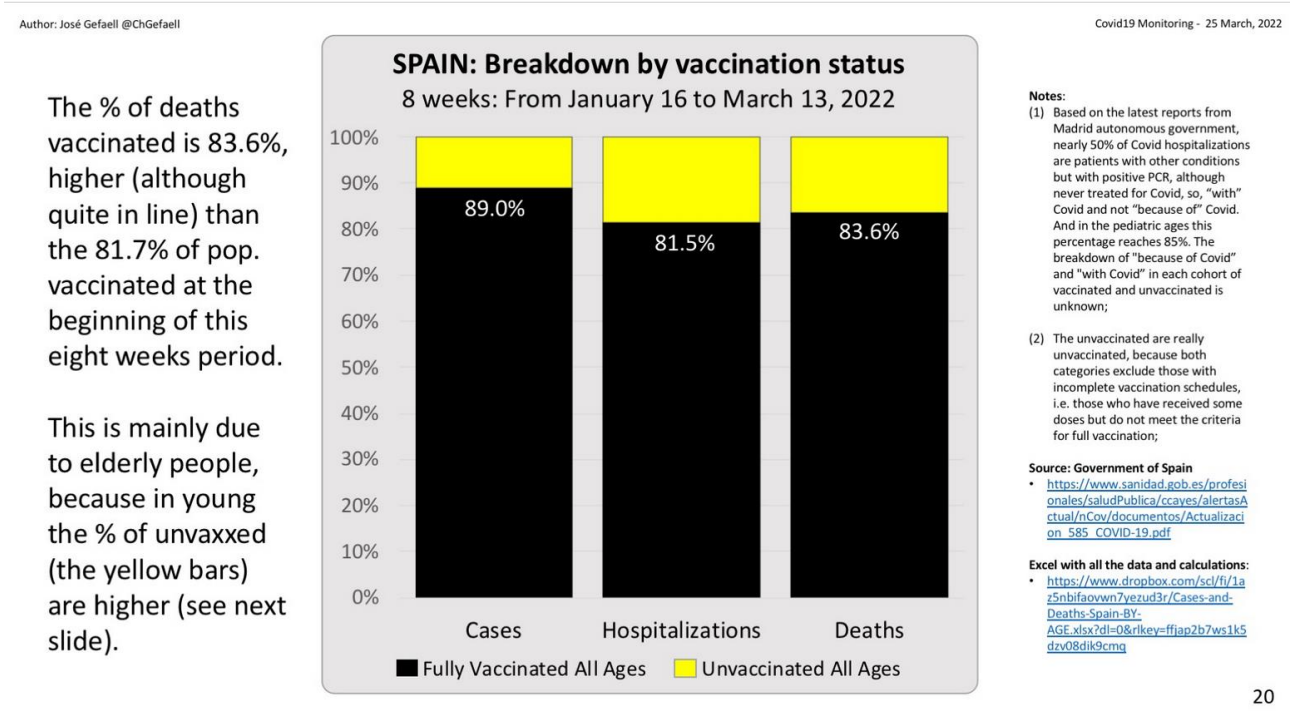
https://www.euronews.com/next/2021/11/21/covid-boosters-is-the-definition-of-fully-vaccinated-about-to-change-to-mean-3-vaccine-dos
https://ourworldindata.org/covid-vaccinations

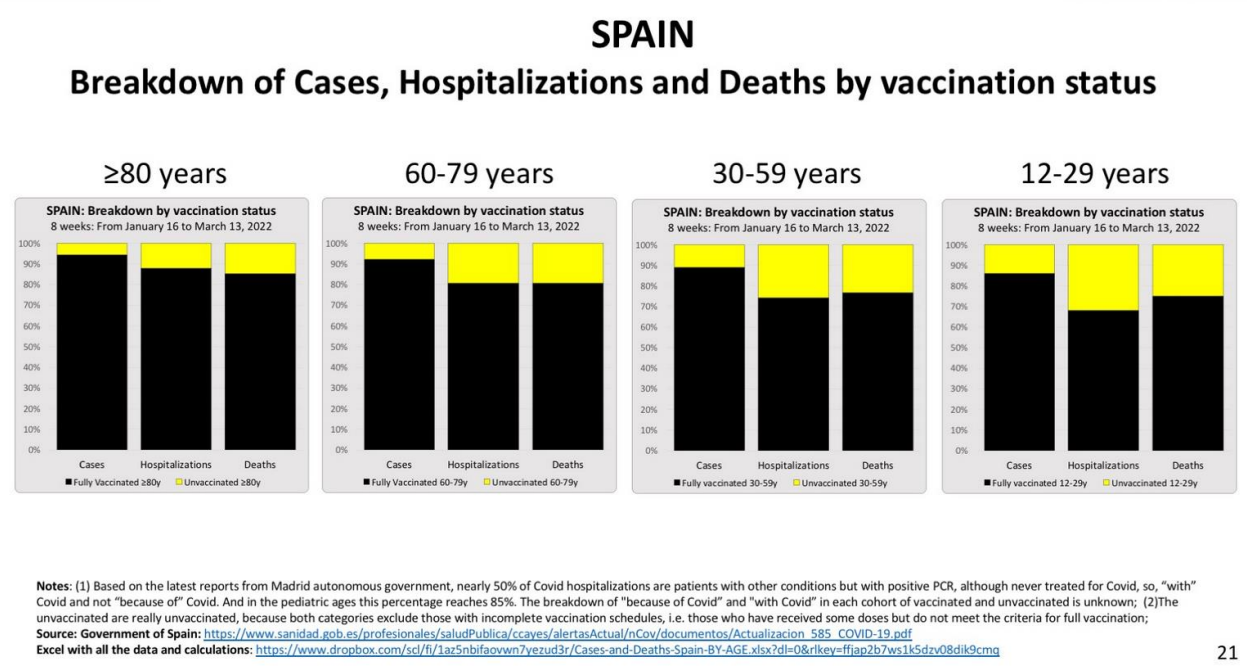
Here is another graph from a Tweet by Ian Miller @ianmSC



Spain, one of the highest vaccinated countries of the world is seeing a major percentage of cases, hospitalizations and deaths in the fully vaccinated

Yes, but people will say “if they are so highly vaccinated of course the percentage of cases (especially) and even hospitalizations and deaths will be more predominate in the vaccinated.” How many times have we heard that or something like it? But if the injections work to prevent hospitalizations and deaths as we hear ad nauseum, explain how as the data and the graph below shows, 81.7% are fully vaccinated, yet they represent 83.6% of the COVID-19 deaths.





You can follow JOSE GEFAELL on Twitter @ChGefaell

In light of the stories about escalating hospitalizations and deaths in the fully vaccinated check out this next story…

Dr. Geert Vanden Bossche makes a dire prediction that highly contagious variants will continue to develop in the most highly vaccinated countries and escalate into more severe disease and death in vaccinees

Dr. Vanden Bossche has been an outspoken critic of the policy driving mass vaccination in the midst of a pandemic and mandates that would require them. His resume is extensive, and he is highly qualified to speak on these subjects. Since it became obvious that these experimental gene therapy injections were going to be the route of choice for nations globally, he has been predicting outcomes and warning the World Health Organization and public health agencies all over the world about the potential consequences of such actions. And, to date he has been spot-on with his predictions. This latest prediction is a dire warning to those continuing to receive these injections. The 45-page paper he has produced (link below), is well organized and very comprehensive.

Quote from the paper

"I SERIOUSLY expect that a series of new highly virulent and highly infectious SARS-CoV-2 (SC-2) variants will now rapidly and independently emerge in highly vaccinated countries all over the world and that they will soon spread at high pace. I expect the current pattern of repetitive infections and relatively mild disease in vaccinees to soon aggravate and be replaced by severe disease and death. Unfortunately, there is no way vaccinees can rely on assistance from their innate immune system to protect against coronaviruses as their relevant innate IgM antibodies are increasingly being outcompeted by infection-enhancing vaccinal Abs, which are continuously recalled due to the circulation of highly infectious Omicron variants. In contrast, Omicron's high infectiousness would enable the non-vaccinated to train their innate immune defense against SC-2 while the infectious and pathogenic capacity of the new SC-2 variants would be debilitated in the non-vaccinated for lack of infection-enhancing Abs in their blood. Unless..."

Link to the website and the 45 page paper: https://www.voiceforscienceandsolidarity.org/scientific-blog/predictions-gvb-on-evolution-c-19-pandemic

I have covered many stories related to Dr. Vanden Bossche in past issues. For those of you not familiar with his qualifications, here his part of his resume.

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

Study in mainstream journal cites: "Vaccine escape mutation" viral strains caused by "vaccine induced evolutionary pressure" leading to high rates of infections "among highly vaccinated populations"

This study is just one of a growing number of published studies showing that the vaccines are causing an evolutionary pressure on the virus to mutate, making highly vaccinated individuals more susceptible to these variants. This can clearly be seen in data coming out of countries that are publishing their full data like the UK as shown in other stories in this issue and previous issues.

The study was released after peer review in the journal ***ACS Infectious Diseases*** and titled, **Emerging Vaccine-Breakthrough SARS-CoV-2 Variants.**

The abstract

The surge of COVID-19 infections has been fueled by new SARS-CoV-2 variants, namely Alpha, Beta, Gamma, Delta, and so forth. The molecular mechanism underlying such surge is elusive due to the existence of 28 554 unique mutations, including 4 653 non-degenerate mutations on the spike protein. Understanding the molecular mechanism of SARS-CoV-2 transmission and evolution is a prerequisite to foresee the trend of emerging vaccine-breakthrough variants and the design of mutation-proof vaccines and monoclonal antibodies. We integrate the genotyping of 1 489 884 SARS-CoV-2 genomes, a library of 130 human antibodies, tens of thousands of mutational data, topological data analysis, and deep learning to reveal SARS-CoV-2 evolution mechanism and forecast emerging vaccine-breakthrough variants. We show that prevailing variants can be quantitatively explained by infectivity-strengthening and vaccine-escape (co-)mutations on the spike protein RBD due to natural selection and/or vaccination-induced evolutionary pressure. We illustrate that infectivity strengthening mutations were the main mechanism for viral evolution, while vaccine-escape mutations become a dominating viral evolutionary mechanism among highly vaccinated populations. We demonstrate that Lambda is as infectious as Delta but is more vaccine-resistant. We analyze emerging vaccine-breakthrough comutations in highly vaccinated countries, including the United Kingdom, the United States, Denmark, and so forth. Finally, we identify sets of comutations that have a high likelihood of massive growth: [A411S, L452R, T478K], [L452R, T478K, N501Y], [V401L, L452R, T478K], [K417N, L452R, T478K], [L452R, T478K, E484K, N501Y], and [P384L, K417N, E484K, N501Y]. We predict they can escape existing vaccines. We foresee an urgent need to develop new virus combating strategies.

https://pubmed.ncbi.nlm.nih.gov/35133792/

Study on brain cells exposed to Pfizer's injection show several aberrations that can cause multiple issues in the nervous system including ones similar to that seen in brain cancer

The study published on the pre-print server ***bioRxiv*** March 2nd, 2022, titled, **Decoding COVID-19 mRNA Vaccine Immunometabolism in Central Nervous System: human brain normal glial and glioma cells by Raman imaging**, reveals some shocking revelations about the product's damaging effects on nerve and brain cells.

***My comment:**
Obviously some of the language in the study is somewhat technical, but I've bolded the key parts of the study to grasp and given some context or explanation in italics.

Context:

Originally, **glial cells**—also called glia or neuroglia—were believed to just provide structural support. The word glia literally means "neural glue."

Discoveries in recent years have revealed that they perform all kinds of functions in the brain and the nerves that run throughout the body.

The abstract

The paper presents the effect of COVID-19 mRNA (Pfizer/BioNT) vaccine on in vitro glial cells of the brain studied by means of Raman spectroscopy and imaging. The results **obtained for human brain normal and tumor glial cells of astrocytes** *(a type of specialized glial immune cell that tiles the entire nervous system)***, astrocytoma** *(cancer of the astrocytes)***, glioblastoma incubated with the Covid-19 mRNA vaccine Pfizer/BioNT vaccine show alterations in the reduction-oxidation pathways associated with Cytochrome c**.

We found that the Pfizer/BioNT vaccine down regulate *(decrease)* the concentration of cytochrome c *(a protein that helps with massive cellular energy production, reduced oxidative stress thus protection of mitochondria the organelles in cells that make energy, and helps in destruction of abnormal cells with DNA damage or cancer)* **in mitochondria** upon incubation with normal and tumorous glial cells. **Concentration of oxidized form of cytochrome c in brain cells has been shown to decrease upon incubation the mRNA vaccine. Lower concentration of oxidized cytochrome c results in lower effectiveness of oxidative phosphorylation (respiration)** *(production of ATP or energy)***, reduced apoptosis** *(the positive orchestrated cell death of damaged and mutated cells)* **and lessened ATP production.** Alteration of Amide I concentration, which may reflect the decrease of mRNA adenine nucleotide translocator. **Moreover, mRNA vaccine leads to alterations in biochemical composition of lipids that suggest the increasing role of signaling. mRNA vaccine produce statistically significant changes in cell nucleus due to histone alterations. The results obtained for mitochondria, lipid droplets, cytoplasm may suggest that COVID-19 mRNA (Pfizer/BioNT) vaccine reprograms immune responses** *(NOT good)***. The observed alterations in biochemical profiles upon incubation with COVID-19 mRNA in the specific organelles of the glial cells are similar to those we observe for brain cancer vs grade of aggressiveness** *(WOW! Not good at all!)***.**

Conclusions

We showed that new tools of Raman imaging we present in this paper raise exciting possibilities for new ways to understand links between pathways of cancer, immune responses, and recognize metabolites that regulates these pathways.

We used Raman spectroscopy to monitor changes in the redox state of the mitochondrial cytochromes in human brain cells *in vitro* of normal astrocytes, astrocytoma, glioblastoma upon incubation with mRNA vaccine. We observed the effect of the mRNA vaccine on biodistribution of different chemical components, particularly cytochrome c, in the specific organelles of human brain glial cells: nucleus, mitochondria, lipid droplets, cytoplasm, rough endoplasmatic reticulum and membrane.

We showed that mRNA vaccine (Pfizer) changes mitochondria by downregulation of cytochrome c resulting in lower effectiveness of respiration (oxidative phosphorylation) and lower ATP production. **It can lead to lower immune system response.**

Decrease of Amide I concentration in mitochondrial membrane potential may suggest functional deterioration of the adenine nucleotide translocator. mRNA vaccine modifies significantly de novo lipids synthesis in lipid droplets. The results presented in paper suggest that upon incubation with mRNA the role of signaling function of lipid droplets increases. **The observed alterations in biochemical profiles upon incubation with the Pfizer/BioNT in the specific organelles of the glial cells are similar to those we observe for brain cancer vs grade of aggressiveness.** *(Had to highlight that one again, because it is so shocking, disturbing and may be a foreshadowing of a future uptick, maybe even epidemic of many different diseases, health problems, including brain cancer).*

https://www.biorxiv.org/content/10.1101/2022.03.02.482639v1

Speaking of the injections leading to impaired immune response, I would like to recommend reading this next excellent article posted March 22, 2022 in ***The Defender*** on ***Children's Health Defense*** web site.

HIV gene sequences are in the spike protein of the SARS-CoV-2 virus AND the vaccines seem to impair the innate immune system of those getting the shots

The article titled, **Repeated COVID Vaccines May Impair Immune System's Natural Ability to Fight** Disease, is by Rob Verkerk Ph.D., founder of ***Alliance for Natural Health International***, explores the links between SARS-CoV-2, COVID-19 vaccines, HIV and immune deficiency.

Here are some bullet points discussed in the article…

Topline:

- Jean Claude Perez and Nobel laureate Luc Montagnier identified 18 gene sequences in HIV-1 that are present in the spike protein of SARS-CoV-2.
- Among these are gp120 that facilitates the attachment of the "spike" of HIV to host cells as well as helping HIV target CD4 T cells.

- Emerging evidence shows that chronic exposure to COVID-19 “vaccines” that occur through administration of regular boosters can disrupt T cells generally, and, more particularly, suppress CD4 T cells that are targeted by gp120.

- Such chronic exposure can also erode all-important innate immunity and increase the risk of new-onset autoimmune conditions. These might contribute to what has been described as VAIDS (vaccine-induced acquired immunodeficiency syndrome).

- Despite known harms to HIV/AIDS patients from a genetically engineered common cold virus (adenovirus type-5) used as a vector in the STEP trials in the early 2000s, some vaccine manufacturers, with the World Health Organization’s (WHO) approval, are continuing pre-clinical or clinical development with these same adenovirus vectors.

- Some of the HIV motifs present in SARS-CoV-2 are highly functional in terms of facilitating attachment and fusion on host target cells, but are missing from the genetically very similar SARS virus.

- People who are already immune compromised or have had a history of cancer should very carefully weigh up the risks of COVID-19 and the vaccines, as well as the benefits. They should also consider the many alternatives before simply complying with what have now become social norms despite a common absence of evidence of medical need.

Regarding effects on the immune system, this section…

Immune erosion by COVID-19 injections

Added to this was mounting concern among scientists, such as renowned Belgian vaccinologist Geert Vanden Bossche Ph.D., that successive COVID-19 injections may compromise the effectiveness of the immune system, especially trained innate immunity gained following naturally-acquired infection.

Vanden Bossche has proposed that high levels of non-sterilizing (“leaky”) “vaccinal” antibodies produced following injection, suppress all-important, polyreactive, antibodies produced by specialized subsets of B cells (B-1 and marginal zone B cells) associated with the innate immune system.

While innate immunity is the first line of defense for everyone, it is children in particular who are most reliant on it, given the immaturity of the adaptive arm of their immune systems, the latter being the primary mechanism of defense against respiratory pathogens in adults.

The absence of any substantive scientific or medical rationale for “vaccinating” children against COVID-19 is dealt with comprehensively by Kostoff et al., (2021). and Seneff et al., (2022).

The intended purpose of COVID-19 injections is, of course, not to up-regulate the innate immune system, but rather, neutralizing antibodies in the adaptive arm of the immune system (the humoral immune response). Therefore any erosion of innate immunity or disruption of cell-mediated adaptive immunity (through T cells) associated with regular exposure to COVID-19 injections should be viewed as collateral damage.

While mechanistic, clinical and even epidemiological evidence of such immune system disruption is beginning to emerge, it may be years before the significance of the effects of such erosion or disruption on different population groups with varying health status is widely understood and recognized.

Another emerging piece of the jigsaw that connects potential immune erosion with HIV is the possibility of the development of "vaccine acquired immunodeficiency syndrome" or VAIDS.

Attempts by "fact-checkers" and the mainstream media have been made to debunk such claims but these challenges to the existence of VAIDS are scientifically hollow and appear to be politically or economically motivated.

With increasing frequency of exposure of people to COVID-19 injections that erode innate immunity and disrupt cell-mediated (T cell) immune responses, it is highly likely we will witness a rise in VAIDS.

It may be longer before health authorities and vaccine manufacturers who have pushed to achieve incredibly high rates of vaccine coverage in many industrialized countries are prepared to recognize that the injections are the cause.

Read the entire article here:
https://childrenshealthdefense.org/defender/repeated-covid-vaccines-impair-immune-system/

In addition to the potential HIV gene sequence connection, don't think the SARS-CoV-2 virus had other gain of function lab alterations? Check out this next study.

New research confirms that a patented 19-nucleotide gene sequence not found in nature was inserted precisely in the position of the spike protein of the SARS-CoV-2 virus, that would make it more likely to infect human cells

A February 21st, article published in ***Frontiers in Virology*** article titled, **MSH3 Homology and Potential Recombination Link to SARS-CoV-2 Furin Cleavage Site**, presents some very damning evidence that the Wuhan Virus was engineered in a lab. The furin cleavage site is what gives the virus the ability to infect with higher transmission, bind with human ACE-2 receptors, cause infection and ultimately a greater ability of the virus to replicate at higher levels and potentially overwhelm the immune system. In animal models, the furin cleavage site has been shown to cause more severe disease. And, bear in mind that this furin cleavage site does not appear in any other coronaviruses that some claim "evolved" into SARS-CoV-2.

The abstract

Among numerous point mutation differences between the SARS-CoV-2 and the bat RaTG13 coronavirus, only the 12-nucleotide furin cleavage site (FCS) exceeds 3 nucleotides. A BLAST search revealed that a 19 nucleotide portion of the SARS.Cov2 genome encompassing the furing cleavage site is a 100% complementary match to a codon-optimized proprietary sequence that is the reverse complement of the human mutS homolog (MSH3). The reverse complement sequence present in SARS-CoV-2 may occur randomly but other possibilities must be considered. Recombination in an intermediate host is an unlikely explanation. Single stranded RNA viruses such as SARS- CoV-2 utilize negative strand RNA templates in infected cells, which might lead through copy choice recombination with a negative sense SARS-CoV-2 RNA to the integration of the MSH3 negative strand, including the FCS, into the viral genome. In any case, the presence of the 19-nucleotide long RNA sequence including the FCS with 100% identity to the reverse complement of the MSH3 mRNA is

highly unusual and requires further investigations.

From the article

A BLAST search for the 12-nucleotide insertion led us to a 100% reverse match in a proprietary sequence (SEQ ID11652, nt 2751-2733) **found in the US patent 9,587,003 filed on Feb. 4, 2016** (10) (**Figure 1**). Examination of SEQ ID11652 revealed that the match extends beyond the 12-nucleotide insertion to a 19-nucleotide sequence: 5′-CTACGTGCCCGCCGAGGAG- 3′ (nt 2733-2751 of SEQ ID11652), such that the resulting mRNA would have 3′- GAUGCACGGGCGGCUCCUC-5′, or equivalently 5′- CU **CCU CGG CGG GCA** CGU AG-3′ (nucleotides 23547-23565 in the SARS-CoV-2 genome, in which the four bold codons yield PRRA, amino acids 681–684 of its spike protein). This is very rare in the NCBI BLAST database.

The correlation between this SARS-CoV-2 sequence and the reverse complement of a proprietary mRNA sequence is of uncertain origin. Conventional biostatistical analysis indicates that the probability of this sequence randomly being present in a 30,000-nucleotide viral genome is 3.21×10^{11} ***(My comment: That is over a 1 in 3 trillion probability that it was by chance).***

The presence in SARS-CoV-2 of a 19-nucleotide RNA sequence encoding an FCS at amino acid 681 of its spike protein with 100% identity to the reverse complement of a proprietary MSH3 mRNA sequence is highly unusual. Potential explanations for this correlation should be further investigated.

https://www.frontiersin.org/articles/10.3389/fviro.2022.834808/full

My comments: It appears that the furin cleavage sequence was inserted at precisely the location where it would enable the virus to enter a human cell. That 19-nucleotide sequence was an exact copy of a previously patented sequence (which therefore doesn't occur in nature; otherwise, it couldn't have been patented) and it was inserted in precisely the location where it could produce a "gain of function".

Keep in mind that the whole SARS-CoV-2 genome is approximately 30,000 base pairs. Most mutations found in nature are a 3-nucleotide mutation, making this one beyond highly improbable and about as impossible as it could get, as stated above. The sequences, also has within it a sequence labeled MSH-3. This is a human protein.

Once inside the cell, the cells machinery makes more copies, which increase the amount to MSH-3 inside our cells. This can cause overexpression of MSH-3 and slow repair of our DNA and could cause cancers. All of this is discussed in the study. Also, you can watch Dr. Been's podcast about this here: https://www.youtube.com/watch?v=zPoZTtruaB0&t=2034s

An eye-opening, jaw dropping editorial opinion in the *British Medical Journal* pulls back the curtain on the out-of-control corruption that occurs between Big Pharma, regulatory agencies and researchers as business as usual

The piece was published March 16th, 2022 and titled, **The illusion of evidence based medicine**. The authors are very experienced and knowledgeable in this subject, as they have authored a 2020 book release titled, **The Illusion of Evidence-Based Medicine: Exposing the Crisis of Credibility in Clinical Research**. The editorial has excellent references showing examples of what they claim which can be accessed from the link at the bottom

of the editorial below.

The editorial in full

Evidence based medicine has been corrupted by corporate interests, failed regulation, and commercialisation of academia, argue these authors.

The advent of evidence based medicine was a paradigm shift intended to provide a solid scientific foundation for medicine. The validity of this new paradigm, however, depends on reliable data from clinical trials, most of which are conducted by the pharmaceutical industry and reported in the names of senior academics. The release into the public domain of previously confidential pharmaceutical industry documents has given the medical community valuable insight into the degree to which industry sponsored clinical trials are misrepresented. Until this problem is corrected, evidence based medicine will remain an illusion.

The philosophy of critical rationalism, advanced by the philosopher Karl Popper, famously advocated for the integrity of science and its role in an open, democratic society. A science of real integrity would be one in which practitioners are careful not to cling to cherished hypotheses and take seriously the outcome of the most stringent experiments. This ideal is, however, threatened by corporations, in which financial interests trump the common good. Medicine is largely dominated by a small number of very large pharmaceutical companies that compete for market share, but are effectively united in their efforts to expanding that market. The short term stimulus to biomedical research because of privatisation has been celebrated by free market champions, but the unintended, long term consequences for medicine have been severe. Scientific progress is thwarted by the ownership of data and knowledge because industry suppresses negative trial results, fails to report adverse events, and does not share raw data with the academic research community. Patients die because of the adverse impact of commercial interests on the research agenda, universities, and regulators. The pharmaceutical industry's responsibility to its shareholders means that priority must be given to their hierarchical power structures, product loyalty, and public relations propaganda over scientific integrity. Although universities have always been elite institutions prone to influence through endowments, they have long laid claim to being guardians of truth and the moral conscience of society. But in the face of inadequate government funding, they have adopted a neo-liberal market approach, actively seeking pharmaceutical funding on commercial terms. As a result, university departments become instruments of industry: through company control of the research agenda and ghostwriting of medical journal articles and continuing medical education, academics become agents for the promotion of commercial products. When scandals involving industry-academe partnership are exposed in the mainstream media, trust in academic institutions is weakened and the vision of an open society is betrayed.

The corporate university also compromises the concept of academic leadership. Deans who reached their leadership positions by virtue of distinguished contributions to their disciplines have in places been replaced with fundraisers and academic managers, who are forced to demonstrate their profitability or show how they can attract corporate sponsors. In medicine, those who succeed in academia are likely to be key opinion leaders (KOLs in marketing parlance), whose careers can be advanced through the opportunities provided by industry. Potential KOLs are selected based on a complex array of profiling activities carried out by companies, for example, physicians are selected based on their influence on prescribing habits of other physicians. KOLs are sought out by industry for this influence and for the prestige that their university affiliation brings to the branding of the company's products. As well paid members of pharmaceutical advisory boards and speakers' bureaus, KOLs present results of industry trials at medical conferences and in continuing medical education. Instead of acting as independent, disinterested scientists and critically evaluating a drug's performance, they become what marketing executives refer to as "product champions."

Ironically, industry sponsored KOLs appear to enjoy many of the advantages of academic freedom, supported as they are by their universities, the industry, and journal editors for expressing their views, even when those views are incongruent with the real evidence. While universities fail to correct misrepresentations of the science from such collaborations, critics of industry face rejections from journals, legal threats, and the potential destruction of their careers. This uneven playing field is exactly what concerned Popper when he wrote about suppression and control of the means of science communication. The preservation of institutions designed to further scientific objectivity and impartiality (i.e., public laboratories, independent scientific periodicals and congresses) is entirely at the mercy of political and commercial power; vested interest will always override the rationality of evidence.

Regulators receive funding from industry and use industry funded and performed trials to approve drugs, without in most cases seeing the raw data. What confidence do we have in a system in which drug companies are permitted to "mark their own homework" rather than having their products tested by independent experts as part of a public regulatory system? Unconcerned governments and captured regulators are unlikely to initiate necessary change to remove research from industry altogether and clean up publishing models that depend on reprint revenue, advertising, and sponsorship revenue.

Our proposals for reforms include: liberation of regulators from drug company funding; taxation imposed on pharmaceutical companies to allow public funding of independent trials; and, perhaps most importantly, anonymised individual patient level trial data posted, along with study protocols, on suitably accessible websites so that third parties, self-nominated or commissioned by health technology agencies, could rigorously evaluate the methodology and trial results. With the necessary changes to trial consent forms, participants could require trialists to make the data freely available. The open and transparent publication of data are in keeping with our moral obligation to trial participants—real people who have been involved in risky treatment and have a right to expect that the results of their participation will be used in keeping with principles of scientific rigour. Industry concerns about privacy and intellectual property rights should not hold sway.

End of editorial

https://www.bmj.com/content/376/bmj.o702

My comment: This information is certainly not new. There have been books over decades written about these practices and corruption. It has been known, but nothing has ever been done about it. And now with this pandemic, we are seeing in real-time how bad the corruption is and how deep it goes. The fact that the companies manufacturing these products and the people they control have so overplayed their hand may backfire, awakening an increased public awareness to these insidious and blatantly incestuous relationships and the incalculable harm they have and are causing. Hopefully this increased public awareness to the problem will bring about the necessary changes. Creating change will be difficult however, because of the regulatory capture and the layers of institutional corruption, especially the amount of money pharma has to throw around to key influencers, politicians, organizations, institutions and the media.

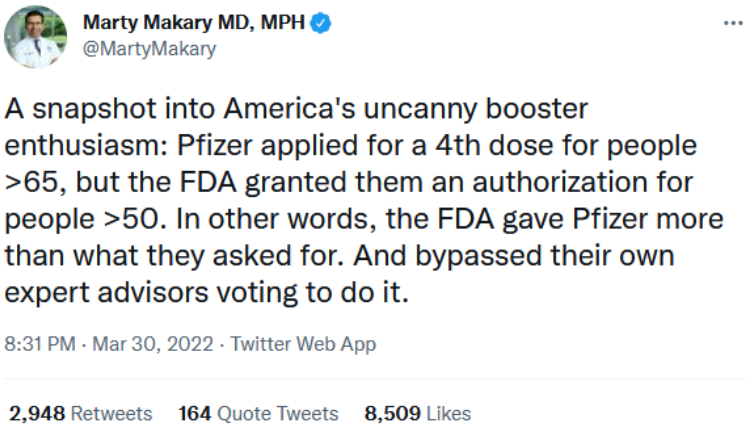
Want a contemporary example of this in action? Check out this tweet on the next page by Dr. Marty Makary from Johns Hopkins University and the Project Veritas undercover video embedded in it

Project Veritas captures undercover video of an FDA regulator spilling the beans

Read Dr. Marty Makary's post at the top of the screen capture below. Then after reading the Tweet post and watching the video, see his follow-up Tweet one day later.

Click on this link to watch the video: https://twitter.com/gurillaapp/status/1508818305918050306

One day later…



I think we can safely say that the FDA is running roughshod over all due process.

Pharmaceutical companies and the fines they've paid 1991-2017. Guess who's the #2 worst offender?

A report published by ***Public Citizen*** March 14th, 2018 titled, **Twenty-Seven Years of Pharmaceutical Industry Criminal and Civil Penalties: 1991 Through 2017** reports an extensive array of statistics on the penalties and fines paid by pharmaceutical companies over nearly three decades.

Table from the report…

Public Citizen Pharmaceutical Industry Settlements: 1991-2017

Table 4. Pharmaceutical Company Penalties: Worst Offenders, 1991-2017

Company*	Total Financial Penalties ($ millions)	Percent of Total**	Number of Settlements***
GlaxoSmithKline	$7,901	20.4%	32
Pfizer	$4,728	12.2%	34
Johnson & Johnson	$2,857	7.4%	20
Teva	$1,990	5.1%	16
Merck & Co.	$1,840	4.8%	22
Abbott	$1,840	4.8%	16
Eli Lilly	$1,742	4.5%	15
Schering-Plough	$1,339	3.5%	6
Novartis	$1,275	3.3%	21
Mylan	$1,180	3.1%	22
AstraZeneca	$1,035	2.7%	13
Amgen	$901	2.3%	12
TAP	$875	2.3%	1
Bristol-Myers Squibb	$815	2.1%	14
Serono	$704	1.8%	1
Purdue	$646	1.7%	5
Allergan	$601	1.6%	2
Daiichi Sankyo	$586	1.5%	8
Boehringer Ingelheim	$441	1.1%	16
Cephalon	$425	1.1%	1
Other****	$4,100	10.6%	196
Total	$37,822	97.9%	473

*Parent company at time of settlement. If company is non-existent now, name at time of most recent settlement was used.

**Percent of $38.647 billion in overall penalties.

https://citizen.org/sites/default/files/2408.pdf

The federal government paid $1,000,000,000 (one billion) dollars to news agencies to promote the COVID-19 injections

The March 7th article written by Bob Unruh is titled, **Documents reveal feds paid news outlets to praise COVID vaccines.**

I've decided to include the full article because it contains many details that help in understanding the context…

The article

Only recently has it been revealed that one of the "vaccines" for COVID-19, pushed by the federal government and pharmaceutical industry on Americans, many unwillingly, over the past two years can cause acute kidney injury, acute flaccid myelitis, anti-sperm antibody positive, brain stem embolism, brain stem thrombosis, cardiac arrest, cardiac failure and cardiogenic shock.

And among the 1,291 adverse side effects listed in an appendix of one federal report also are central nervous system vasculitis, deep vein thrombosis, encephalitis brain stem, encephalitis hemorrhagic, frontal lobe epilepsy, foaming at mouth, epileptic psychosis, facial paralysis, fetal distress syndrome, gastrointestinal amyloidosis and generalized tonic-clonic seizure.

Also Hashimoto's encephalopathy, hepatic vascular thrombosis, herpes zoster reactivation, immune-mediated hepatitis, interstitial lung disease, jugular vein embolism, juvenile myoclonic epilepsy, liver injury and low birth weight.

And hundreds more.

And now it has been revealed that while Americans were facing those life-and-death threats, the federal government was paying news outlets $1 billion to promote the experimental shots.

The Blaze reported through a Freedom of Information Act procedure, it found that the government purchased advertising from ABC, CBS and NBC as well as cable news stations Fox News, CNN and MSNBC, "legacy media publications including the New York Post, the Los Angeles Times, and the Washington Post, digital media companies like BuzzFeed News and Newsmax, and hundreds of local newspapers and TV stations."

The report explained, "These outlets were collectively responsible for publishing countless articles and video segments regarding the vaccine that were nearly uniformly positive about the vaccine in terms of both its efficacy and safety."

Chairman Mat Staver of Liberty Counsel, which has been active in fighting COVID-19 shot requirements, said, "People have been injured and died as a result of the most extensive propaganda campaign in U.S. history and it was paid for with our taxpayer dollars.

"These COVID shots are neither safe nor effective. However, the American public has been given propaganda instead of truth from the news media. Sadly, most of the American corporate media has been paid off by the Biden administration to publish propaganda. The consequence is that many people have needlessly suffered as a result of the censorship and propaganda."

Liberty Counsel explained that according to the investigation, Congress appropriated $1 billion in fiscal 2021 for the secretary of health to hand out in attempts to "strengthen vaccine confidence in the United States."

"Then hundreds of news organizations were paid by the federal government to advertise for the shots as part of a comprehensive media campaign by the U.S. Department of Health and Human Services," the organization reported.

The massive flood of money created a "national initiative to increase public confidence in and uptake of COVID-19 vaccines," the report said, by having "trusted messengers and influencers" speak to news organizations to "provide factual, timely information and steps people can take to protect themselves, their families, and their communities."

The Blaze reported the newsrooms then did not tell their audiences that they were getting paid to promote the vaccination agenda, as "common practice dictates that editorial teams operate independently of media advertising departments and news teams felt no need to make the disclosure, as some publications reached for comment explained."

The Blaze report explained federal law allows HHS to hand out money to "carry out a national, evidence-based campaign to increase awareness and knowledge of the safety and effectiveness of vaccines for the prevention and control of diseases, combat misinformation about vaccines, and disseminate scientific and evidence-based vaccine-related information, with the goal of increasing rates of vaccination across all ages ... to reduce and eliminate vaccine-preventable diseases."

Some of the ads, the report said, were "fear-based," in which patients were allowed to warn others to take the experimental shots.

Some, including Shani George of the Washington Post, said the newsroom is "completely independent" from advertising personnel, and the Los Angeles Times issued a similar comment.

But in fact some articles "reported pro-vaccine statements from CDC director Rochelle Walensky, FDA official Peter Marks, HHS Secretary Xavier Becerra, and University of California, San Francisco epidemiologist George Rutherford," and showed how "boosters work."

Another article advised readers how they could "convince vaccine-hesitant people in their lives to change their minds."

The Blaze reported, "Since the COVID-19 vaccines manufactured by Pfizer-BioNTech, Moderna, and Johnson & Johnson were given emergency approval for use in the United States last year, more than 215 million Americans have been fully vaccinated against COVID-19. An estimated 94.6 million people have also received at least one booster dose. About 65% of the U.S. population has now been fully vaccinated against COVID-19, including 75% of U.S. adults and 88.8% of seniors."

According to Liberty Counsel, Emerald Robinson, an independent journalist who used to be the chief White House correspondent for Newsmax and One America News, reported she was contacted by a whistleblower inside Newsmax who confirmed that Newsmax executives agreed to take the money from Biden’s HHS to push only positive coverage of the new COVID shots."

Liberty Counsel reported "Robinson was also contacted by top Newsmax executives in 2021 and told to stop

any negative coverage of the COVID shots. Newsmax told her 'it was problematic' and she was warned many times by multiple executives. She was also contacted by PR experts who worked with Newsmax and was told that medical experts and doctors who might say negative things about the injections would not be booked as guests."

Liberty Counsel reported that a federal judge now has ordered the Food and Drug Administration to release information it used to license the Pfizer/BioNTech injections, and the first 55,000-age page release included a 38-page report on the list of 1,291 side effects.

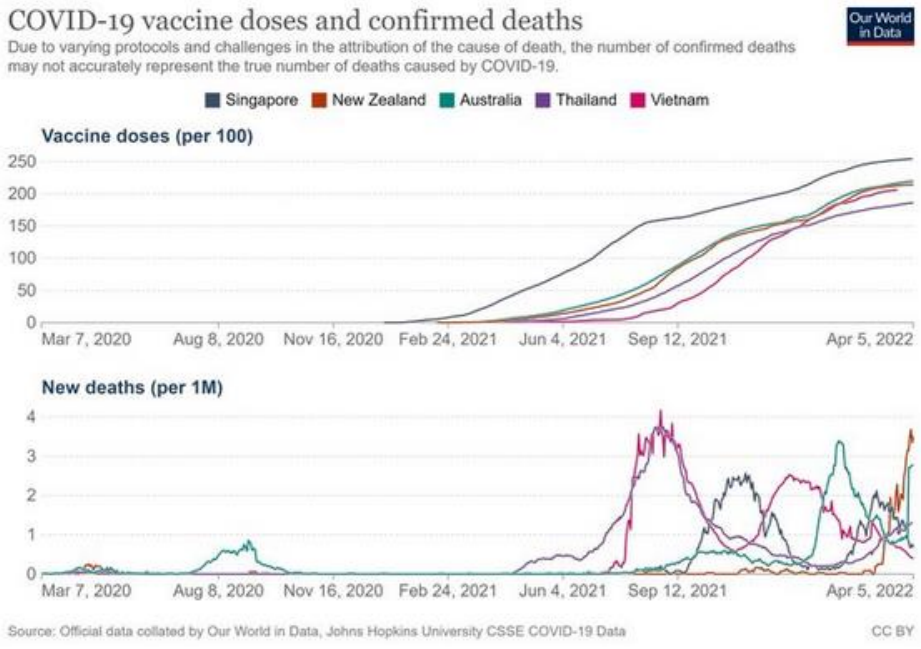
Liberty Counsel said the Centers for Disease Control and Prevention "also recently admitted that it withheld critical COVID-19 data from the public because the agency thought it would be 'misinterpreted' and cause 'vaccine hesitancy' since it weakens the case for booster shots in certain demographics. Apparently, the CDC has been collecting detailed data on COVID-19 infections in the United States and organized it by age, race and vaccination status. However, the agency withheld detailed information to the public about breakthrough cases, hospitalizations and deaths, which it has been collecting since the beginning of the COVID shot rollout in 2021."

A CDC spokeswoman recently told the New York Times that the data was withheld for "fear that the information might be misinterpreted." The Blaze said, "virtually all of these newsrooms produced stories covering the COVID-19 vaccines, the taxpayer dollars flowing to their companies were not disclosed to audiences in news reports."

https://www.wnd.com/2022/03/documents-reveal-feds-paid-news-outlets-praise-covid-vaccines/

Updates May 1st, 2022

The failure of the vaccines to prevent COVID-19 deaths in some of the highest vaccinated countries in one screen capture



Notice how the rise in deaths parallel the rise in vaccination rates in those countries

What's next in the COVID Controller's playbook as the narrative shifts away from the failed vaccine?

In an excellent April 16th Substack article by Meryl Nass MD, a Board-Certified Internal Medicine physician who is an expert in epidemics and anthrax. Dr. Nass explains why the COVID-19 vaccine narrative is unraveling and where the "powers that be" may be going from here.

The title is **COVID persists, but the COVID vaccine narrative has taken on so much water, the powers that be have stopped bailing, and are going to let these vaccines slowly sink.**

But what do they have in store for us next?

Meryl Nass
Apr 16

There has been so much bad news about the vaccines in the last few months, it even leaked into the mainstream media. I think the cabal's plan, at least in the US but probably everywhere, is to stop propping the ludicrous vaccine claims up and allow them to die a natural death. I explain why below.
There was just too much bad news, too few getting boosted, too much resistance from parents. Getting 8 or 10 doses into everyone was not going to happen. The terrified obedient masses were becoming fewer and fewer.

For example, here is one story that got lots of traction: ABC News covered the fact that "At least 72 COVID cases in the fully vaccinated resulted from the Gridiron dinner." Not only did Nancy Pelosi test positive, but several members of Biden's Cabinet and many other Beltway glitterati did too. All of whom had to have been vaccinated in order to attend.

There was plenty of happy talk that the afflicted politicians in DC had only mild COVID cases. Good for them. But, if vaccinations caused them to become ***a*symptomatic** spreaders instead of spreaders with symptoms, who would know to stay home while sick, the vaccines could actually be doing more harm than good in terms of transmission. They could be causing **more** COVID cases, not less.

By now, it has to be apparent to everyone who walks by a newsstand or turns on the TV that the media are begging much too hard for more shots.

It must be obvious to all that the shots do not prevent spread and therefore there is no logical way you can mandate them. Because if my shot does not protect you (and only with lots of fairy dust will it protect me) why would you have any interest in whether or not I am vaccinated?

Once **you** stop caring about **my** vaccination status, the cabal's nexus of control starts to fall apart. That was their ace in the hole. Time for them to move on to something else.

The kicker for childhood vaccines: the New York state Department of Health study of vaccine efficacy in children. After 2 months, efficacy in the 5-11 year olds had fallen to 12%. In other words, 7 out of 8 vaccinated kids derived no benefit after 2 months, only risk. The data were derived from 365,000 children, and apparently there was no way CDC could spin them, or 12% was the best spin they could put on the data. This report is a huge obstacle to universal child vaccinations. They cabal cannot surmount it.

It is important to mention again--because we keep forgetting--that while the vaccines are nominally licensed for adults, in fact you can only find the EUA (unlicensed) product in the US, and legally an EUA is experimental--and therefore forcing someone to be vaccinated is a Nuremberg violation and a violation of federal law.

The imposition of mandates for these experimental gene therapy products is therefore a crime, being committed by states, federal government and certain companies and other institutions. It seems that because US law was not designed for situations in which the government is the criminal, it has been very difficult to use the judicial system to change what is happening. But surely if this persisted much longer an honest judge somewhere would finally rule that the vaccines are experimental and the COVID mandate house of cards would then collapse. Like Humpty Dumpty (it is Easter today after all): ***All the king's horses and all the king's men couldn't put COVID mandates together again***

What else has been happening that undermines the vaccine story? Well, in addition to all the collapsing athletes, there is now a large collection of mayors suddenly dropping dead throughout Germany.
In Australia, Queensland's health minister just admitted that ambulances are being summoned for a lot more calls for cardiac events and sudden deaths: 40% more to be exact. Thanks to Igor Chudov for following this story, and including a video of the clueless minister admitting it, but having no idea why...

Then there were the 3 insurance companies, one each from the US, India and Germany, that admitted there were about 40% more deaths than expected in working-age people in the second half of 2021. The German official who blew the whistle, a CEO or VP, was immediately fired, which is a strong indication he was telling the truth.

Three doctor whistleblowers released a large cache of data from the military's DMED database showing huge increases in service-member deaths. There has been a lot of confusion about these data. In part, that is because the military then reissued its data for the preceding several years, making the 2021 comparison look less dire. Mathew Crawford has some ideas about what really happened to the data. The only thing that is absolutely clear so far is that there has been a coverup, and the health of vaccinated members of the military appears to have taken a dive. But we don't know how deep.

Everyone in the world must have heard the term 'myocarditis' by now, and knows that it is a vaccine injury. A lot of people also know that CDC Director Rochelle Walensky said post-vaccination myocarditis was extremely "rare but mild," except it isn't and she lied. The rate of myocarditis she cited is at least 10 times too low. About 1 in 2000 young men aged 18-24 sought care for this diagnosis after getting their second mRNA shot.

In fact, CDC was so intensely worried about blowback regarding its recommendation to vaccinate teens (despite the risk of myocarditis) it got the heads of about 20 professional medical organizations to sign on to a declaration supporting CDC's recommendation. Wonder how much CDC paid for that. Getting such back-up was an unusual move, but perhaps unsurprising for risk-averse bureaucrats who worry about their own butt but not anyone else's. Rochelle even mentions these "cosigners" from many medical organizations in her ABC-TV interview. Collecting a bunch of "co-signers" is actually the proof that CDC knew its vaccine recommendation was going to considerably harm children.

While no one in a federal health agency has admitted it, many people must be aware that myocarditis is only the tip of the COVID vaccine injury iceberg. Myocarditis got attention because it's life-threatening and almost always happens within 4 days of the second shot--it can't be written off as coincidence, the way heart attacks,

strokes, pulmonary emboli, sudden deaths and perhaps many other diagnoses have been.

As if there wasn't enough bad vaccine news, there was information from the Medicare database that FDA posted last July, but it only recently got attention. FDA revealed that heart attacks, pulmonary emboli, disseminated intravascular coagulation (DIC, a life-threatening, bleeding plus clotting disorder) and ITP (another bleeding disorder) were related to the Pfizer vaccination in Medicare beneficiaries. FDA promised to study this rigorously, but instead remained silent, and subsequently has never denied the relationship.
And then there is ivermectin. So many ivermectin stories have been leaking into the popular press. Tennessee's legislature made ivermectin essentially an over-the-counter drug last week. New Hampshire's house voted in favor of this as well, while the NH Senate is now taking it up. Several states gave healthcare providers an immunity guarantee for the use of ivermectin and hydroxychloroquine for COVID. Kansas' Senate voted to strengthened religious exemptions and give safe harbor to those prescribing ivermectin, effectively undermining school vaccine mandates if it is enacted. Kansas also refused to enforce any adult vaccine mandates.

Coupled with stories about lawsuits against hospitals for refusing to supply ivermectin to dying relatives, like this one, people are finally realizing there is probably something to this drug, and they have been cheated. They were given a shot that barely works, is unsafe, and they were stopped from getting the good drug. And what if they lost their business to the lockdowns? There must be a lot of anger simmering by now. I imagine the Great Reset cabal must be worried about this, and has decided to loosen its grip for the moment and hopefully let off some citizen steam.
There is more surprising vaccine news. While many institutions are still imposing mandates (and we need to find out what $ carrots were given to universities and other entities to impose illegal mandates of experimental vaccines) in other, surprising places the mandates are disappearing. Out west in Woke Land, the Washington state Department of Health said it would not require COVID vaccines to attend school after all. Despite Gavin Newsom's 2021 executive order mandating vaccines for school kids as soon as they are licensed, California's Department of Health has just done the same thing that Washington's did: killed the COVID vaccine mandate for the 2022-23 school year.

Finally, Fauci himself and various media now openly admit the vaccines will not take us to herd immunity (no matter how many shots we get).

This is why I am convinced the ship is turning and the current vaccine programs will be scuttled. Those states' health departments take their orders from CDC and DC. I do not think FDA is going to be issuing any more fake licenses for COVID vaccines. [I say fake because a) the vaccines do not meet licensure criteria, and b) after issuing the Moderna and Pfizer vaccines licenses for adults, neither licensed product has been distributed in the US for actual use]. The Advisory Committee meeting to deliberate on vaccines for kids aged 6 months up to 5 years was delayed from February to April, and now from April till June. It seems like our unvaxxed kids will be spared. Hallelujah!

During the April 6, 2022 Vaccine and Related Biological Products Advisory Committee (VRBPAC) meeting, which I live-blogged and summarized, both briefers and committee members acknowledged that the neutralizing antibody titers that have been used as a surrogate for immunity in order to issue EUAs, were in fact not valid surrogates.

This had been obvious for awhile, but a recent Israeli study in healthcare workers made it crystal clear. While neutralizing antibody titers rose tenfold after a fourth vaccination, by 2 months out the Pfizer vaccine had only 30% efficacy against infection, and the Moderna vaccine had only 11%. So the high antibody titers were, in

fact, meaningless.

This is really important, because Pfizer and Moderna have been relying on titers to get their vaccines okayed for the younger age groups, those below 16 and 18 respectively. They don't have data showing the vaccines are actually reducing cases by 50% or more, which is the standard FDA said was necessary. They don't have data showing that the vaccines prevent serious cases or deaths, another standard.

Up until now, FDA accepted titers in lieu of actual efficacy results from clinical trials to issue its EUAs for children--but with the recent VRBPAC admissions, which must have been planned in advance (otherwise why did multiple people at the meeting discuss it as settled fact when they had never mentioned it before?) FDA can no longer do so.

Another thing that happened at the VRBPAC meeting was that Peter Marks, the head of FDA's Center for Biologics and highest FDA official there, said that if a new type of COVID vaccine is developed for the next booster, then the current vaccines would no longer be used, because it would be too confusing (according to STAT). Too confusing?! I believe this was another effort to prepare us for the demise of the current mRNA vaccines.

The fall of the vaccines means the fall of the vaccine passports. This ought to slow down the imposition of CBDCs and all-digital money for a bit. If we don't have to show our vaccine certificate to go shop, eat, etc., (and people stop being fearful of catching something from each Other) people will be a lot less inclined to "show their papers" to go about their lives. It's our job to explain over and over that this was how the Nazis maintained control.

Here I read the tea leaves

If there is a new vaccine waiting in the wings, FDA and its briefers were not telling us about it at the VRBPAC meeting, which was the time to do so. For right now, I think the current crop of vaccines and the vaccine passports are going away. I don't think the authorities anticipate another severe COVID wave in the foreseeable future...as most people now have Omicron immunity. The COVID fear will dissipate.

The original Wuhan strain appeared out of nowhere. No natural progenitor could be found. And the original Omicron strain appears to have also originated in a lab. If I was a member of the Great Reset cabal, I would be quite hesitant about releasing yet a third lab-engineered virus on the population. Because millions of people will be looking for one, and it won't take long before its laboratory provenance is discovered. Then the pitchforks might really come out.

On the other hand, I do believe the cabal has bet the farm on their Reset, they can't go back, and they are simply moving on to another means of accomplishing it besides COVID. The over-the-top WHO Treaty/Constitution and its amendments designed to assume sovereignty over the world in the event of a pandemic is an ambitious Plan B.

But I don't think it will fly. Too many people know the WHO was wrong about virtually everything regarding management of this pandemic, not to mention the 2009 swine flu. And then there was that little matter of WHO undertaking the SOLIDARITY Trial, in which WHO officials deliberately poisoned over 1,000 COVID patients with excessive doses of hydroxychloroquine and in many cases failed to obtain signed informed consents. The WHO could be liable for manslaughter.

Will Russia and China really agree to give up their sovereignty to Tedros? China, maybe. Brazil? India? Indonesia? Japan? Nigeria? Can all of their leaders, and their local power centers, have been sufficiently corrupted to turn over their nations to the cabal? I think that could be a stretch.
I suspect the cabal will try their best to get a legal OK to take over the world with the upcoming WHO pandemic treaty, but it won't fly. Too many people already know about these plans.

After the WHO, the cabal will move on to something else, Plan C. Climate catastrophe? Yet more wars? Aliens? I'm guessing it will be a few years before we get hit with another nasty bug. By then maybe the fiat currencies will have finally crashed, and the cabal won't have as tight control of the reins. By then, Fauci, Walensky, Biden, Macron, Johnson, Trudeau, Draghi will hopefully be unpleasant memories.
I am not thinking we will all sing kumbaya. I expect a good deal of misery as the cabal pushes all the levers at its disposal.

The Shanghai city and port closure (China's largest city and the world's largest port) seems to me a deliberate attempt to interfere with worldwide transit of goods and to reduce food availability. The Chinese know how to treat COVID. They *make* the drugs and herbs. There is no need for them to lock down.
Don't miss all the food warehouses that caught fire recently, or the refusal of the Union Pacific railroad to carry 20% of the fertilizer the US's biggest fertilizer producer expected to ship.

We are finally understanding that the awful government policies were deliberate — intended to cement control over and impoverish us. But maybe we can start to build something a whole lot better.
We are shaking loose of the educational indoctrination system, the ruination of our foods, the user-unfriendly and health-damaging healthcare system. We are starting to grasp that our governments acted with malice aforethought to stupefy and eventually enslave us.

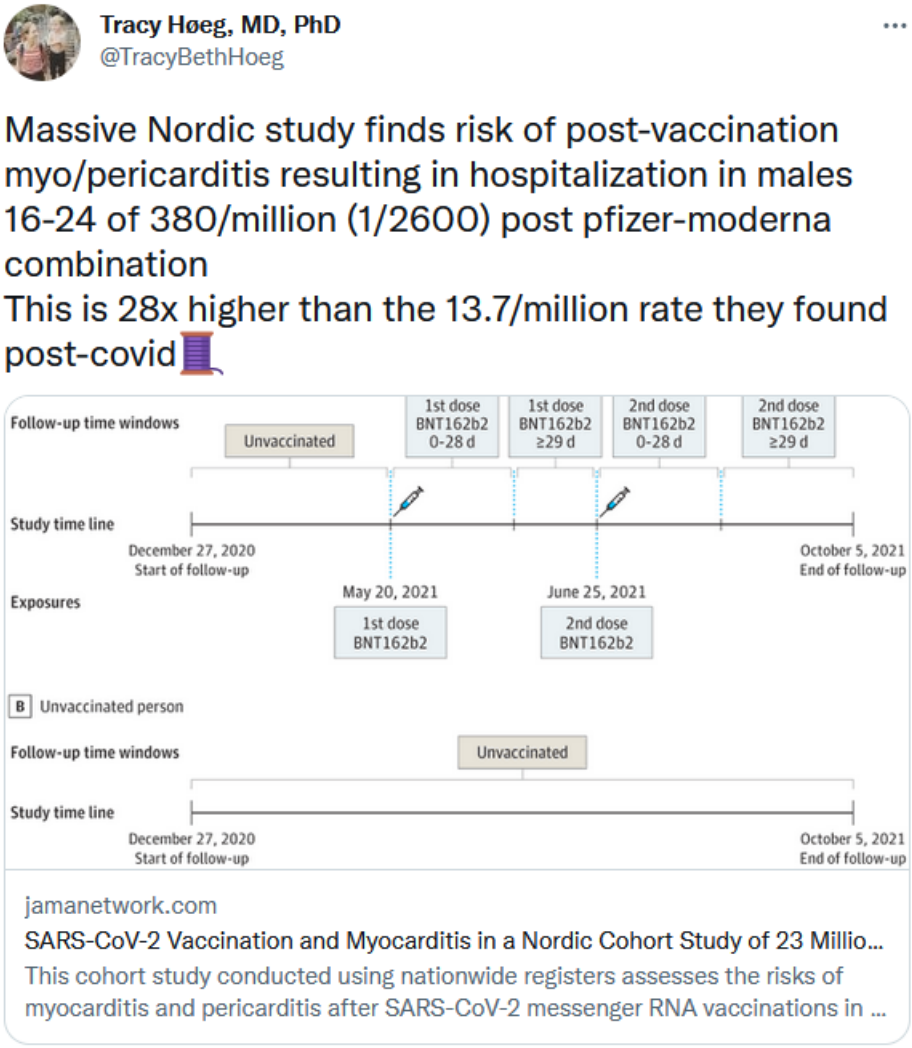
People are breaking free and taking responsibility for their future. Where I live, people are learning self-sufficiency skills, creating home-schooling coops, building greenhouses and growing food. The migration to the countryside was deliberate.

A better life? It just takes everybody waking up. Despite all the acrimony we have faced, the time is ripe to help our fellows see things clearly. We have to love them, help them, meet them where they are. Maybe it is just to talk about the Gridiron dinner. Or ivermectin. They won't get it in a day. But keep trying. It is our only solution.

https://merylnass.substack.com/p/covid-persists-but-the-covid-vaccine

You can follow Dr. Nass at https://merylnass.substack.com/

Nordic study shows myocarditis is 28X higher in vaccinated than in those infected with SARS-CoV-2



This is the study she referred to: https://jamanetwork.com/journals/jamacardiology/fullarticle/2791253

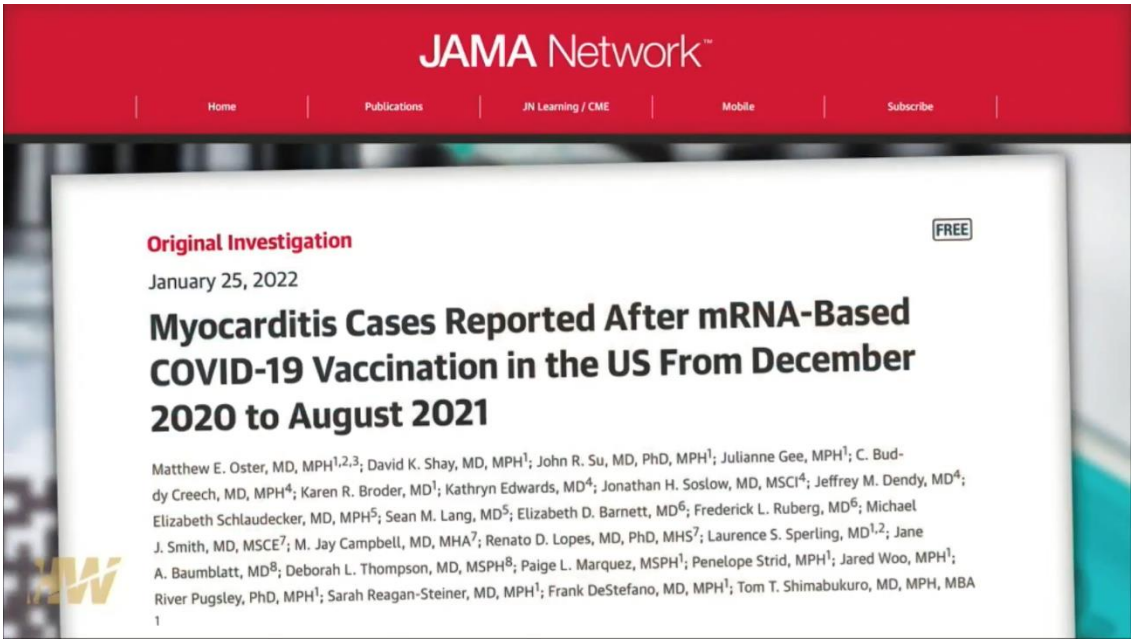
Even though the results showed an alarming rate of myocarditis, the authors still tried to sugar coat it.

A study in the Journal of the American Medical Association reveals just how devastating the number of cases of myocarditis after the injection really are

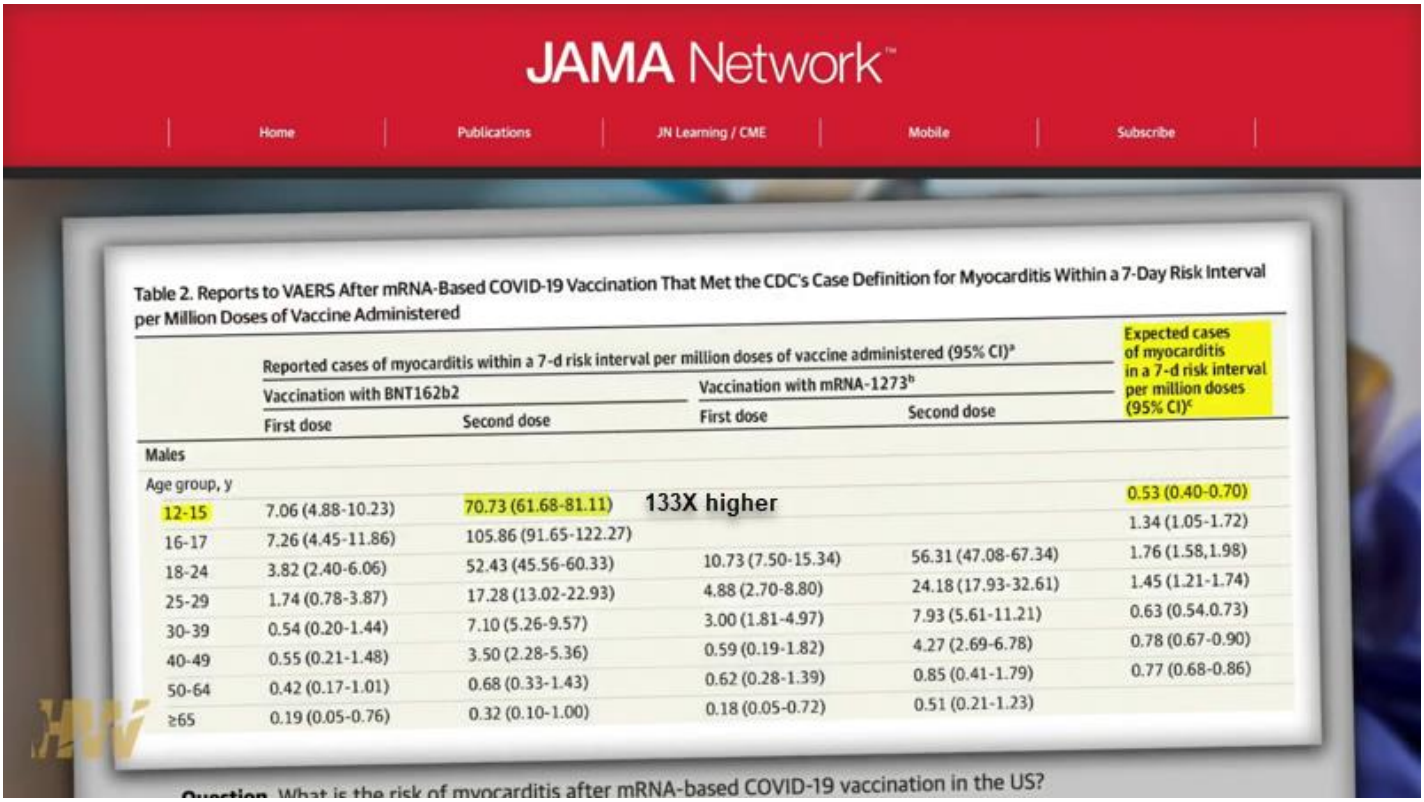
The study that is the source of this story was published in the ***Journal of the American Medical Association*** January 25th, 2022 and titled, **Myocarditis Cases Reported After mRNA-Based COVID-19 Vaccination in the US From December 2020 to August 2021.** https://jamanetwork.com/journals/jama/fullarticle/2788346

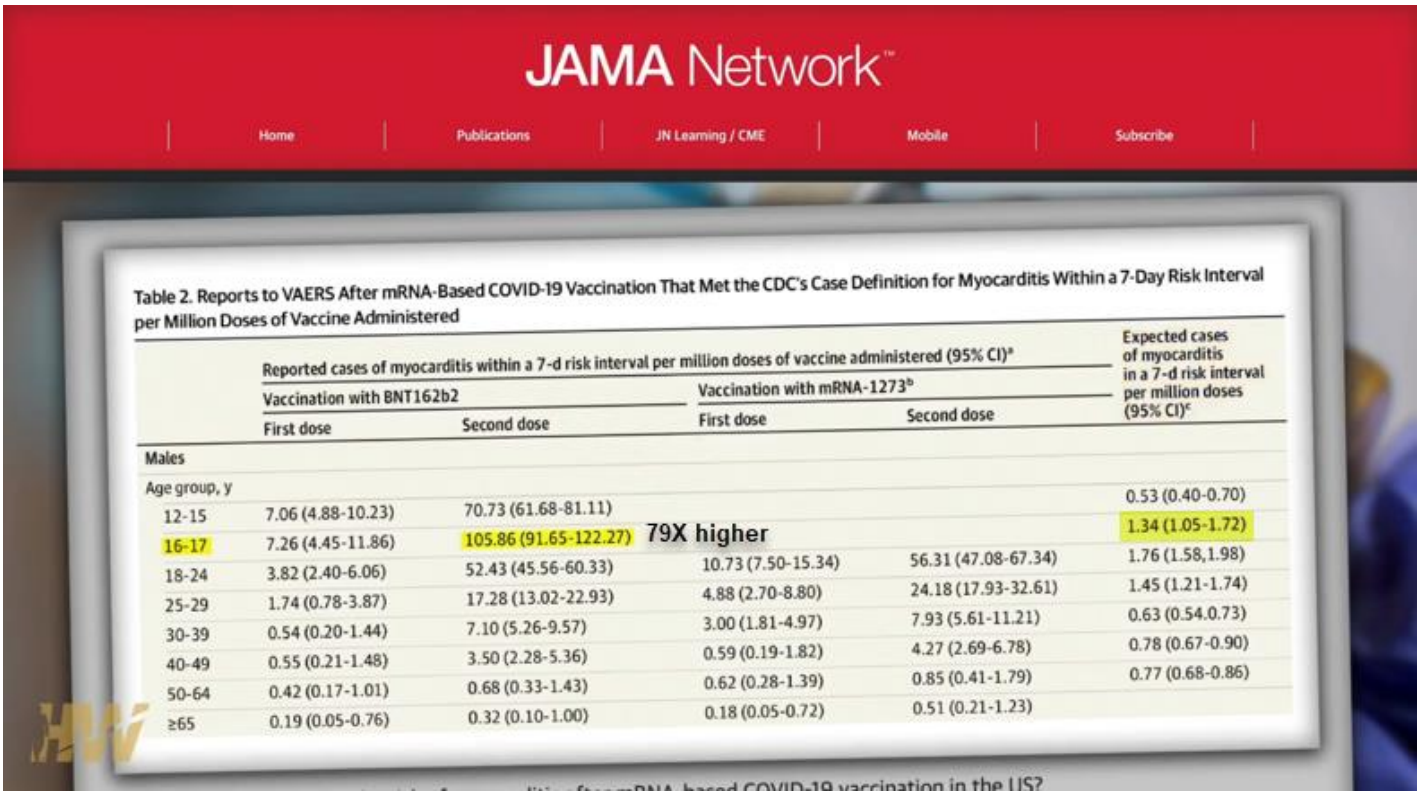
The following screen captures from the study are from the March 10th, 2022 episode of ***the Highwire***. Del Bigtree interviewed Dr. Peter McCullough in one of the best interviews I've seen on the Highwire (and that's saying a lot because there have been so many!).

*(I have added the 79X and 133X tags to two of the captures)

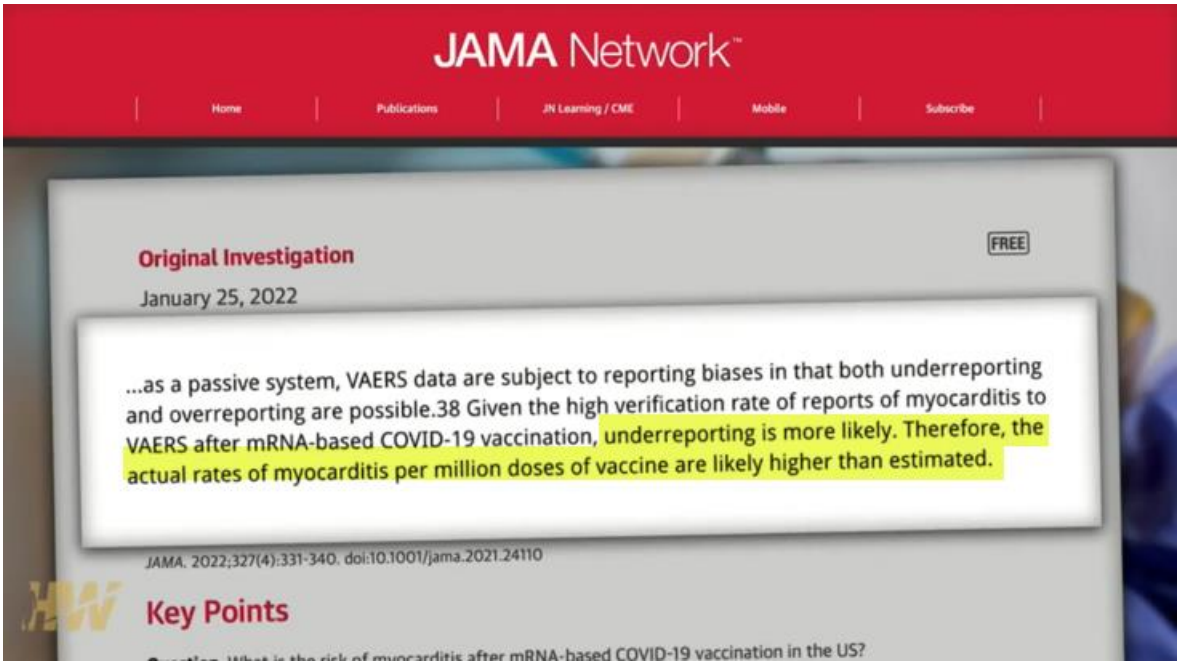


Look at the rates of myocarditis after the first and especially the second dose, as compared to the expected rates in the column on the far right.



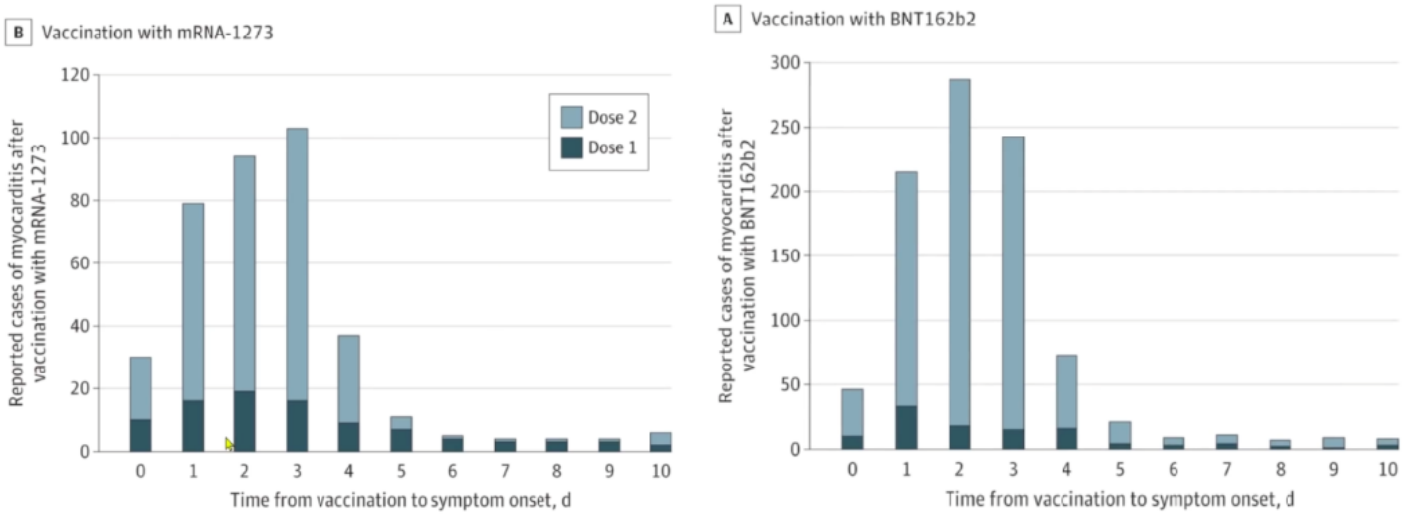


With those horrendous rates considered, even the authors admit that the real numbers may even be much higher as this next capture reveals.



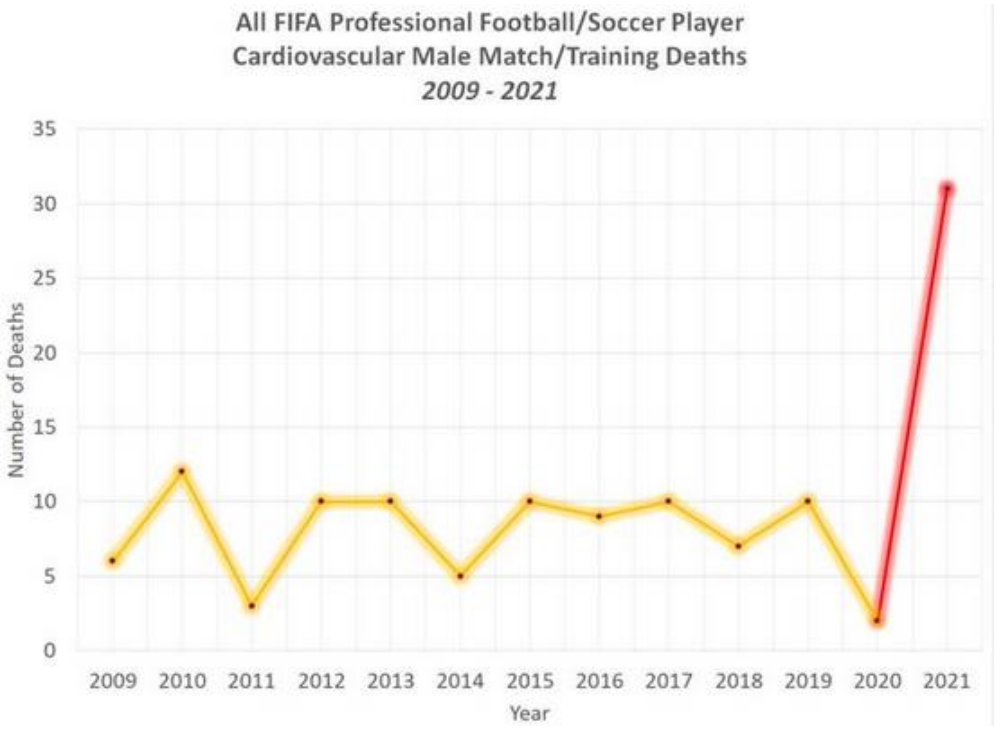
https://thehighwire.com/videos/are-we-doing-more-harm-than-good/

Other graphs from the study continued on the next page…



The study above contradicts the often-heard narrative that the rates of myocarditis from the disease is higher in those infected than from the vaccines. In fact, Dr. McCullough in that same interview explained why this pre-print study (**Risk of Myocarditis from COVID-19 Infection in People Under Age 20: A Population-Based Analysis** at https://pubmed.ncbi.nlm.nih.gov/34341797/), showed that the rate of infections from COVID infection were much higher than they really are. He stated that the "cases" were not clinically verified and that all they measured were troponin levels which are considered an indication of cardiac stress or muscle damage. Dr. McCullough explained that troponin levels can rise just with the stress of being in the hospital and by themselves do not verify cardiac damage. He said they didn't do the proper imaging or other tests that would have needed to be done to confirm the cases as myocarditis. That's the most published author in the world in cardiology with over 700 published studies speaking. I think I'll go with Dr. McCullough's opinion.

Speaking of myocarditis and worse- Professional soccer players dropping dead from heart attacks at meteoric rates since COVID shot requirements



Mysterious cases of hepatitis in children- What's the real cause?

An April 7th, 2022 article in ***Sky News*** titled, **Hepatitis: Parents warned to check for signs after 'unusual' spike in liver condition in under-10s** describes the condition, an inflammation of the liver that in some children has led to the need for liver transplants and the mystery behind cases in Europe and so far limited to Alabama in the U.S.

The article

Jaundice, dark urine, itchy skin, muscle and joint pain, loss of appetite and a high temperature are among the symptoms of the inflammatory liver condition.

Parents in the UK are being warned to check their children for signs of hepatitis after more than 70 youngsters aged under 10 were diagnosed with the illness.

Jaundice, dark urine, itchy skin, muscle and joint pain, loss of appetite and a high temperature are among the symptoms of the inflammatory liver condition.

Around 60 cases have been found in children in England and 11 cases in Scotland saw children sent to hospital.

Dr Meera Chand, director of clinical and emerging infections at the UK Health Security Agency, said "investigations for a wide range of potential causes are under way, including any possible links to infectious diseases.

The aim, she said, is to raise awareness among healthcare professionals so any other cases in children "can be identified early and the appropriate tests carried out."

Parents, Dr Chand said, should recognise the symptoms of jaundice, including "skin with a yellow tinge which is most easily seen in the whites of the eyes - and to contact a healthcare professional if they have concerns." While the condition may have occurred for a number of reasons, including several viral infections common in children, the cases under investigation have not found the common viruses which usually cause the condition. Health managers in Scotland admitted the speed it has moved, the severity of cases and geographical spread made the outbreak "unusual".

Cases have been diagnosed across the country in Lanarkshire, Tayside, Greater Glasgow and Clyde and Fife. There are currently no clear causes and no obvious connection between them, Public Health Scotland (PHS) said.

Dr Nicholas Phin, PHS director of public health, said their investigation was in its early stages.
He said: "If you have a child who is showing signs of jaundice, where the skin has a yellow tinge, and is most easily seen in the whites of the eyes, then parents should contact their GP or other healthcare professional.
"We are continuing to investigate these cases and will provide further updates as and when they are available."

Hepatitis: Parents warned to check for signs after 'unusual' spike in liver condition in under-10s | UK News | Sky News
Apparently, these cases are not Hepatitis A, B or C. They are liver inflammation unconnected to these more

common versions of hepatitis.

While the article doesn't speculate as to the cause, I have some theories.

1. Several cases have been in young children, too young to have had the COVID injection, which on the surface seems to rule out the vaccines. I say that because I don't believe that the potential issue of "shedding", probably more accurately "transmission" of the spike protein from the shots has not been ruled out scientifically. If parents, grandparents or siblings have had the shots and are spending time in close proximity to the young children there could be cross-contamination. Read the two articles in this issue about the spike protein from the injections circulate freely and within small vesicles called exosomes throughout the blood stream (see the section on vaccine generated spike proteins in exosomes later in this issue). The fact that scientists are discovering this phenomenon leaves the door open for the possibility.

2. Any children who are infants could have potentially been exposed in utero if the mother had the shot. With evidence that the spikes are circulating in the blood of the injected and can even cross the protective blood-brain barrier in adults, there would be no reason that they wouldn't travel through the umbilical cord and circulate in the unborn child. Remember, the liver is the filter for the blood.

3. Children around the world have been masked, denied the exposure to microbes because many well-meaning parents and teachers have disinfected and sanitized all surfaces and touchpoints the child comes in contact with. This invariably prevents the child's immune system from developing and maturing as it should. This would make children more susceptible to infection of various kinds. There is some that feel many of these cases may be associated with adenovirus exposure. Adenoviruses are a group comprised of 5-dozen different versions that can cause respiratory, cold and flu like symptoms.

4. Fear- Children have been exposed to an unbelievable amount of fear the last 2-years. All the media theatrics played out in televisions all over the world. Masking, schools closed, having to socially isolate, listening to frightened parents reinforce the need to avoid germs and more, all have precipitated a level of non-stop and sustained stress that children have rarely experienced in history. This is incredibly immunosuppressive. Read my ***Article of the Month*** titled, **DO NOT FEAR- Understand your true risk from COVID-19** later in this issue.

Think the vaccine angle may be a stretch? Check out these next two stories!

COVID-19 vaccine induced hepatitis can be serious and leave long-lasting effects

April 21st, 2022 in the ***Journal of Hepatology***, **SARS-CoV-2 vaccination can elicit a CD8 T-cell dominant hepatitis**

From the article

Here, our analysis highlights that activated cytotoxic CD8 T cells including vaccine-induced spike-specific CD8 T cells could contribute to disease pathogenesis.

Background & Aims

Autoimmune hepatitis episodes have been described following SARS-CoV-2 infection and vaccination but their pathophysiology remains unclear. Here, we report the case of a 52-year-old male, presenting with bimodal episodes of acute hepatitis, each occurring 2-3 weeks after BNT162b2 mRNA vaccination and sought to identify the underlying immune correlates. The patient received first oral budesonide, relapsed, but achieved remission under systemic steroids.

Methods

Imaging mass cytometry for spatial immune profiling was performed on liver biopsy tissue. Flow cytometry was performed to dissect CD8 T cell phenotypes and identify SARS-CoV-2-specific and EBV-specific T cells longitudinally. Vaccine-induced antibodies were determined by ELISA. Data was correlated with clinical labs.

Results

Analysis of the hepatic tissue revealed an immune infiltrate quantitatively dominated by activated cytotoxic CD8 T cells with panlobular distribution. An enrichment of CD4 T cells, B cells, plasma cells and myeloid cells was also observed compared to controls. The intrahepatic infiltrate showed enrichment for CD8 T cells with SARS-CoV-2-specificity compared to the peripheral blood. Notably, hepatitis severity correlated longitudinally with an activated cytotoxic phenotype of peripheral SARS-CoV-2-specific, but not EBV-specific CD8+ T cells or vaccine-induced immunoglobulins.

Conclusions

COVID19 vaccination can elicit a distinct T cell-dominant immune-mediated hepatitis with a unique pathomechanism associated with vaccination induced antigen-specific tissue-resident immunity requiring systemic immunosuppression.

From the discussion

Whilst these reports raise the possibility of an antigen-independent T cell-mediated hepatitis, **another possible explanation could be the presence of their cognate antigen, i.e. the spike protein**. While we could not detect spike protein by IHC in the liver, it has to be noted that biopsy was performed 27 days after the second vaccine dose and transient expression after vaccination, which could have caused CXCR6-expressing spike-specific CD8 T cells to home to the liver and target antigen-presenting cells, cannot be excluded. However, additional mechanisms, such as antigen cross-recognition may also contribute to the immunopathology. In sum, BNTb163b2 vaccine may trigger immune-mediated hepatitis by mechanisms linked to vaccine-induced cellular immunity. This case illustrates the induction of an unusual CD8 T cell-dominant autoimmune hepatitis after BNT162b2 mRNA vaccination, with enrichment of vaccine-induced SARS-Cov2-specific CD8 T cells. In patients with hepatitis manifesting after the first vaccine dose, additional doses may trigger significant hepatic autoimmunity and require long-term immune suppression.

Lay summary

Liver inflammation is observed during SARS-CoV-2 infection but can also occur in some individuals after vaccination and shares some typical features with autoimmune liver disease. In this report, we show that highly activated T cells accumulate and are evenly distributed in the different areas of the liver in a patient with liver inflammation following SARS-CoV-2 vaccination. Moreover, within these liver infiltrating T cells, we

observed an enrichment of T cells that are reactive to SARS-CoV-2, suggesting that these vaccine-induced cells can contribute to the liver inflammation in this context.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9021033/

S1 portion of the vaccine spike protein circulates freely in the bloodstream and causes numerous problems, some of them outlined here in these studies

A study in the journal ***Clinical Infectious Diseases*** March 1st 2022 study titled, **Circulating Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) Vaccine Antigen Detected in the Plasma of mRNA-1273 Vaccine Recipients** demonstrates conclusive evidence that the S1 portion of the spike protein from the vaccines circulates in the blood throughout the body.

This study was performed by Brigham and Women's Hospital and Harvard Medical School Boston, MA. And Division of Infectious Diseases Quebec Canada.

From the study

In this study, 11 participants exhibit S1 antigen in plasma after the first injection, while nucleocapsid concentrations are insignificant in all participants, confirming that the detected S1 originates from vaccination and not natural infection.

The presence of S1 is likely due to the nature of the encoded mRNA-1273 spike protein, which contains a cleavable S1-S2 site and enables release of S1 from the spike trimer. We hypothesize that release of S1 protein could result from cleavage via mammalian cell proteases or circulating proteases. We observe an increase in S1 over an initial period of one to five days, suggesting that mRNA translation begins immediately after vaccine inoculation. Interestingly, spike protein appears in three of thirteen participants on average eight days after S1 is produced.

The Simoa antigen assays for the full spike protein are designed to require antibody binding to both the S1 and S2 subunits for detection, resulting in a cleaved spike protein to be undetectable... ***My comment:*** *This may be a reason why it has gone previously undetected.*

We hypothesize that the cellular immune responses triggered by T-cell activation, which would occur days after the vaccination, lead to direct killing of cells presenting spike protein and an additional release of spike into the blood stream. The mechanisms underlying release of free S1 and the subsequent detection of the intact spike protein remain unclear and require further studies…

There is no significant increase in IgG and IgA against nucleocapsid, confirming that the immune response was specific to the vaccine, which does not contain mRNA for nucleocapsid. For all participants, the increase in IgG against S1 and spike directly corresponds to the decline in S1 or spike protein by the second injection. The inverse correlation between antibody and antigen levels observed is consistent with previous studies investigating SARS-CoV-2 natural infection, in which patients with severe COVID-19 with high plasma antigen levels exhibited antigen clearance upon production of antibodies. Our Simoa antigen assays cannot detect antigen-antibody immune complexes. ***My comment:*** *This is one explanation why levels appear to drop after the second injection, as the antibodies have bound to the spike making them undetectable by this assay. As demonstrated in another article in this issue, these immune complexes can present their own harmful effects in*

the body as they settle on tissue surfaces causing a hyper-inflammatory immune response.

Although S1 protein is present in most participants, serological data shows that some participants exhibit an initial enhancement in antibody levels by day 14 compared to those who do not show an enhancement until day 28. These differences in antibody dynamics could be explained by early antibody production due to previous asymptomatic infection, which has recently been demonstrated in seropositive participants. Here, we observe two participants (Participants #3, #4) with high IgG-spike baseline levels compared to all other participants who produce increased IgG-spike levels by day 14.

Limitations of the current study include the small sample size and potential biases that result from enrolling healthy, young adults, which may not be representative of the general population. Future studies should also examine the dynamics of antigen production with neutralization antibodies.

Nonetheless, evidence of systemic detection of spike and S1 protein production from the mRNA-1273 vaccine is significant and has not yet been described in any vaccine study, likely due to limitations in assay sensitivity and timing assessment. The clinical relevance of this finding is unknown and should be further explored. **These data show that S1 antigen production after the initial vaccination can be detected by day one and is present beyond the site of injection and the associated regional lymph nodes…(Emphasis mine)**

https://pubmed.ncbi.nlm.nih.gov/34015087/

One example of the danger of this is that the S1 segment can enter the brain

I have shown the following study from ***Nature Neuroscience*** dated March 24th, 2021, in a previous issue of my newsletter demonstrating the S1 portion of the spike protein can cross the blood-brain barrier in mice. This is extremely concerning and may be one reason why so many people are experiencing brain-fog and other neuro and cognitive deficits. The study is titled, **The S1 protein of SARS-CoV-2 crosses the blood-brain barrier in mice**. https://pubmed.ncbi.nlm.nih.gov/33328624/

From the abstract

SARS-CoV-2 binds to cells via the S1 subunit of its spike protein. **We show that intravenously injected radioiodinated S1 (I-S1) readily crossed the blood-brain barrier (BBB) in male mice, was taken up by brain regions and entered the parenchymal brain space. I-S1 was also taken up by lung, spleen, kidney, and liver.** Intranasally administered I-S1 also entered the brain, though at ~10 times lower levels than after intravenous administration. APOE genotype and sex did not affect whole-brain I-S1 uptake, but had variable effects on uptake by the olfactory bulb, liver, spleen, and kidney. I-S1 uptake in the hippocampus and olfactory bulb was reduced by lipopolysaccharide-induced inflammation. Mechanistic studies indicated that I-S1 crosses the BBB by adsorptive transcytosis, and that murine angiotensin-converting enzyme-2 is involved in brain and lung uptake, but not in kidney, liver, or spleen uptake.

Another problem is that S1 can react with platelets and fibrin and cause hypercoagulability or blood clots

An August 27th, 2021 study published in ***Bioscience Reports*** journal titled, **SARS-CoV-2 spike protein S1 induces fibrin(ogen) resistant to fibrinolysis: implications for microclot formation in COVID-19**, details the

mechanisms by which the S1 portion of the spike protein causes microclots in the circulation of those exposed.

The 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.

The spike protein showing the S1 and S2 subunits

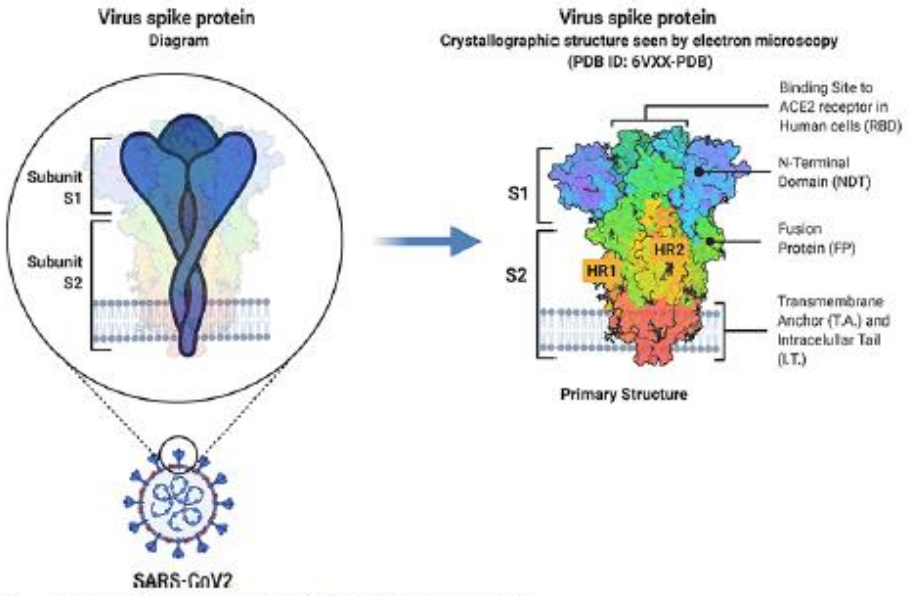


Figure 1. Schematic representation of SARS-CoV-2 Spike glycoprotein
Adapted from [21]. Abbreviations: HR1, heptad repeat 1; HR2, heptad repeat 2; S1, subunit 1; S2, subunit 2. This image was created with BioRender (https://biorender.com/).

Healthy vs. Unhealthy Coagulation

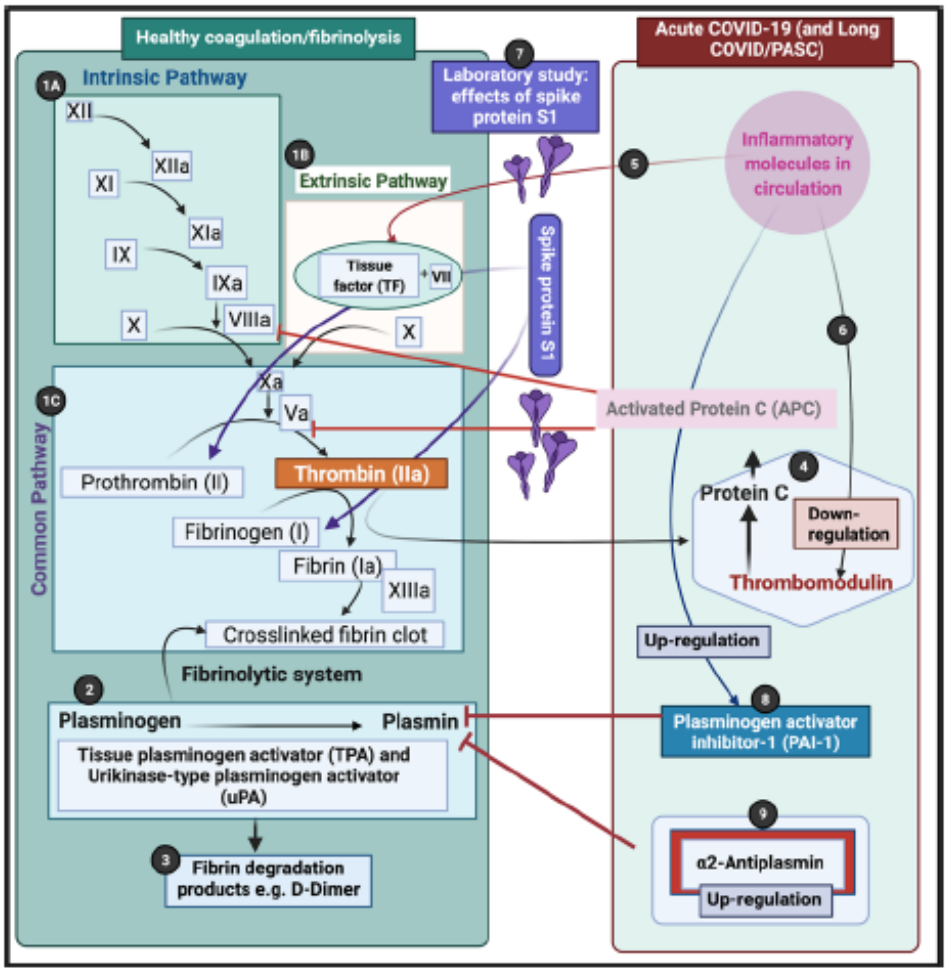


Figure 9. Simplified coagulation diagram depicting healthy and pathological processes
(**1A**) The intrinsic and (**1B**) extrinsic pathways converge into the (**1C**) common pathway. These pathways lead to the conversion of soluble fibrinogen to insoluble fibrin, catalyzed by thrombin. (**2**) Tissue plasminogen activator (tPA) or urokinase-type plasminogen activator (uPA) converts plasminogen into plasmin. A healthy fibrinolytic system regulates the coagulation pathway and assists with successful lysis of the insoluble fibrin clot. (**3**) Plasmin cleaves fibrin into fibrin degradation products (FDPs), including D-dimer. (**4**) Protein C and thrombomodulin both regulate coagulation: thrombin binds to its receptor, thrombomodulin, resulting in activated protein C (APC). APC then inhibits both Va and VIIIa. (**5**) Dysregulated inflammatory molecules may interfere with tissue factor (TF) expression. (**6**) Dysregulated inflammatory molecules may also down-regulate thrombomodulin, resulting in hypercoagulation, as Va and VIIIa activities are then not sufficiently modulated. (**7**) In our laboratory study, we added Spike protein S1 to healthy plasma. Pathophysiology was noted in both prothrombin and fibrinogen chains. (**8**) Dysregulated inflammatory molecules in circulation can inhibit of the fibrinolytic system via up-regulation of plasminogen activator inhibitor-1 (PAI-1). PAI-1 up-regulation interferes with tPA function, and ultimately results in a dysregulated coagulation system. (**9**) α2AP inhibits plasmin and ultimately will prevent sufficient fibrinolysis to happen. (Figure created with Biorender.com).

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8380922/

Here are a couple other studies that add more to this clotting discussion:

Erythrocyte, Platelet, Serum Ferritin, and P-Selectin Pathophysiology Implicated in Severe Hypercoagulation and Vascular Complications in COVID-19 from the ***International Journal of Molecular Sciences*** November 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7662625/

Covid-19: The Rollercoaster of Fibrin(Ogen), D-Dimer, Von Willebrand Factor, P-Selectin and Their Interactions with Endothelial Cells, Platelets and Erythrocytes from the ***International Journal of Molecular Sciences*** July 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7403995/

The spike proteins can bind with ACE-2 receptors on cell surfaces and shift the body to a pro-inflammatory state

This is one thing that can shift the body towards a cytokine storm, which is a hyper-inflammatory over-reaction of the immune system leading to tissue pathology and organ damage.

An example of one study that describes this effect, is a June 2020 study published in ***Frontiers in Cellular and Infection Microbiology*** titled, **ACE2, Much More Than Just a Receptor for SARS-COV-2.**

The rapidly evolving pandemic of severe acute respiratory syndrome coronavirus (SARS-CoV-2) infection worldwide cost many lives. The angiotensin converting enzyme-2 (ACE-2) has been identified as the receptor for the SARS-CoV-2 viral entry. As such, it is now receiving renewed attention as a potential target for anti-viral therapeutics. We review the physiological functions of ACE2 in the cardiovascular system and the lungs, and how the activation of ACE2/MAS/G protein coupled receptor contributes in reducing acute injury and inhibiting fibrogenesis of the lungs and protecting the cardiovascular system. **In this perspective, we predominantly focus on the impact of SARS-CoV-2 infection on ACE2 and dysregulation of the protective effect of ACE2/MAS/G protein pathway vs. the deleterious effect of Renin/Angiotensin/Aldosterone. We discuss the potential effect of invasion of SARS-CoV-2 on the function of ACE2 and the loss of the protective effect of the ACE2/MAS pathway in alveolar epithelial cells and how this may amplify systemic deleterious effect of renin-angiotensin aldosterone system (RAS) in the host.** ***My comment:*** *This upregulates or increases the inflammatory state of the body.*

Furthermore, we speculate the potential of exploiting the modulation of ACE2/MAS pathway as a natural protection of lung injury by modulation of ACE2/MAS axis or by developing targeted drugs to inhibit proteases required for viral entry.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7294848/

Atypical white blood cells pick up S1 proteins and cause inflammatory reactions throughout the body

The ***bioRxiv preprint*** dated June 25th, 2021, and titled, **Persistence of SARS CoV-2 S1 Protein in CD16+ Monocytes in Post-Acute Sequelae of COVID-19 (PASC) Up to 15 Months Post-Infection**, unravels some of the mystery of the persistent health problems some individuals have post-infection and post COVID-19 vaccination.

Bruce Patterson M.D. and his team at IncellDx Inc. in San Carlos, California have been researching and developing treatments for Long-COVID or sometimes referred to as Long-haulers, people that develop long-lasting serious and even debilitating symptoms long after the infection has passed. They have been using sophisticated computer modeling and working on therapeutic modalities. Dr. Patterson and his team have since also found very similar patient presentations in those that have had the COVID injections with the same atypical monocyte containing spike protein sub-units and causing similar pathological issues in those people. This is a paper based on their work.

The abstract (emphasis mine)

The recent COVID-19 pandemic is a treatment challenge in the acute infection stage but the recognition of chronic COVID-19 symptoms termed **post-acute sequelae SARS-CoV-2 infection (PASC)** may affect up to 30% of all infected individuals. The underlying mechanism and source of this distinct immunologic condition three months or more after initial infection remains elusive. Here, we investigated the presence of SARS-CoV-2 S1 protein in 46 individuals. We analyzed T-cell, B-cell, and monocytic subsets in both severe COVID-19 patients and in patients with post-acute sequelae of COVID-19 (PASC).

The levels of both intermediate (CD14+, CD16+) and non-classical monocyte (CD14Lo, CD16+) were significantly elevated in PASC patients up to 15 months post-acute infection compared to healthy controls (P=0.002 and P=0.01, respectively). **A statistically significant number of non-classical monocytes contained SARS-CoV-2 S1 protein in both severe (P=0.004) and PASC patients (P=0.02) out to 15 months post-infection.** Cells from 4 out of 11 severe COVID-19 patients and 1 out of 26 also contained SARS-CoV-2 RNA.

Non-classical monocytes are capable of causing inflammation throughout the body in response to fractalkine/CX3CL1 and RANTES/CCR5.

From the Discussion

The hallmark of PASC is the heterogeneity of symptoms arising in a variety of tissues and organs. These symptoms are likely associated with the inflammatory phenotype of these senescent nonclassical monocytes. The CD14lo, CD16+, S1 protein+ monocytes could be preferentially recruited into anatomic sites expressing fractalkine and contribute to vascular and tissue injury during pathological conditions in which this monocyte subset is expanded as previously demonstrated in non-classical monocytes without S1 protein. Previously, CD16+ monocytes were demonstrated to migrate into the brain of AIDS patients expressing high levels of CX3CL1 (fractalkine) and SDF-126, and mediate blood-brain barrier damage and neuronal injury in HIV-associated dementia via their release of proinflammatory cytokines and neurotoxic factors. These sequelae are very common in PASC and these data could represent the underlying mechanism for the symptoms. Interestingly, a number of papers have been written discussing the increased mobilization of CD14lo, CD16+ monocytes with exercise. These data support the reports of worsening PASC symptoms in individuals resuming pre-COVID exercise regimens

In summary, the mechanism of PASC discussed in this report suggests that intermediate monocytes remain in circulation due to low CCL4 levels extending their time to differentiate leading to an accumulation of non-classical monocytes. The utility of using CCR5 antagonists in preventing migration of intermediate and non-classical monocytes due to the elevated levels of CCL5/RANTES in PASC5. Further, our data suggests that interruption of the CX3CR1/fractalkine pathway would be a potential therapeutic target to reduce the survival of S1-containing non-classical monocytes and the associated vascular inflammation previously discussed and presented here.

https://www.biorxiv.org/content/10.1101/2021.06.25.449905v1

Spike protein from the COVID-19 shots circulate within exosomes throughout the body

An article published on November 15th, 2021 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**, describes another way that the dangerous spike proteins from the vaccine are transported throughout the body, even into the brain. This activity can then cause inflammation in the brain as the second study at the end of this section demonstrates.

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.

My comment: On the surface as the authors present, this may sound like a good thing to them and another way that the immune system is stimulated by the vaccines or infection in order to boost immunity. However, a problem arises when the immune system, natural killer cells and macrophages in particular destroy these exosomes because they are presenting the antigen of the spike on their surface can cause a release of full and partial components of the spike protein leading to many of the issues cited in the previous studies.

https://www.jimmunol.org/content/207/10/2405

Another problem with this uptake of spike by the exosomes is demonstrated by this next study.

A study in ***International Journal of Molecular Sciences*** published June 2020 titled, **Transport of Extracellular Vesicles across the Blood-Brain Barrier: Brain Pharmacokinetics and Effects of Inflammation**

An explanation of exosomes from the Introduction in the study

Exosomes are a subset of small extracellular vesicles (EVs) that are produced by all normal and malignant cells and are present in all body fluids. EVs are heterogeneous, comprising vesicles with various sizes that originate from many different cell types. Currently, the nomenclature of these various EV types and methods for their isolation from body fluids are not firmly established. Among the various EVs, exosomes are sized at 30–150 nm in diameter and are of special interest because of their origin, their ability to freely circulate and infiltrate

various tissues and their molecular content mirroring that of parental cells. Exosomes originate from the endosomal compartment of parent cells, where they are formed by inverse membrane invagination as intraluminal vesicles inside multivesicular bodies (MVBs). When MVBs fuse with the cell membrane, exosomes are released into the extracellular space. The orientation of surface proteins in exosome membranes resembles that in the cell membrane of parent cells. These virus-sized vesicles differ from larger (250–1000 nm) microvesicles (MVs) and even larger (>1000 nm) apoptotic bodies. In contrast to exosomes, MVs are formed by "budding off" from the parent cell membrane, and apoptotic bodies are products of dying cells.

Exosomes serve as an intercellular communication system, shuttling messages between cells and also conveying peptides, proteins, and genetic materials from parental to recipient cells. Exosomes derived from the central nervous system (CNS) and circulating in the blood can be useful as diagnostic biomarkers and/or as markers of disease progression. They may also signal to the peripheral immune system that a CNS injury has occurred, stimulating the trafficking of immune cells into the CNS. In turn, these immune cells, reprogrammed by exosomes, can deliver substances to brain tissues, altering CNS functions.

With that in mind…

The abstract

Extracellular vesicles can cross the **blood–brain barrier (BBB)**, but little is known about passage. Here, we used multiple-time regression analysis to examine the ability of 10 exosome populations derived from mouse, human, cancerous, and non-cancerous cell lines to cross the BBB. All crossed the BBB, but rates varied over 10-fold…..

In summary, all exosomes tested here readily crossed the BBB, but at varying rates and by a variety of vesicular-mediated mechanisms involving specific transporters, adsorptive transcytosis, and a brain-to-blood efflux system.

More from the study

Inflammation induces alterations across the BBB of many substances by many different mechanisms, including BBB disruption and enhancement of vesicular pathways

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7352415/

My comment: As the previous article from the ***Journal of Immunology*** showed, these exosomes stimulate the immune system. When the immune system is stimulated it leads to inflammation. This means that the astrocytes, pericytes, microglia, and neurons of the brain could suffer from an upregulation of inflammation as these vesicles cross into the brain with surface antigen expression of the spike protein on them. This can lead to altered function of these cells and increased oxidative stress leading to greater harm.

Now that we've demonstrated that the toxic spike protein can cross the blood brain barrier into the brain, check out this study that gets into more detail about how that causes damaging effects in brain cells

A pre-print study released by Europe PMC on March 2nd, 2022, titled, **Decoding COVID-19 mRNA Vaccine Immunometabolism in Central Nervous System: human brain normal glial and glioma 2 cells by Raman**

imaging reveals some disturbing mechanisms or ways that the Pfizer vaccine disrupts cellular energy production and leads to damaging consequences in brain cells.

The Abstract

The paper presents the effect of COVID-19 mRNA (Pfizer/BioNT) vaccine on in vitro glial cells of the brain studied by means of Raman spectroscopy and imaging. The results obtained for human brain normal and tumor glial cells of astrocytes, astrocytoma, glioblastoma incubated with the Covid-19 mRNA vaccine Pfizer/BioNT vaccine show alterations in the reduction-oxidation pathways associated with Cytochrome c. **We found that the Pfizer/BioNT vaccine down regulate the concentration of cytochrome c in mitochondria** upon incubation with normal and tumorous glial cells. **Concentration of oxidized form of cytochrome c in brain cells has been shown to decrease upon incubation the mRNA vaccine. Lower concentration of oxidized cytochrome c results in lower effectiveness of oxidative phosphorylation (respiration), reduced apoptosis and lessened ATP production.** Alteration of Amide I concentration, which may reflect the decrease of mRNA adenine nucleotide translocator. **Moreover, mRNA vaccine leads to alterations in biochemical composition of lipids that suggest the increasing role of signaling. mRNA vaccine produce statistically significant changes in cell nucleus due to histone alterations. The results obtained for mitochondria, lipid droplets, cytoplasm may suggest that COVID-19 mRNA (Pfizer/BioNT) vaccine reprograms immune responses. The observed alterations in biochemical profiles upon incubation with COVID-19 mRNA in the specific organelles of the glial cells are similar to those we observe for brain cancer vs grade of aggressiveness.**

My comment: WOW, that is devastating!

https://europepmc.org/article/PPR/PPR464162

Another serious and even life-threatening potential mechanism for injury from the COVID-19 shots

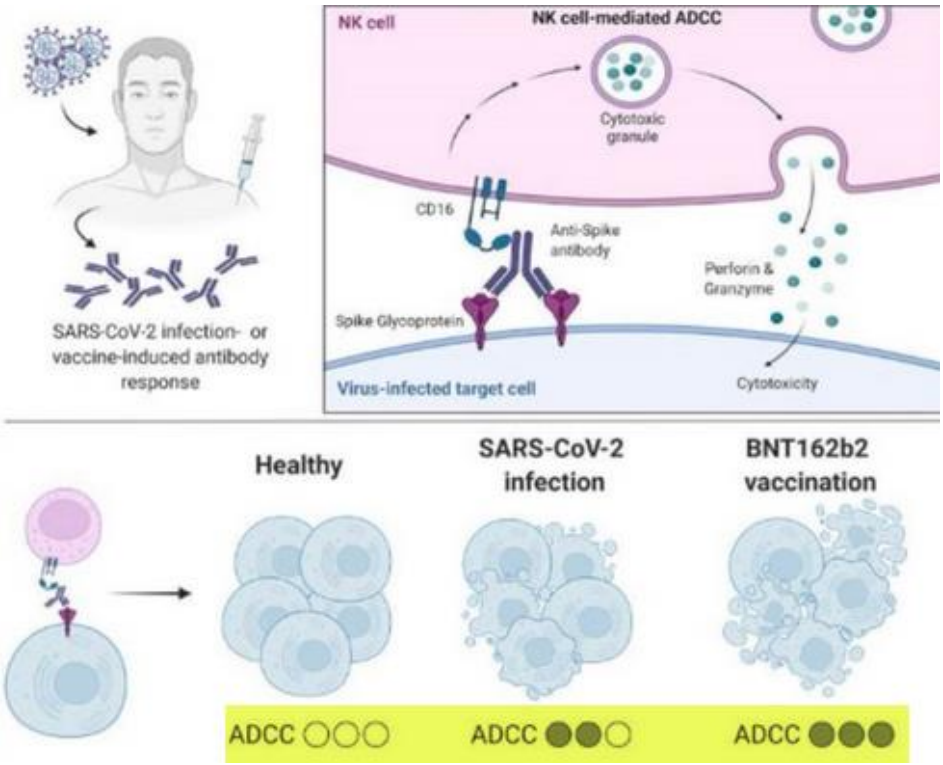
An article published in the ***European Journal of immunology*** April 13th, 2022 titled, **Natural killer cell-mediated ADCC in SARS-CoV-2-infected individuals and vaccine recipients**, discussed how the infection and the vaccines can cause Antibody-Dependent Cellular Cytotoxicity (ADCC) and lead to serious, even life-threatening consequences.

The abstract

COVID-19, caused by SARS-CoV-2, has emerged as a global pandemic. While immune responses of the adaptive immune system have been in the focus of research, the role of NK cells in COVID-19 remains less well understood. Here, we characterized NK cell-mediated SARS-CoV-2 antibody-dependent cellular cytotoxicity (ADCC) against SARS-CoV-2 spike-1 (S1) and nucleocapsid (NC) protein. Serum samples from SARS-CoV-2 resolvers induced significant CD107a-expression by NK cells in response to S1 and NC, while serum samples from SARS-CoV-2-negative individuals did not. Furthermore, serum samples from individuals that received the BNT162b2 vaccine induced strong CD107a expression by NK cells that increased with the second vaccination and was significantly higher than observed in infected individuals. As expected, vaccine-induced responses were only directed against S1 and not against NC protein. S1-specific CD107a responses by NK cells were significantly correlated to NK cell-mediated killing of S1-expressing cells. Interestingly, screening of serum

samples collected prior to the COVID-19 pandemic identified two individuals with cross-reactive antibodies against SARS-CoV-2 S1, which also induced degranulation of NK cells. Taken together, these data demonstrate that antibodies induced by SARS-CoV-2 infection and anti-SARS-CoV-2 vaccines can trigger significant NK cell-mediated ADCC activity, and identify some cross-reactive ADCC-activity against SARS-CoV-2 by endemic coronavirus-specific antibodies.

https://pubmed.ncbi.nlm.nih.gov/35416291/



The genetically modified mRNA in the COVID-19 shots induce suppression of the innate immune system which leads to a higher risk of a variety of serious health problems including cancer

The pre-print was published on ***Researchgate*** January 21st, 2022 and titled **Innate Immune Suppression by SARS-CoV-2 mRNA Vaccinations: The role of G-quadruplexes, exosomes and microRNAs**.

Abstract

The mRNA SARS-CoV-2 vaccines were brought to market in response to the widely perceived public health crises of Covid-19. The utilization of mRNA vaccines in the context of infectious disease had no precedent, but desperate times seemed to call for desperate measures. The mRNA vaccines utilize genetically modified mRNA encoding spike proteins. These alterations hide the mRNA from cellular defenses, promote a longer biological half-life for the proteins, and provoke higher overall spike protein production. However, both experimental and observational evidence reveals a very different immune response to the vaccines compared to the response to infection with SARS-CoV-2. As we will show, the genetic modifications introduced by the vaccine

are likely the source of these differential responses.

In this paper, we present the evidence that vaccination, unlike natural infection, induces a profound impairment in type I interferon signaling, which has diverse adverse consequences to human health. We explain the mechanism by which immune cells release into the circulation large quantities of exosomes containing spike protein along with critical microRNAs that induce a signaling response in recipient cells at distant sites. We also identify potential profound disturbances in regulatory control of protein synthesis and cancer surveillance. These disturbances are shown to have a potentially direct causal link to neurodegenerative disease, myocarditis, immune thrombocytopenia, Bell's palsy, liver disease, impaired adaptive immunity, increased tumorigenesis, and DNA damage. We show evidence from adverse event reports in the VAERS database supporting our hypothesis. We believe a comprehensive risk/benefit assessment of the mRNA vaccines excludes them as positive contributors to public health, even in the context of the Covid-19 pandemic.

Discussion

There has been an unwavering message about the safety and efficacy of mRNA vaccinations against SARS-CoV-2-CoV-2 from the public health apparatus in the US and around the globe. The efficacy is increasingly in doubt, as shown in a recent letter to the Lancet Regional Health by Gunter Kampf [215]. Kampf provided data showing that the vaccinated are now as likely as the unvaccinated to spread disease. He concluded:
It appears to be grossly negligent to ignore the vaccinated population as a possible and relevant source of transmission when deciding about public health control measures."

In this paper we call attention to three very important aspects of the safety profile of these vaccinations. (I have added the bullet points)

- First is the extensively documented subversion of innate immunity, primarily via suppression of IFN-a and its associated signaling cascade. This suppression will have a wide range of consequences, not the least of which include the reactivation of latent viral infections and the reduced ability to effectively combat future infections.

- Second is the dysregulation of the system for both preventing and detecting genetically driven malignant transformation within cells and the consequent potential for vaccination to promote those transformations.

    - Third, mRNA vaccination potentially disrupts intracellular communication carried out by exosomes, and induces cells taking up spike mRNA to produce high levels of spike-carrying exosomes, with

  potentially serious inflammatory consequences. Should any of these potentials be fully realized, the impact on billions of people around the world could be enormous and could contribute to both the short-term and long-term disease burden our health care system faces.

Given the current rapidly expanding awareness of the multiple roles of G4s in regulation of mRNA translation and clearance through stress granules, the increase in pG4s due to enrichment of GC content as a consequence of codon optimization has unknown but likely far-reaching consequences. Specific analytical evaluation of the safety of these constructs in vaccines is urgently needed, including mass spectrometry for identification of cryptic expression and immunoprecipitation studies to evaluate the potential for disturbance of or interference with the essential activities of RNA and DNA binding proteins.

Conclusions

It is imperative that worldwide administration of the mRNA vaccinations be stopped immediately until

further studies are conducted to determine the extent of the potential pathological consequences outlined in this paper. It is not possible for these vaccinations to be considered part of a public health campaign without a detailed analysis of the human impact of the potential collateral damage. It is also imperative that VAERS and other monitoring system be optimized to detect signals related to the health consequences of mRNA vaccination we have outlined. We believe the upgraded VAERS monitoring system described in the Harvard Pilgrim Health Care, Inc. study, but unfortunately not supported by the CDC, would be a valuable start in this regard [208].

In the end, we are not exaggerating to say that billions of lives are at stake. We call on the public health institutions to demonstrate, with evidence, why the issues discussed in this paper are not relevant to public health, or to acknowledge that they are and to act accordingly. Until our public health institutions do what is right in this regard, we encourage all individuals to make their own health care decisions with this information as a contributing factor in those decisions.

https://www.researchgate.net/publication/357994624_Innate_Immune_Suppression_by_SARS-CoV-2_mRNA_Vaccinations_The_role_of_G-quadruplexes_exosomes_and_microRNAs

Despite all of these serious potential complications from the shots and the incredibly low risk to children from the virus, these maniacs are still coming for your children

Even though the science has conclusively shown the risk to children from this virus is miniscule and the pandemic is waning, society is opening up and dropping restrictions like masking and vaccine mandates, there have been renewed efforts to subject children to unnecessary risk from experimental injections. This post from ***Children's Health Defense*** Instagram account says it all…

If you think it's unreasonable to question these people, check out this next story from Lifenews.

British children up to 52 times more likely to die following a COVID shot according to government data

The article is titled **British children up to 52 times more likely to die following a COVID shot: gov't report**

- Data from Britain's Office for National Statistics show a stark increase in deaths among children both single- and double-jabbed compared to their un-jabbed counterparts.

Britain's Office for National Statistics (ONS) has released data indicating that children who received the COVID-19 jabs have suffered a death rate 54 times greater than that of their un-jabbed counterparts.
In December, the ONS published age-standardized data on the mortality rates of individuals in 5-year age sets in Britain, grouped by their "vaccination" status for the COVID-19 shots. The data accounts for the period from January 1 to October 31, 2021.

The ONS tabulated "Monthly age-standardised mortality rates by age-group and vaccination status for deaths involving COVID-19, per 100,000 person-years" but presented the data only for ages 18 and over. However, the jabs are available to children as young as 12, and those children are allowed to receive the shot against their parents' wishes. In limited cases, children as young as 5 have been given a reduced dosage of the shots. Nevertheless, as noted by *The Exposé*, a separate table outlining "deaths and person-years by vaccination status" includes 5-year age groups from 10-years-old and up. From the data provided, a calculation of the mortality rate per 100,000 person-years can be made.

The rate per 100,000 person-years delineation is used in preference over the simpler 100,000 population calculation to better represent the mortality rates over a specific period of time, as people in one "vaccination" group – such as un-jabbed, single-jabbed, and double-jabbed – soon move into the next group. Table 9 of the ONS report shows the "deaths and person-years by vaccination status and five-year age group" for the entire ten-month period. According to the report, the un-jabbed 10–14-year-old group represents 2,094,711 person-years, and the 15–19 age set 1,587,072 person-years over the same time.

Table 9: Whole period counts of deaths and person-years by vaccination status and five year age group, England, deaths occurring between 1 January 2021 and 31 October 2021[1]

Vaccination status	Age group	Person-years	Deaths involving COVID-19	Non-COVID-19 deaths	All deaths
Unvaccinated	10-14	2,094,711	2	94	96
Unvaccinated	15-19	1,587,072	18	142	160

Table 9, ONS Report

From the above table the 100,000 person-years calculation can be made, with the younger group coming out at 20.9 un-jabbed per 100,000 person-years and the older group at 15.9. Following this, the mortality rate per 100,000 person-years is worked out by dividing the number of deaths within each group by the 100,000 person-years calculation.

The result is that for the 10–14 year group, the un-jabbed mortality per 100,000 person-years is 4.6 while the un-jabbed mortality rate per 100,000 person-years for the 15–19 group is 10.1. Using the same data set and calculation, the mortality rate for 10–14-year-olds who received one dose of the jabs suffered a 45.1 per

100,000 person-years death rate, while 15–19-year-olds with one jab suffered 18.3 deaths per 100,00 person-years.

Table 9: Whole period counts of deaths and person-years by vaccination status and five year age group, England, deaths occurring between 1 January 2021 and 31 October 2021

Vaccination status	Age group	Person-years	Deaths involving COVID-19	Non-COVID-19 deaths	All deaths
Received only the first dose, at least 21 days ago	10-14	6,648	0	3	3
Received only the first dose, at least 21 days ago	15-19	174,667	0	32	32

Table 9, ONS Report

Table 9: Whole period counts of deaths and person-years by vaccination status and five year age group, England, deaths occurring between 1 January 2021 and 31 October 2021[1]

Vaccination status	Age group	Person-years	Deaths involving COVID-19	Non-COVID-19 deaths	All deaths
Received the second dose, at least 21 days ago	10-14	1,678	0	4	4
Received the second dose, at least 21 days ago	15-19	127,842	1	41	42

Table 9, ONS Report

Among those who received two doses of the COVID jabs in both young age groups, the death rates were higher still, with 32.9 deaths per 100,000 person-years among the 15–19 age group and a staggering 238.4 deaths per 100,000 person-years among 10–14-year-olds in the U.K.

The data show a stark increase in deaths among children both single- and double-jabbed compared to their un-jabbed counterparts. For children aged 15–19, the risk of death increases by almost double if they take the first shot and by over three times if they take the second.

10–14-year-olds, on the other hand, run the risk of dying almost by a factor of ten following the first dose while the second dose brings a 51.8 times greater risk of death than if they had remained un-jabbed.
On average, it means that children between 10 and 19 years of age who had received at least one shot of the COVID jabs had a 3.7 times greater chance of dying between January and October last year.

Additionally, according to the ONS' "five-year average weekly deaths by sex and age group" figures between 2015 and 2019 among children ages 10-14, recorded deaths have risen by 44 percent above the average in weekly figures provided by the ONS for 2021.

The JCVI, an independent adviser to the U.K. government on immunization programs, determined in a September 3 statement that the "available evidence indicates that the individual health benefits from COVID-19 vaccination are small in those aged 12 to 15 years." They added that any benefit granted by the shots is only "marginally greater than the potential known harms," while acknowledging that "there is considerable uncertainty regarding the magnitude of the potential harms."

Given the uncertainty of risks involved with the COVID shots, the JCVI considered the benefits "too small to support advice on a universal programme of vaccination of otherwise healthy 12- to 15-year-old children at this time."

Moreover, COVID shot trials have never produced evidence that the vaccines stop infection or transmission. They do not even claim to reduce hospitalization, but the measurement of success is in preventing severe symptoms of COVID-19 disease. Indeed, there is strong evidence that the "vaccinated" are just as likely to carry and transmit the virus as the unvaccinated.

Many Catholics and other Christians have rejected the currently available COVID inoculations because they were developed or tested using cell lines derived from aborted children.

https://www.lifesitenews.com/news/children-in-britain-up-to-52-times-more-likely-to-die-following-a-covid-shot-report-finds/

Israeli study shows that 4th booster protection from infection wanes after just 4-weeks

A study published in the New England Journal of medicine April 5th, 2022, titled, **Protection by a Fourth Dose of BNT162b2 against Omicron in Israel**, involving over 1,000,000 subjects shows that the confirmed infection rate protection begins to wane rapidly after just four weeks post 4th booster, yet some protection against severe illness appears to last at least six weeks. One thing to consider however, is that this study was done when the omicron variant was at its peak and that omicron infection rarely leads to severe illness.

From the study

Comparing the rate ratio over time since the fourth dose (Fig. 2) suggests that the protection against confirmed infection with the omicron variant reaches a maximum in the fourth week after vaccination, after which the rate ratio decreases to approximately 1.1 by the eighth week; these findings suggest that protection against confirmed infection wanes quickly.

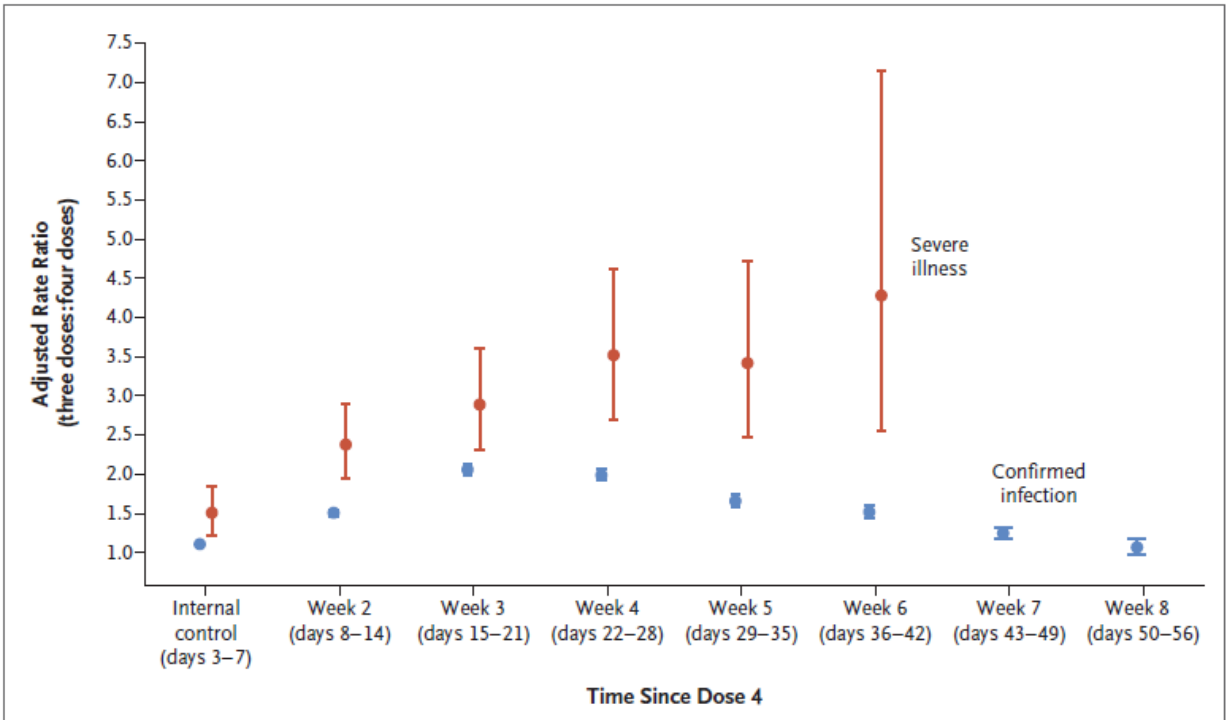


Figure 2. Adjusted Rate Ratios for Confirmed Infection and Severe Illness.

Shown are adjusted rate ratios for confirmed SARS-CoV-2 infection and severe Covid-19 in the group of persons eligible for a fourth dose who had not yet received it (three-dose group) as compared with those who had received a fourth dose, as a function of time since the fourth dose (the higher the rate ratio, the greater the protection conferred by the fourth dose of vaccine). Persons in the internal control group had received a fourth dose 3 to 7 days earlier (a period in which the fourth dose was not expected to affect the rate of confirmed infection or severe illness). Because of the 14-day follow-up period for severe Covid-19, the study period for this outcome was 2 weeks shorter than that for confirmed infection, and therefore the estimates of the adjusted rate ratio for severe illness end at week 6 instead of week 8.

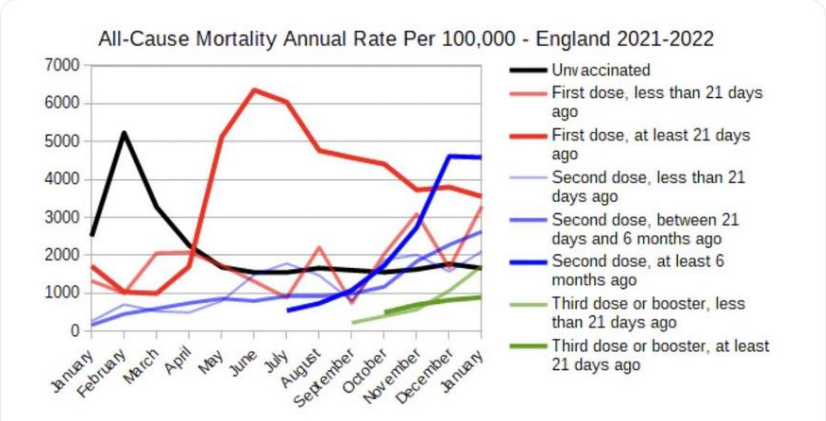
https://www.nejm.org/doi/full/10.1056/NEJMoa2201570

All-cause mortality strikingly higher in the vaccinated

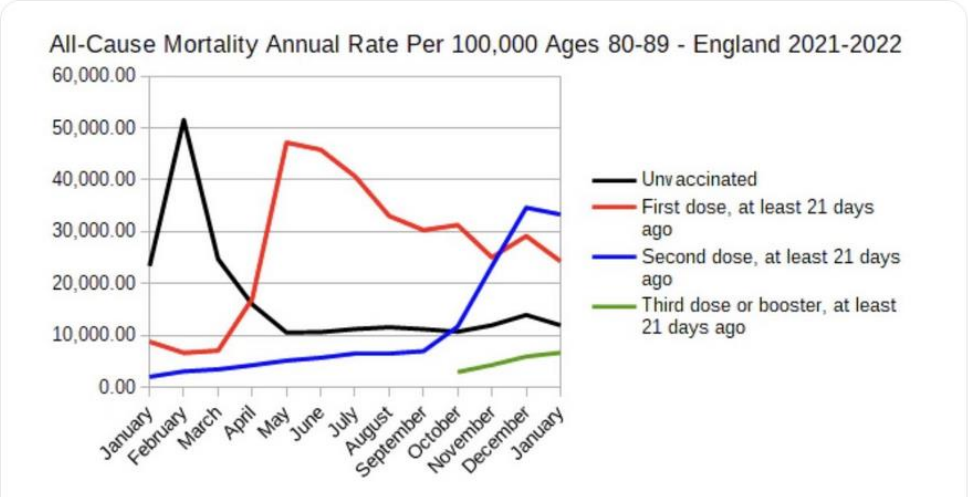
Charts are based on U.K. government data… continued on the next page

Ben
Follow @USMortality
Apr 15 · 4 tweets · 2 min read

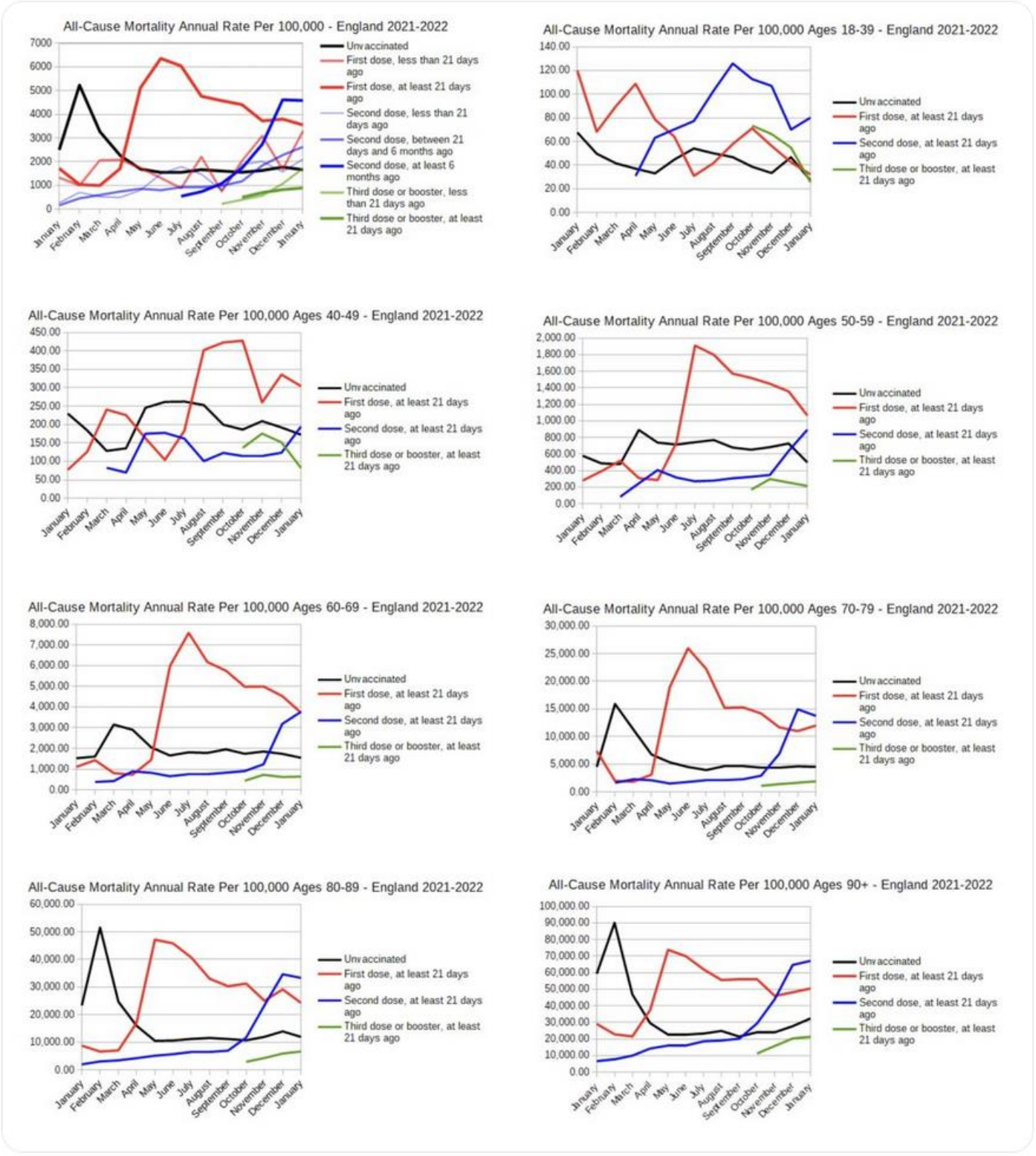
UK All-Cause Mortality by Vaccination status shows a clear picture!
> Initially the vaccinated appear to be dying less, which could be due to statistical effects
> After several months all vaccinated end up with higher mortality rates than the unvaccinated.
1/n #Covid #Covid19



Even stratified by age we can see this effect, here for example people aged 80-89 years old.
There's a brief time where vaccinated appear to be better off, but since October single and double vaxxed are now worse than the unvaccinated.
2/n



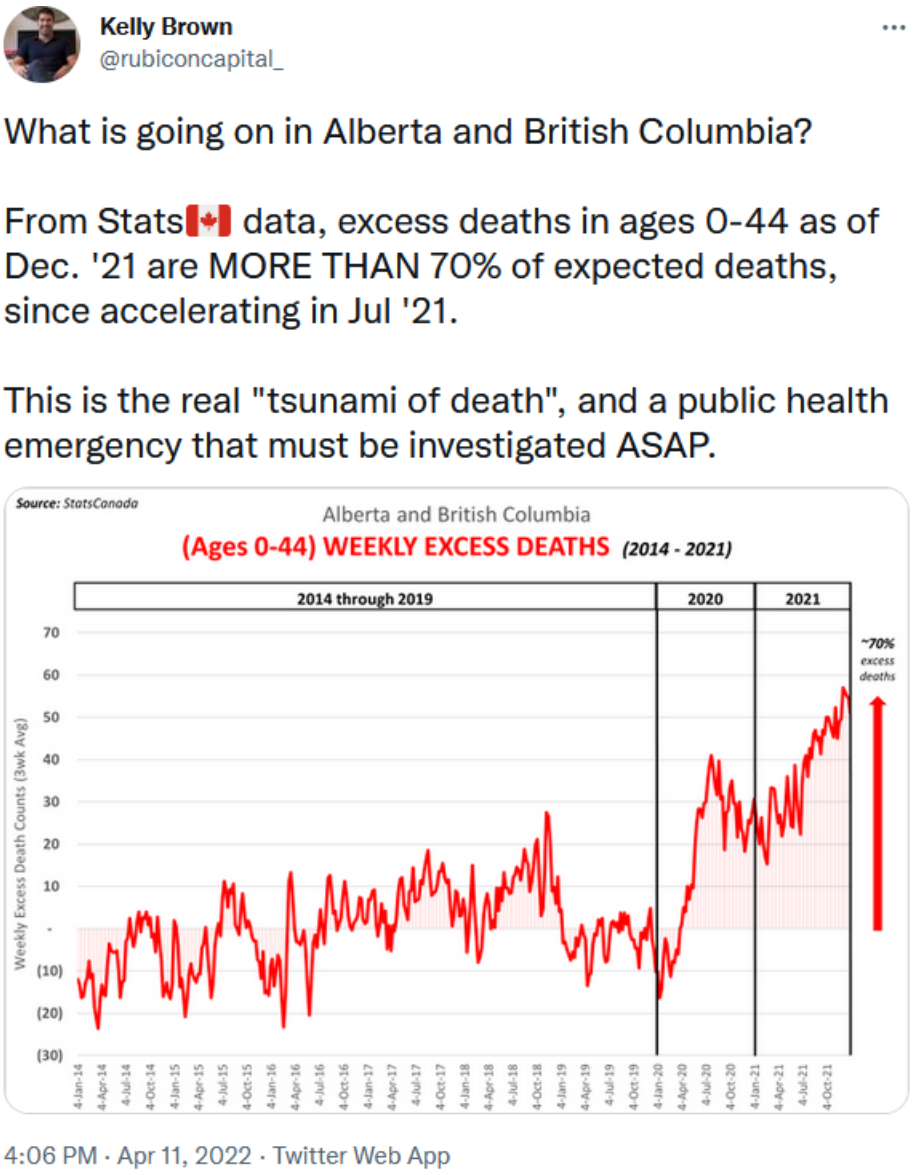
Here's the full picture by all age groups:



H/T to @ExcessBurden for these charts!

Sources: excessburden.substack.com/p/all-cause-mo...

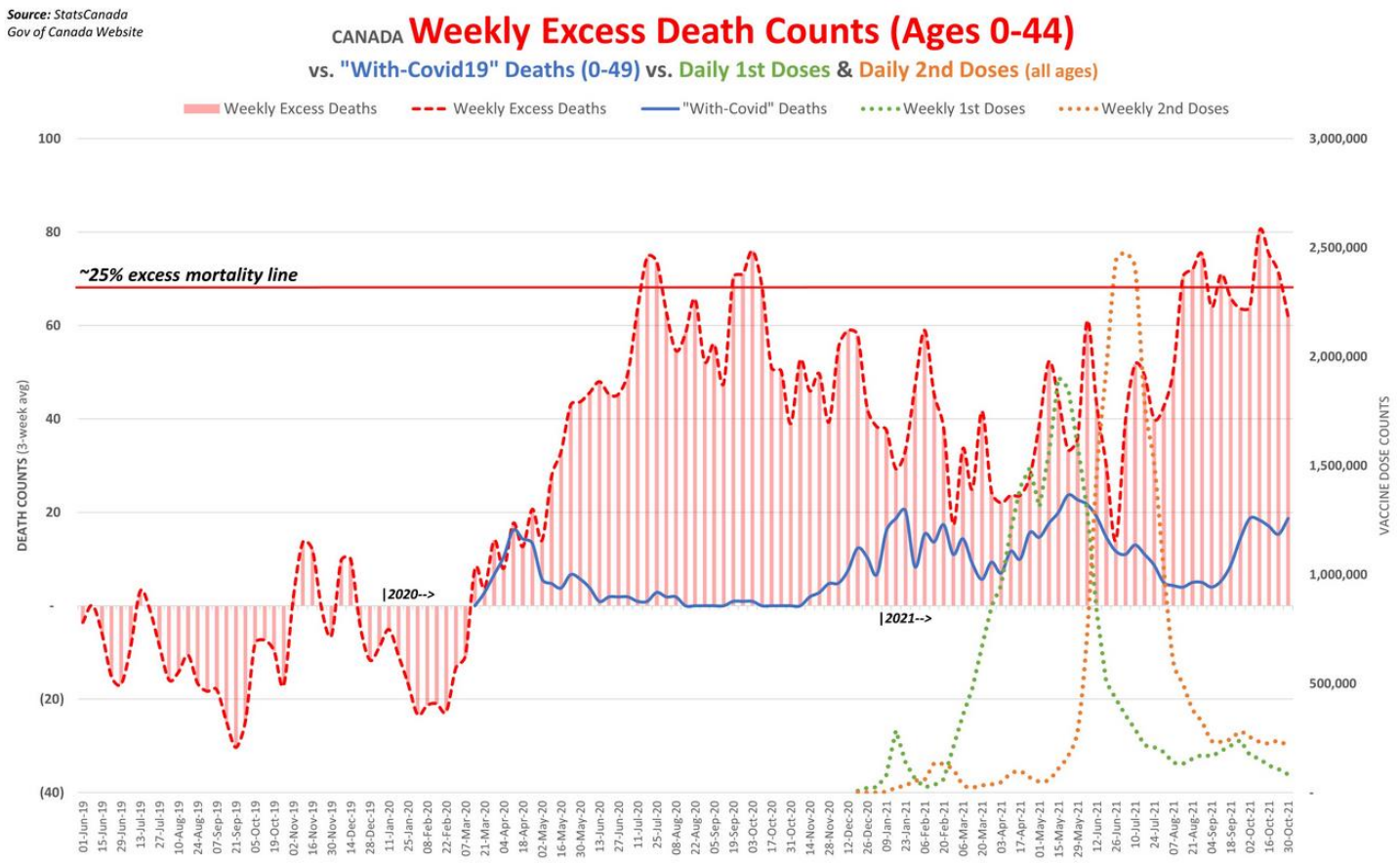
All-cause mortality in excess deaths are also escalating in Canada also as of summer of 2021



More from Kelly Brown looking at the alarmingly high rate of excess deaths in the 0–44-year-old age group across Canada on the next page…

This cohort including millennials, saw persistent >25% weekly excess deaths to Oct. 2021, after a rapid acceleration in July 2021. The rate of change starting in July can't be explained by a sudden rush of suicides, overdoses, cancers, etc.

Lockdown-related deaths were clear drivers of excess mortality in this group in 2020. Excess deaths began trailing off at the end of 2020 / start of 2021, but then re-accelerated suddenly in summer 2021, as Covid-19 deaths were low and declining, and as vaccine programs finished.



Sources Weekly Death Counts: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310076801 Excess Death Estimates: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310079201 Canadian Covid-19 Death Data: https://dc-covid.site.ined.fr/en/data/canada (Note Jan-Nov 2020 C19 deaths are Ontario prorated for Canada based on pop.)
Canadian Vax Data: https://health-infobase.canada.ca/covid-19/vacci

More evidence that boosters are not getting the job done in elderly people

An April 6th, 2022, study published in the British medical journal ***Lancet*** titled, **Dynamics of humoral and T-cell immunity after three BNT162b2 vaccinations in adults older than 80 years**, showed that T cell protection against the virus was not further increased by a third dose and that people who had recovered from the virus maintained robust levels of interferon production compared to boosted individuals. While antibodies appeared to get a short-term boost from the third shot, T-cells, an important player in protection against the virus did not respond accordingly.

From the article

A third mRNA-based booster vaccination is the currently favoured strategy to maintain protection against SARS-CoV-2 infection. **Yet, significant waning of specific immunity within 6 months after two doses, along with a higher incidence of breakthrough infections associated with the time elapsed since the second dose, raise concerns regarding the durability of immunity also after the booster vaccination.**

Quantified cytoplasmic expression of the effector cytokine interferon γ (IFNγ) indicated functional enhancement of spike-specific T cells upon second **but not further upon third vaccination**, **while more cytoplasmic IFNγ was found in spike-specific CD4 T cells from adults older than 80 years who had recovered from COVID-19** (appendix p 5). Thus, even a third BNT162b2 dose failed to induce durably enhanced quantities of spike-specific T cells and a functional quality reached after natural infection.

As for our cohort, our data show two important aspects of a third compared with a second dose—namely, **peak virus-specific T-cell frequencies were not further increased by a third dose, and average per-cell production of IFNγ remained unaltered and was still remarkably lower than in recovered donors of a similar age.** Thus, at least in older adults, the durability and quality of vaccine-induced immunity should be considered in the recommendation of booster vaccinations, in addition to the severity of breakthrough SARS-CoV-2 infections caused by current and future viral mutants.

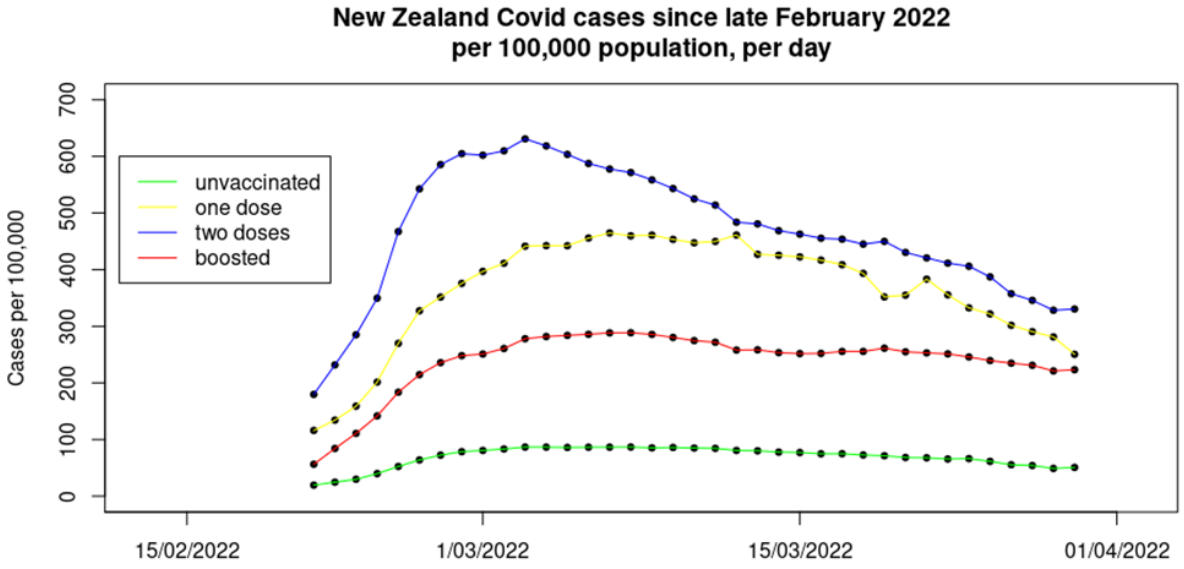
Dynamics of humoral and T-cell immunity after three BNT162b2 vaccinations in adults older than 80 years - The Lancet Infectious Diseases

While I decided to share this study in the vaccine section of this issue, it very well could have been shared in the Section highlighting the power of natural immunity as well.

How are the vaccinated doing in New Zealand compared to the unvaccinated?

The article published April 9th, 2022 on the ***dailyskeptic.org*** is titled, **Vaccinated Have Up To SIX Times the Infection Rate of Unvaccinated, New Zealand Government Data Show**

From the article
New Zealand is somewhat helpful in that it does publish daily cases, hospitalisations and deaths by vaccine status; *somewhat* because it doesn't allow easy access to anything other than the current day's report. Thankfully, the Wayback Machine ensures that at least some web pages aren't forever lost to history. These data were collated for dates since mid February 2022 and smoothed with a seven-day moving average to create a time series of Covid cases by vaccine status.



The first time the above graph popped up on my computer screen I had to go and double check all the data sources – and then I triple checked them. The data shown on the graph are notable for several reasons:

- Firstly the obvious one – during the most recent Covid wave there was a much lower infection rate in the unvaccinated, compared with those that had been given one, two or three doses of vaccine. What's more, this isn't a small effect – over the period shown approximately:
    - 10% of the triple vaccinated in New Zealand were infected.
    - 14% of the single vaccinated were infected.
    - An astounding 18% of the double vaccinated were infected.
    - Yet only 3% of the unvaccinated appear to have been infected.

https://dailysceptic.org/2022/04/09/vaccinated-have-up-to-six-times-the-infection-rate-of-unvaccinated-new-zealand-government-data-show/

The full article also gets in-depth with regard to mortality rates and excess mortality in the vaccinated versus the unvaccinated.

Hard to believe - Stanford kicks out and even deports students that will not keep up with the never-ending vax schedule

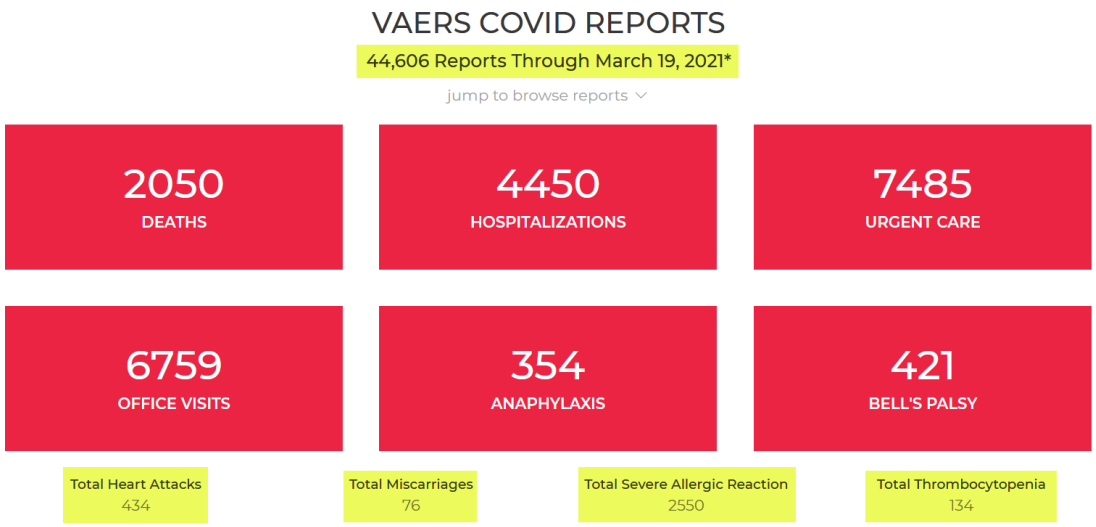
Martin Kulldorff @MartinKulldorff [243.6K Followers]

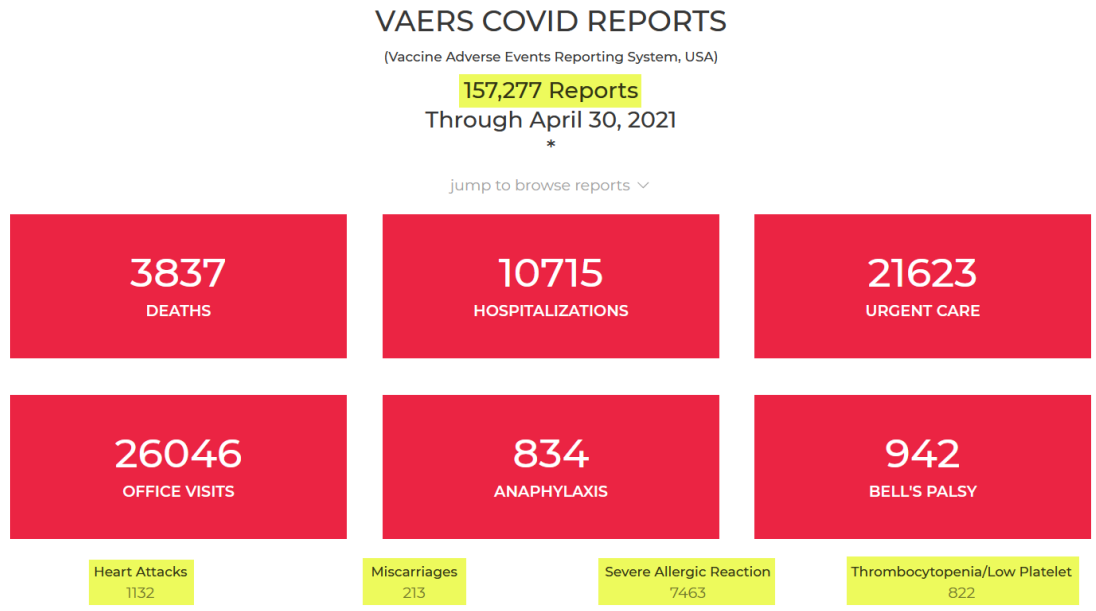
- Epidemiologist. Biostatistician. Infectious disease outbreaks. Vaccine safety.
- Free SaTScan/TreeScan/RSequential software.
- Former Harvard Professor of Medicine.

USA[gbdeclaration.org]

VAERS Red Box COVID-19 monthly casualty comparisons over time

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





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

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.

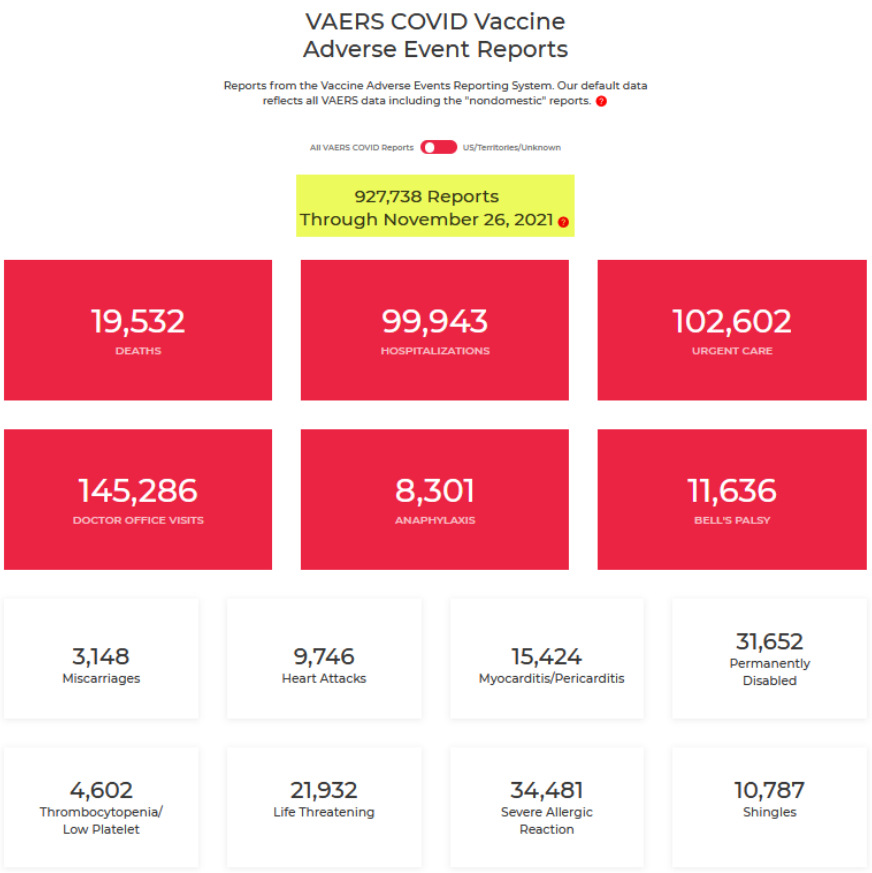
All VAERS COVID Reports | US/Territories/Unknown

837,593 Reports Through October 22, 2021

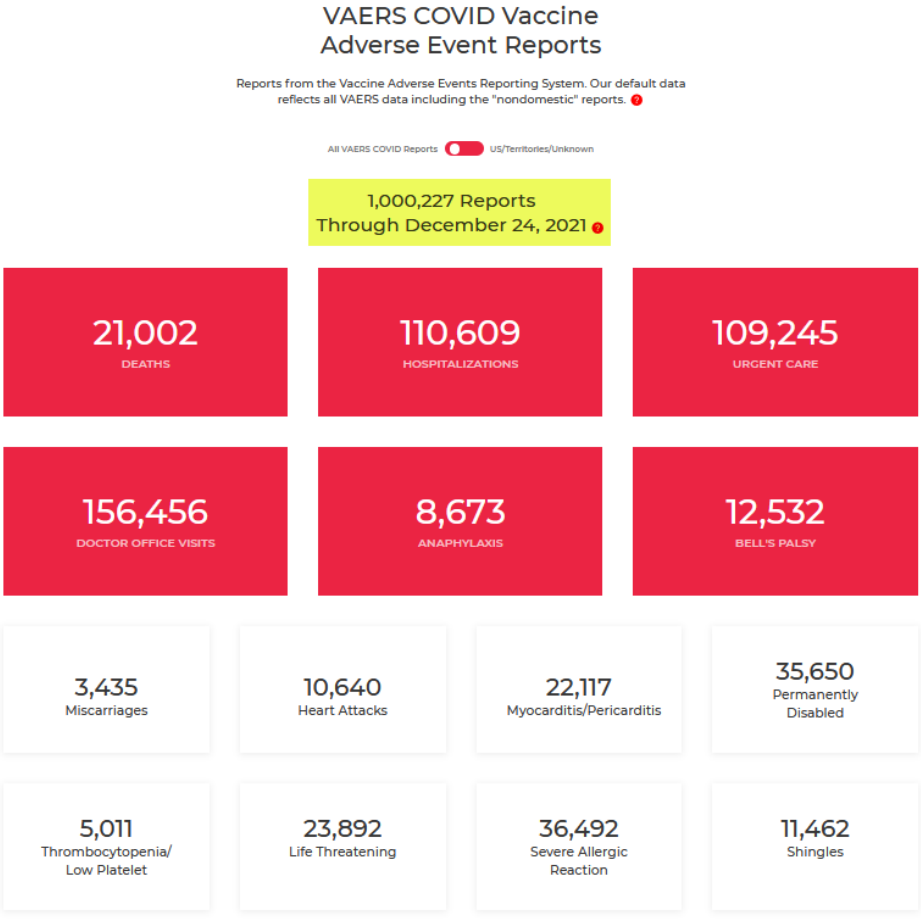
110,630 adverse reactions were added in the last 30 days

17,619 DEATHS — 2,233 deaths were added in the last 30 days	86,542 HOSPITALIZATIONS — 19,900 were added in the last 30 days	94,163 URGENT CARE — 11,309 were added in the last 30 days
130,795 DOCTOR OFFICE VISITS	7,706 ANAPHYLAXIS	10,465 BELL'S PALSY

2,712 Miscarriages	8,656 Heart Attacks	10,956 Myocarditis/Pericarditis	27,277 Permanently Disabled — 6,488 were added in the last 30 days
4,014 Thrombocytopenia/ Low Platelet	19,584 Life Threatening — 3,527 were added in the last 30 days	32,305 Severe Allergic Reaction	9,987 Shingles



And the number of reported adverse events has just passed 1 million!



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

1,071,854 Reports
Through January 21, 2022

22,607 DEATHS	121,597 HOSPITALIZATIONS	115,335 URGENT CARE
166,738 DOCTOR OFFICE VISITS	8,952 ANAPHYLAXIS	13,348 BELL'S PALSY

3,786 Miscarriages	11,502 Heart Attacks	29,716 Myocarditis/Pericarditis	40,069 Permanently Disabled
5,350 Thrombocytopenia/ Low Platelet	25,777 Life Threatening	38,603 Severe Allergic Reaction	12,068 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

1,134,982 Reports
Through February 18, 2022

24,402 DEATHS	133,057 HOSPITALIZATIONS	120,552 URGENT CARE
175,921 DOCTOR OFFICE VISITS	9,262 ANAPHYLAXIS	14,157 BELL'S PALSY

4,142 Miscarriages	12,511 Heart Attacks	34,448 Myocarditis/Pericarditis	44,512 Permanently Disabled
5,725 Thrombocytopenia/ Low Platelet	27,811 Life Threatening	40,123 Severe Allergic Reaction	12,566 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

1,195,934 Reports Through March 18, 2022

26,059 DEATHS	143,554 HOSPITALIZATIONS	124,777 URGENT CARE
183,634 DOCTOR OFFICE VISITS	9,500 ANAPHYLAXIS	14,827 BELL'S PALSY

4,377 Miscarriages	13,360 Heart Attacks	37,133 Myocarditis/Pericarditis	48,342 Permanently Disabled
6,164 Thrombocytopenia/ Low Platelet	29,444 Life Threatening	41,174 Severe Allergic Reaction	13,139 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

1,247,129 Reports Through April 22, 2022

27,532 DEATHS	152,946 HOSPITALIZATIONS	128,134 URGENT CARE
189,907 DOCTOR OFFICE VISITS	9,643 ANAPHYLAXIS	15,327 BELL'S PALSY

4,570 Miscarriages	14,096 Heart Attacks	39,639 Myocarditis/Pericarditis	51,163 Permanently Disabled
6,494 Thrombocytopenia/ Low Platelet	30,748 Life Threatening	41,595 Severe Allergic Reaction	13,599 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/

My Health Coaching website has lots of free educational resources on health, diet, nutrition and healthy lifestyle habits. You can access it all at https://awellnessdoc4u.com