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SARS-CoV-2 and the Vaccination Hype

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ABSTRACT

SARS-COV-2 and the corresponding infectious disease COVID-19 hold their grip on a large portion of humanity. The global race for a counter strategy quickly turned into a search for a vaccine as the preferred means to contain the virus. An unusually rapid development of different and completely new classes of experimental therapies that would widely be referred to as "vaccines" raised questions about safety, especially with regard to emergency use approval (EUA) being granted with unprecedented urgency and hardly any critical scrutiny. At present, independent researchers, even some former proponents and insiders, of the currently ongoing global experiment represented as a "vaccination" campaign point primarily to the lack of public safety studies based on empirical datasets that should be obtainable for the tens of millions, even hundreds of millions, of doses of mRNA and DNA vector therapeutics being distributed as "vaccines". Studies regarding efficacy and "side effects" (sometimes fatalities or permanent iatrogenic injuries) of these experimental therapies have been by-passed in favor of short-term field data from real patients which inevitably raises scientific and ethical questions particularly in view of the fact that the persons and entities responsible for public safety hold deep financial and other vested interests in speeding along the distribution of the experimental pharmaceutical products. The lack of an open discussion about the experimental therapies for COVID-19 now being applied across all age groups, even children hardly impacted by COVID-19, is worrying. The core principle of open debate without pre-conceptions or vested interests in outcomes has been and continues to be utterly ignored. We hope to engage scientific discussion with the hope of helping decision-makers, the general public, and the media alike to consider the subject-matter of what is at stake in a context of reason rather than panic.

Keywords: *COVID-19 vaccination*, *quasi-species consortia*, *RNA-/vector-vaccine*, *SARS-CoV-2*

1. Introduction

Within a short time after the emergence over a year ago in China of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), and its subsequent spread as COVID-19, the global

pandemic that followed allegedly caused more than 250 million infections with 4 million deaths also attributed to the virus (Gardner et al., 2021). The disease statistics revised hour by hour were all the while being "confirmed" by health officials using more than 30 cycles of polymerase chain reaction (PCR) testing in a manner guaranteed to produce a huge number of false positive COVID-19 cases as shown by Fleming (2021, pp. 4-12 and others). Nevertheless, the US Centers for Disease Control and Prevention (CDC) has continued up to the present time to use up to 45 amplification cycles of PCR to diagnose hundreds of thousands of "cases" of "COVID infections" in spite of the fact that the inventor of the PCR procedure himself, Kary Mullis (1986), insisted that PCR was and is (see Benevolent Life, Dr. Kary Mullis, 2020) inappropriate for diagnosing *any disease whatsoever*. Moreover, deaths were often attributed to COVID-19 as decreed after the fact by some health official without the deceased ever having manifested symptoms or having been certified as infected with SARS-CoV-2. For documentation, see the interview of the UK Funeral Director, John O'Looney, by Robert F. Kennedy, Jr., on November 13, 2021 (O'Looney, 2021; also Kennedy, 2021, pp. 357-377). To our knowledge, exceedingly few of the deaths attributed to COVID-19 were ever verified by the gold-standard of a careful autopsy, and none of the deaths dealt with personally by John O'Looney were autopsied. None of the persons he dealt with ever showed symptoms of COVID-19 nor were they ever diagnosed as having contracted it while they were still living according to their family members. Nonetheless, COVID-19 was registered as the cause of death by health officials.

1.1 Media Attention

In the hype of media attention that followed the first reported infections and deaths, and particularly after the lockdown impacting the developed nations world-wide in March 2020, it was hardly clear whether any particular death attributed to COVID-19 was of an individual who died after being designated as a "case" infected by SARS-CoV-2, or whether the deceased person was actually killed by the virus (Madl et al., 2021). In the meantime, a frantic search for a quick fix was launched at the expense of taxpayers, which search — a few months later — resulted in several candidate "vaccines" being released by emergency use authorization (EUA). To understand the "patho-physiology" of this novel disease, dubbed COVID-19, in the days and weeks following the outbreak, it became known that the new virus (in several variants) interferes in manifold ways with the host genome. For the details, readers are referred to Fleming (2021). He documents and cites (1) the long public record of research findings reported in prestigious scientific journals, (2) the stream of lucrative patents for virus components and the like, and (3) the series of government grants for millions of dollars in a little more than 141 pages showing how SARS-CoV-2 was manipulated over several years, even decades, leading up to the pandemic that would become known as COVID-19. The genomic interference attributed to the virus, or more correctly according to Fleming, caused by its genetically engineered spike protein (see our Figure 1), triggers what Blaylock (2021) has termed a cytokine storm, and which according to Dotan et al. (2021) is also associated with a host of distinct antibodies as well as autoimmune diseases. Due to its molecular mimicry of human sequences, the spike protein of SARS-CoV-2 readily binds with the membrane based ACE2 (angiotensin converting enzyme 2) receptors (Guzik et al., 2020; South et al., 2020) present in various cell types found in the human lungs, heart, blood vessels, kidneys, liver, testes, and gastrointestinal tract (Figure 1).

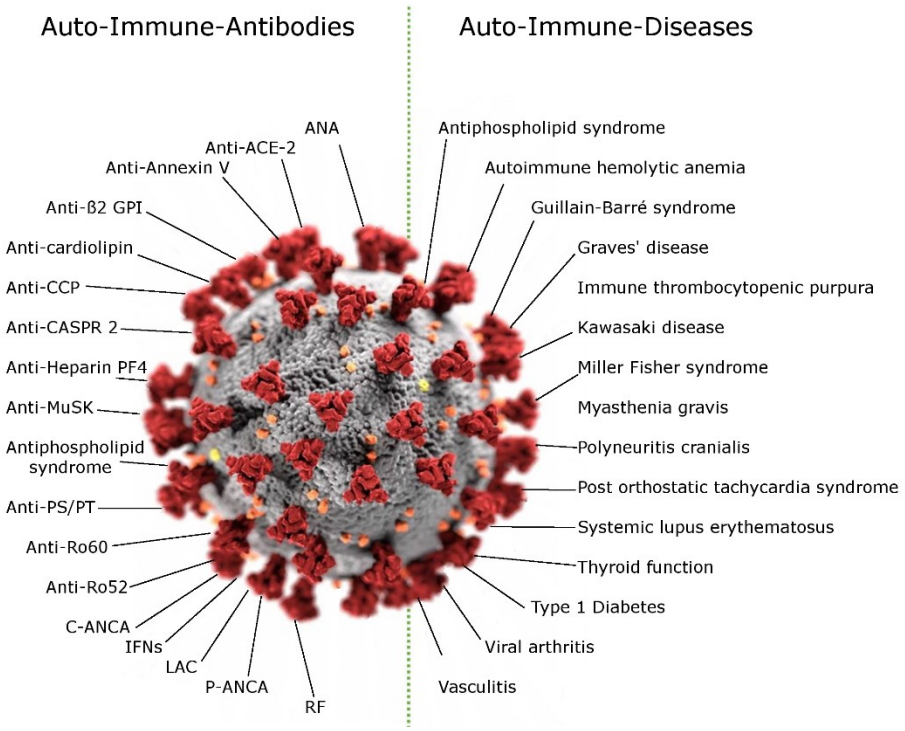

Figure 1.Visualization of SARS-CoV-2 (center) with its ultrastructural morphology. Grouped around the virus appear autoantibodies (left) and autoimmune diseases (right) both linked to the SARS-CoV-2-infection (modified after Dotan et al., 2021), but may also be relevant for the associated "side effects" of the experimental therapies now being represented to the public as "vaccines". Note that the specific named diseases and corresponding auto-antibodies are not actually associated with the particular locations on the SARS-CoV-2 virus suggested in this artwork, but are nonetheless well-attested in relevant research.

As highlighted below, the widespread presence of the ACE2 receptor within the human body makes those cells likely targets of opportunity for potential adverse effects following vaccination. In the majority of cases, a COVID-19 infection passes rather quickly with hardly any noteworthy symptoms. However, in a small percentage of cases, the infected persons report body aches with fever and other flu-like symptoms. But severe cases are relatively rare and deaths unambiguously attributable to SARS-CoV-2, account for only about 6% of the total number of COVID-19 deaths reported by the CDC — numbers, as already noted, greatly inflated by a huge percentage of the "cases" falsely diagnosed as positive for COVID infection by the inappropriate use of PCR tests with an absurdly high number of cycles (see the Fleming, 2021 reference cited above). Even so, 94% of the observed fatalities originally attributed to COVID infection, as admitted by the CDC (2020), involved one or more co-morbid disease conditions that could not be excluded as the proximate cause, of the death in question. Autopsies performed on hospitalized COVID-19 patients that did not recover revealed conditions such as respiratory failure associated with diffuse alveolar damage, and/or multiple-organ failure, cardiac decompensation, complication due to malignant tumors, septic shock, and various other chronic disease conditions and serious disorders. The commonly associated risk factors for severe life-threatening SARS-CoV-2 infections included a litany of life-style-issues such as obesity and hypertension, as well as serious disease conditions such as tumors and diabetes mellitus, or the patients who died were advanced in years with overall poor health. In many instances fatalities involved people who were, already,

nearing the end of their lives before the onset of the COVID-19 pandemic attributed to SARS-CoV-2.

1.2 A Common Dysfunction in Recipients of the Experimental Injections

One common injury attributed to the virus in its various forms was vascular dysfunction with altered endothelial metabolism not only in the lungs but in almost any organ that was closely examined in the severely ill or deceased persons (Haberecker et al., 2021). Given that patients with pre-existing endothelial dysfunction already have a suppressed capacity to restore injured vasculature and are already inhibited by microthrombosis, they are particularly vulnerable to the impact of any variant of SARS-CoV-2.

With all this in mind, it seems stranger than ever that the current spectrum of mRNA and genome vectoring "vaccines" have been granted emergency release at all. Bearing in mind that the therapies in question (see further explanation in reference to our Figure 2 below on page 180) are radically different from traditional vaccines insofar as these new experimental therapies aim to control certain genetic processes formerly, but now no longer, out of the reach of medical interventions. For that reason, in this paper we refer to any of the experimental COVID-19 injections as a "disease component replicating therapy", or a "DCRT-injection" for short. As will be shown later, the associated "side effects" — unintended iatrogenic consequences consisting of injuries of various sorts, some of which are already occurring and others that are known to be possible, even likely, downstream — of these novel classes of experimental genetic therapies logically must interact negatively with the comorbidities that evidently have actually led to some severe or fatal infections by SARS-CoV-2. One of the prominent and obvious dangers, known to those examining the research on DCRT-injections, is that the genome interference brought into hundreds of millions of people by these experimental injections are virtually certain to aggravate any existing distressed endothelial metabolism causing, among other undesirable effects, microthrombosis (see Fleming, 2021; McCullough et al., 2021).

2.0 The Normal Human Virus Sphere Disrupted?

Viruses are believed to be essential and dominant players in microbial ecology (Moelling, 2017), and yet fairly little is known about the patho-physiology of those that can cause disease, their relevant threshold levels, their possible sources (means of transmission), and modes of transformation. The family of single stranded RNA (ssRNA) viruses — to which SARS-CoV-2 belongs — has peculiar properties as it has enormous genomic flexibility, on the one hand and species-specific persistence, on the other. These viruses, as a result, have genetic stability in their own right and at the same time can co-evolve along with changes occurring in their host cells including the manufacture of antibodies against the viruses by the host. Under laboratory conditions, these viruses generate different gene populations in rather short periods of time. However, under natural conditions, without the kinds of artificial disturbances as ordinary vaccine injections produce, viruses themselves tend to maintain significant homogeneity resulting in molecular clocks that run much more slowly than those that seem to be in play with the so-called "acute viruses" (Villarreal, 2005) which change more quickly. In the case of SARS-CoV-2, Fleming (2021, pp. 17-25) documents published research showing how this particular virus was pre-designed for very rapid changes enabling its downstream variants to adapt at Warp Speed to changing conditions in the host population. Given that hundreds of millions of humans have already been impacted by injections containing the genetic vectoring to generate countless copies

of the mutating spike protein itself, SARS-CoV-2 is, it seems, assured of rapid and constant mutation. All this is confirmed by genetic analyses performed six months after the infected persons studied were diagnosed. Results showed dramatic genetic modifications in the novel "mutated" genome compared to its original sequence. The most prominent alterations were in the spike-protein itself at D614G (Zhang et al, 2020a), E484K (Wise, 2021), B.1.1.7 (Rambaut et al., 2020), B.1.351 (Lessells, 2021). Some of the variants found already observed, but new variants were appearing continuously all the while that such analyses of the SARS-CoV-2 variants were being done (CDC, 2021a; ECDC, 2021, Tablizo et al., 2021).

2.1 Quasi-Species Consortia (qS-c)

While mutations are one concern, quasi-Species consortia (qS-c) — quite analogous to quorum sensing in bacteria (Miller and Bassler 2001, Waters and Bassler 2005) — represent another means by which the virus can adapt and increase its own infectivity in hosts. Behavioral motifs of cooperative RNA-agents are the drivers behind the basic viral skills required to invade and infect hosts and which are responsible for the synthesis of *de novo* nucleotide sequences in the host's genomic economy. Changes in the host's genetic material can come about by the virus effecting an insertion, substitution, or deletion in native host sequences (Villarreal and Witzany, 2013; Villarreal, 2015). This means that for every variant (1) a given nucleic acid sequence does not maintain a unique position, but rather depends on its context of use; which in turn implies that (2) the nucleotide sequences follow real-life conditions that aren't randomly arranged. The far-reaching effects of such variations as observed under laboratory conditions are much broader: qS-c (1) concur in related populations and exclude relatives; (2) possess minority populations that are essential for overall fitness; (3) exhibit heterogeneity which is important for fitness but is not observed in the consensus type; (4) are able to repress their own replication through lethal defects; and (5) are composed of members that interfere with the replication of the collective. Hence, qS-c populations are highly diverse, and it is assumed that no two genomes therein are identical — even if a cloned genetically homogeneous template is used to trigger a cycle of infection (Villarreal and Witzany, 2013; 2021), it will not *remain* identical to its own starting sequence. This fact is relevant to the ongoing pandemic and the EUA "DCRT-injections" that are claimed to have the power to stop it. The fact that a non-negligible number of people continue to test positive for COVID-19 long after the infection, and all the symptoms formerly prominent, are gone, suggests that the specific RNAs of SARS-CoV-2 can be and are being reverse-transcribed into human cells (Zhang et al 2020b; Desfarges & Ciuffi, 2012; Villarreal & Witzany, 2021). In patients recovered from Long-COVID-19 (Raveendran et al., 2021),## an unusually elevated concentration of "G-protein coupled receptors" tied to "functional autoantibodies" (GPCR-$_f$AABs) have been detected in their serum. Associated symptoms included alopecia, fatigue, tachycardia, bradycardia, and myocarditis among others (Wallukat et al 2021). So far, only a few cases are available showing host-virus chimeric reads in RNA-sequencing data from SARS-CoV-2 infected cells and samples from COVID-19 patients that would suggest viral integration into the human genome (Yan et al., 2021). Hence, only follow-up studies of Long-COVID cases will show whether this can be determined for sure (Lopez-Leon et al., 2021).

1.2 Cells and Tissues Known to Be Impacted

There is a third concern for human endogenous retroviruses (HERV) fulfilling crucial life functions (Villarreal, 2005) — in particular non-coding retroviral RNA sequences within the human genome are responsible for editing tasks. Phylo-ontogenetically speaking, this feature

accounts for crucial competencies such as the production of "replicase, polymerase, integrase, DNA-repairs, restriction/modifications of gene expression, methylation, the eukaryotic nucleus, the division of transcription and translation, the creation of nuclear pores, tubulin-based chromosome duplication, empowering of the innate immune system, the adaptive immune system, health in cartilage, bones, skin, mucus, milk, the placenta, viviparity just to name a few (Witzany, 2006). Why does this matter? Because at least two of the ongoing DCRT-injection platforms use RNA and DNA technology (Lurie et al., 2020) and according to Lyons-Weiler (2020) reveal immunogenic epitope similarities of SARS-CoV-2 with homologues to human proteins. Adiguzel (2021) drew attention to residual alignments to SARS-CoV-2 peptide with almost a dozen known human proteins. Moreover, over-expression of the spike protein significantly suppresses both homologous recombination and non-homologous end joining (Jiang & Mei, 2021), processes that are essential for DNA repair in cells. Autoimmune reactivity in response to viral antigens following infection or vaccination can easily be derived from cross-reaction with human tissue antigens that share sequence homology with the virus; this includes cells in the heart muscle, skeletal muscles, thyroid gland, kidneys, brain, pituitary gland, testes, lung, blood, gastrointestinal tract, eye, liver, bone marrow, adipose tissue, skin, and many ubiquitous proteins (Vojdani et al., 2021). The major autoimmune findings related to SARS-CoV-2 regard anti-phospholipid, anti-nuclear, p- & c-anti-neutrophil cytoplasmics, anti-cyclic citrullinated peptides, and anti-gangliosides GD1b antibodies (Salle, 2021). Given that the viral spike protein is a potential epitopic target for biomimicry-induced autoimmunological processes it will be extremely important to see if GPCR-$_f$AABs will also become detectable after vaccination against the virus (Wallukat et al 2021).

3.0 The Novel Class of "DCRT-Injections"

About a third of the potentially targeted human proteins (putative autoantigens) are key players in the adaptive immune system. Thus, a gene-based-therapy by any "DCRT-injection" could generate a series of side effects. Specifically, binding antibodies that do not neutralize themselves but only bind to the surface of the virus-infected cell, may render the viral particle invisible to the immune system. Practically, such a "stealth" mode would amplify viral replication, and, in that way make subsequent infections more severe — an effect known as antibody-dependent enhancement (ADE). Such an effect depends on how antibodies target different epitopes of the S-protein (Iwasaki & Yang, 2020). Indeed, ADE was observed almost two decades ago when SARS and MERS first became known (Lee at al., 2020). It is marked symptomatically by the fact a secondary infection is more severe than the primary infection was (Grenfell et al., 2004). As a result, ADE affects safety and efficacy of passive and active immunization schedules (Negro, 2020; Xu et al., 2021). To reduce the risk of such pathogenic priming, all the parts of the epitopes that are homologous to human proteins ought to be excluded from any candidate DCRT-injection/genetic therapies (Cappello et al., 2020). Yet, all DCRT-injections target human protein biosynthesis aiming to manipulate the RNA translation at the ribosome level in order to induce the production of viral proteins as antigens, usually spike proteins — see also the vaccine package leaflet (WHO, 2021; EMA, 2021c,d,e,f). In addition, the allergenic potential of novel adjuvants such as PEG and polysorbate (Garçon et al., 2012; Wang et al., 2010), also commonly referred to as excipients and which are present in DNA vector therapies as well as the mRNA DCRT-injections. Furthermore, the lipid nanoparticles encapsulating mRNA components of the Pfizer and Moderna DCRT-injections may contain conjugated adjuvants or may themselves act as "adjuvants" (Chung et al., 2020; Kim et al., 2021; Zhang & Xia, 2021) — all of this making iatrogenic injuries even more probable (Coors et al., 2005; Jackson et al., 2020; Cabanillas et al., 2020; deVrieze, 2021; Kim et al.,

2021; Kostoff et al., 2021). For example, Pujol et al. (2021) report on three cases of thyroiditis which they diagnose as adjuvant induced acute inflammation (ASIA) "induced by the mRNA-based SARS-CoV-2 vaccination" (in their abstract). With such warning signals in mind, DCRT-injections with the EUA designation already granted: i) should not be deemed to have established a standard of prevention in the settings where they are being introduced (Singh & Upshur, 2020); ii) should require that unresolved safety concerns be properly addressed (Bruno er al., 2021); and iii) should be used only after conventional therapies have been exhausted (Shi, 2020; Inserra et al., 2021; de Melo et al., 2021; McCullough et al., 2021; SWPRS, 2021; Nair et al., 2021). In other words, EUA experimental therapies such as the genetic "DCRT-injections" addressing the COVID-19 "pandemic" should only be used if less invasive conventional therapies have failed (Janiaud, et al, 2021; McCullough et al., 2021).[1]

3.2 A "Trojan Horse" Effect?

Although the evidence is limited, it appears already that the implementation of "genetically modified" so-called "vaccines" — actually experimental genetic therapies — may interfere with the target cell's genome leading to the activation of oncogenes and/or deactivation of anticarcinogenic gene sequences, thus increasing cancer risks (Ura et al., 2014; Hasson et al., 2015; Aubrit et al, 2015). However, the few studies there are underline the likelihood of actual integration of the so-called "vaccine's" components into the human genome. These may consist of i) viral mRNA and adenovirus vector DNA (Doerfler, 2021) the frequency and epigenetic consequences of have yet to be determined; ii) at least for SARS-COV-2 infections whereby occasionally copies of viral subgenomic RNAs may integrate into the DNA of the host cell via reverse transcription — the latter being a cause for symptomatic infections long after any initial infection has cleared (Zhang et al., 2021).

Such an undesirable "Trojan Horse" effect is likely if the transferred nucleic acids designed to mimic human genes are actually integrated into human protein biosynthesis (Chiu et al., 2021; Mansuriya & Altintas, 2021; Xu et al., 2021). Independent researchers examining genetic DCRT-injections, therefore, point out that any short-cuts to clinical evaluations for the development of experimental injections against COVID-19, especially when based on the transduction of nucleic acids (themselves capable of unknown adjuvant-type "side-effects" such as thyroiditis; Pujol et al., 2021), would be a violation of the precautionary principle (Jiang, 2020; Arvay, 2020; Rosenthal and Cummings, 2021). In the long run, and as seen with SARS almost a decade ago, it is shocking, even potentially horrifying, to consider how the novel DCRT-injections introduced into hundreds of millions of people may, over the coming weeks, months, and years, alter specific functions of the human body, especially by damaging the immune system. According to Ryan Cole at the Mayo Clinic, and David Bauer at the Francis Crick Institute (Wilson, 2021), the DCRT-injections are already causing infection rates from autoimmune diseases and cancers to skyrocket. None of this should be surprising given the tumorigenicity of cell substrates used in the production of those DCRT-injections including induction of tumor allografts, transfer of known or unknown viruses, and transfer of oncogenic agents or cell components that may produce *de novo* or re-ignite existing cancerous cells (Aubrit 2015; Arvay, 2020; Sumi et al., 2021). Grave adverse potentials arise as the source material for the manufacture of DCRT-injections rely on animal cell lines *in-vitro*. Combined with the fact that modified "designer cell lines" — derived from duck, monkey, and

[1] only after a year of crisis management with emergency-approved vaccines does the EU come back to conventional therapies in which five seem to get clearance (EC, 2021a)

dog tissues, as well as human embryonic kidney cells, known under brand names like EB66®, AGE1.CR®, PER.C6®, HEK 293, etc.— are being used for the production of novel influenza vaccines along with the new DCRT-injections not only raises ethical questions, but could open a Pandora's box inside human cells (Hsee and Ruan, 2016).

3.3 One or More Self-Replicating Disease Components?

The currently most popular DCRT-injection platforms opted to include RNA-, DNA-, vector-, inactivated, live attenuated-, and protein-subunit-vaccines (Ng et al., 2020). So far, RNA and vector vaccines have been given priority for widespread use in the general public — see Figure 2; for regular updates on their distribution see Mathieau et al. (2021). Yet these experimental "DCRT-injections" are not without known risks. As nanotechnology drugs, which in their essence are gene-therapies they aim to cause host cells to produce the "exogenous" active viral component — a disease agent or component of the suspected cause of disease. As mRNA-based DCRT-injections contain the spike glycoprotein (S) of SARS-CoV-2 encapsulated in lipid nanoparticles (LNPs) (EMA, 2021c), the encapsulation itself being an adjuvant (Chung et al., 2020; Kim et al., 2021; Zhang & Xia, 2021) represents an intentional "Trojan horse" that can by-pass the sensors on the cell membrane and can enter the sacrosanct region of the nucleus and nucleolus undetected. There it can set up shop as a manufacturer of whatever variants of the disease component it may already be programmed to construct, or that may arise based on modifications of the genome of the disease component that may occur after the DCRT-injection has done its preliminary work. The design is such that the liposomes won't activate an immediate defensive response. While pure RNA sections are instantaneously recognized and upon entrance into the cell become neutralized, an LNP is easily phagocytized and penetrates the cytoplasm where the external lipid membrane is degraded releasing the glycoprotein load.

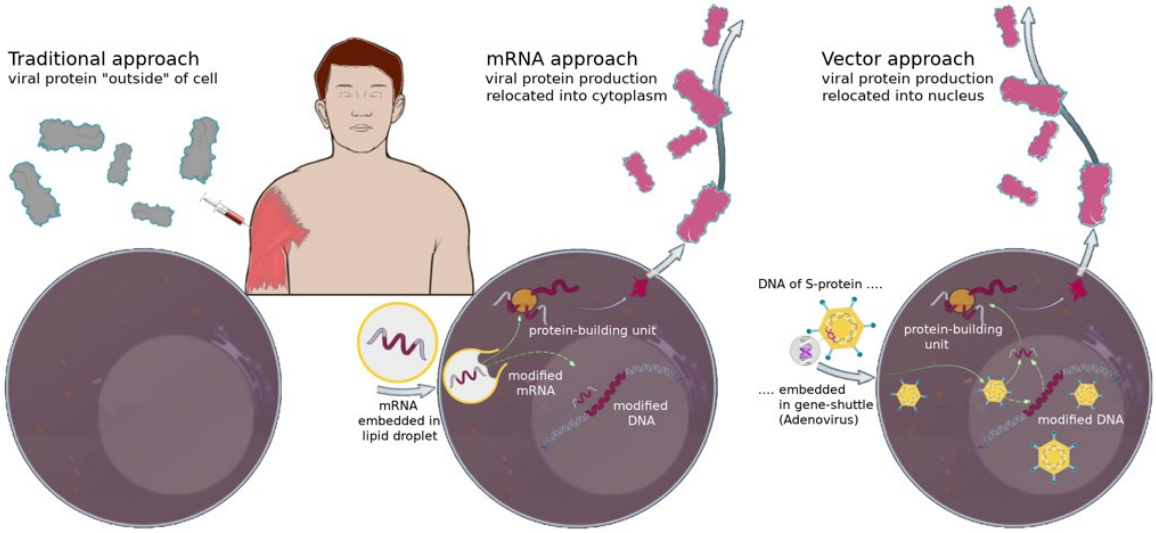

Figure 2. Traditional intramuscular injection of viral proteins (left); RNA injection designed to enable the cell to produce the active component of the vaccine itself (center); and vector introduced via gene shuttle also aiming to produce the active vaccine component (right). The dashed lines represent the hypothetical case where the injected RNA is reverse transcribed or the DNA becomes persistently integrated into the host cell genome. Collectively, the models in the middle and at the right of the figure represent the intended working of what we are calling "DCRT-injections".

The use of vector DCRT-injections involves recombinant adenovirus type-5 (Ad5) vectors that have already been found to be problematic in studies associated with HIV. Participants involved in

such studies, after being artificially infected with the adenovirus, tested positive and as such were at elevated risk of HIV-1 infection (Buchbinder et al., 2020).

3.4 Emergency Use Authorization for Half-Baked Ideas?

Up until the COVID-19 crisis, no mRNA drug or DCRT-injection had been licensed for use in humans. There was a feasibility study with an RNA-DCRT-injection several years ago (Bahl et al., 2017), but given that the technology is still in its "infancy", it is not surprising that it is exceedingly difficult to get RNA into cells without triggering serious side effects (NatBiotech, 2016). On theoretical grounds, based on many different disease conditions, Oller and Shaw (2019) showed how any penetration into the nucleus, particularly the nucleolus where the main cache of DNA is stored and normally well-protected against toxicants and other invasive factors, appears to be essential to the initiation of metastatic cancers. How can vector-based therapies, posing now more or less as traditional "vaccines", be optimized to avoid unintended RNA-splicing reactions? How can we be assured of the safety of pharmaceutical products that deliberately breach the most intensive biological barriers of the body (Kowarz et al., 2021)? Currently, we cannot rule out the possibility that the spike open-reading frame of SARS-CoV-2 can be disrupted by arbitrary (unpredictable) splicing events when transcribed inside the nucleus, possibly leading to soluble spike protein variants. The protein content roughly consists of about 2/3 of human and 1/3 of viral origin, together accounting for about 1,000 different proteins present in a vector DCRT-injection. This also includes protein impurities that contribute to the strong clinical reactions with flu-like symptoms that are often observed following vaccination (Krutzke et al., 2021). For compositional analysis of mRNA and vector therapies represented as "vaccines" see Seneff and Nigh (2021) and also Broudy and Kyrie (2021).

Both approaches raise ethical concerns as they purport to reduce the living languages of the genome to a computer-like operating system, supposedly making the "software" of life fully accessible to genetic engineers. Based on current knowledge, these novel DCRT-injections urgently need further research as so-called "chromosomal insertions" are known to happen to a certain extent, and can have undesirable effects (Baum et al., 2006).

4.0 An Unending Series of Shots and Booster-Boosters?

With these considerations in mind, any efforts to tame or even eliminate (zero-COVID approach) the spread of SARS-CoV-2 viruses via novel biotechnological tools is an impossible goal to achieve. And even if it could be achieved, COVID-19 immunity could be lost within months (Seow et al., 2020), making frequent booster shots an inevitable routine, while at the same time demonstrating the lack of coverage or power of the prior shots against a rapidly diversifying set of moving targets (Ou et al., 2021; Pachetti et al., 2020). Will any number of boosters be more effective than the ones already currently being deployed? Experience from the past has already made it evident that recipients of trivalent inactivated influenza vaccines (TIV) had an increased risk (4.40) of virologically confirmed non-influenza infections (Cowling et al 2012), and, though denied by researchers, a surprisingly high rate of interference with embryological development resulting in congenital defects or fatality to the unborn (Eaton et al., 2018). Especially for non-influenza viruses, the chances to find both coronavirus and human meta-pneumovirus among vaccinated subjects were significantly higher (OR = 1.36 and 1.51, respectively) than in unvaccinated individuals (Wolff, 2020).

Candidates against the feline coronavirus FIPV (passive vaccination) led to adverse effects with the consequence that vaccinated cats showed an increased risk of a symptomatic infection compared with cats that didn't receive the vaccine (Takano et al., 2019).

4.1 Is the Notorious Inefficacy of Influenza Vaccines Relevant?

This immediately raises the question of vaccination efficiency (VE), which often is found to be age-dependent. Data on VE are rather scarce — the data available, however, report age-dependent VE against laboratory-confirmed influenza A(H1N1) for Denmark and the UK (Kissling et al., 2019). A similar age-dependent trend in VE of laboratory confirmed A(H1N1) and A(H3N2) influenza cases was also documented in Germany — there, the negative VE values for some age-groups are even more striking (Buda et al., 2019). Figure 3 depicts such an exemplary trend. A negative VE-value implies that no statistically significant protection of the vaccinated individual against influenza can be demonstrated compared to unvaccinated people; i.e. in other words, a vaccinated person has a higher risk of contracting influenza at the same exposure conditions than an unvaccinated individual.

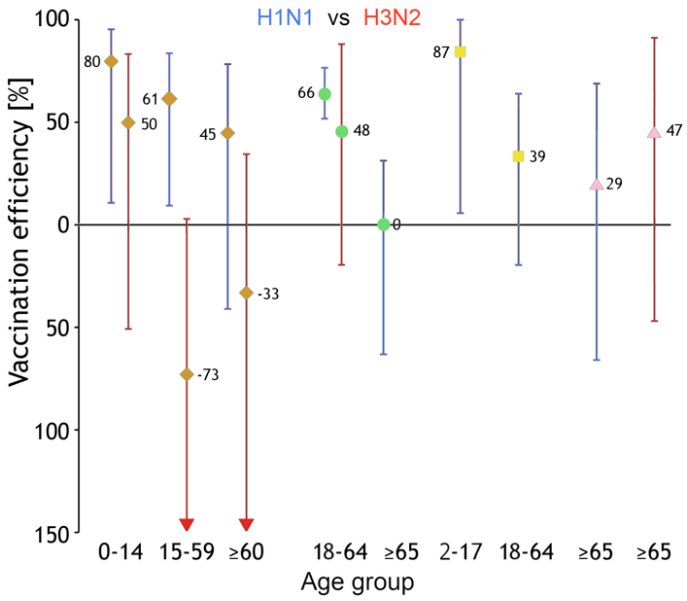

Figure 3. Estimation of the effectiveness of vaccination against influenza A(H1N1) and influenza A(H3N2) in three age groups during the 2018/19 season, based on a point estimate and a 95 % confidence interval. The arrowheads indicate a value outside the y-axis shown. FRG (◊), DK (○), UK (□), EU (Δ); (composite figure based on data from Kissling et al. (2019) and Buda et al. (2019).

4.2 VAERS and the Death Toll of DCRT-Injections

A similar relationship exists for other traditional vaccines. In the case of polio vaccines, for example, it has been observed that vaccination campaigns triggered polio incidence in regions where the virus was endemic (wild poliovirus, WPV), while in regions with non-endemic polio, as a result of vaccination there were vaccine-derived poliovirus cases, cVDPV that would actually increase steadily over the following years (Jenkins et al., 2010; PGEI, 2021). Paradoxically, as we aim to move toward global polio eradication, the burden of vaccine-induced polio is becoming increasingly important (Lopalco, 2017, Leslie, 2021).

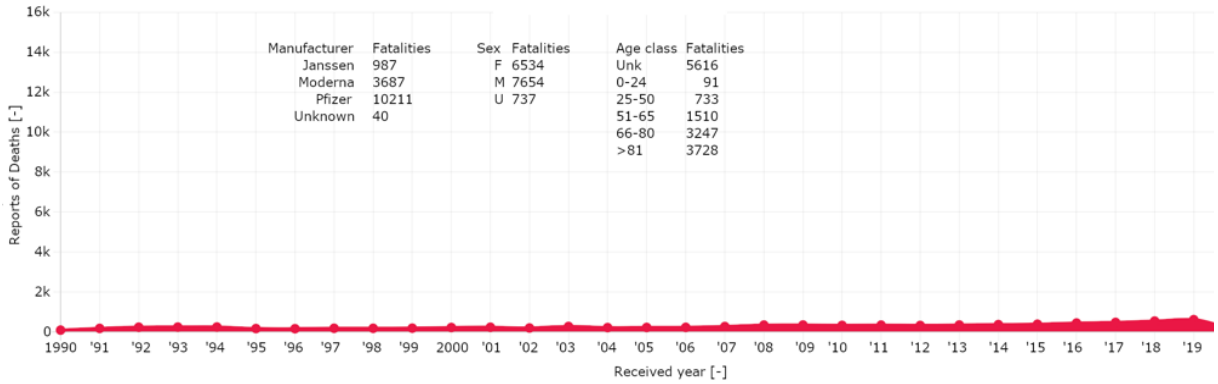

Figure 4. Cumulative reports of Vaccine Mortality Rate per year. The period of the COVID-19 DCRT-injection introduction reflects data only till September 2021 (VAERS, 2021).

4.3 DRCT-Injection Recipients at Greater Risk of COVID Infection?

In spite of the size of the ongoing experiment, with tens, even hundreds of millions, being injected during the world-wide SARS-CoV-2 vaccination campaign, it seems — as stressed in Figure 4 — that the novel line of vector-DCRT-injections is resulting in markedly higher fatality rates not only among the elderly but across the broad spectrum of persons already being exposed — all this in contrast to traditional vaccines, especially, the conventional influenza vaccines (EudraVigilence, 2021; VAERS, 2021).[2] While the efficacy of the current vector-DCRT-injections is still being evaluated (i.e. initially, a relative risk reduction to contract COVID-19 of ≈95 % for the mRNA DCRT-injections and ≈67 % for vector DCRT-injections, which translates to an absolute risk reduction of only ≈0.84-1.2 % and 1.3 % respectively (Olliaro et al., 2021), a significant drop in efficiency is already observable (Wadman, 2021; Uriu et al., 2021; Keehner et al., 2021). With the emergence of the "delta" and now "omicron" variants, the proclaimed protection by the novel vector-DCRT-injections is becoming more and more doubtful as the probability of spreading the virus not only equivalizes in recipients of the experimental DCRT-injections, but seems likely to greatly surpass infections in unvaccinated persons (Chau et al., 2021). In the instance of the "delta" variant, the health care professionals in the hospital setting studied had

> viral loads of breakthrough Delta variant infection . . . 251 times higher than those of cases infected with old strains detected between March-April 2020. Time from diagnosis to PCR negative was 8–33 days (median:

[2] VAERS data released by the Centers for Disease Control and Prevention (CDC) showed that between Dec. 14 2020 and Aug. 27 2021, for the US alone a total of 650,077 total adverse events were reported, including 13,911 deaths out of roughly 357 million doses administered (equivalent of 179 million fully vaccinated US-citizens receiving two doses), which translates to an adverse effect rate of 0.36%. EudraVigilence on adverse reactions due to mRNA and Vector Vaccines (May 22 2021) lists 12,184 fatalities and 1,196,190 injuries.

Moderna:
https://dap.ema.europa.eu/analytics/saw.dll?PortalPages&PortalPath=%2Fshared%2FPHV%20DAP%2F_portal%2FDAP&Action=Navigate&P0=1&P1=eq&P2=%22Line%20Listing%20Objects%22.%22Substance%20High%20Level%20Code%22&P3=1+40983312
Biontech:
https://dap.ema.europa.eu/analytics/saw.dll?PortalPages&PortalPath=%2Fshared%2FPHV%20DAP%2F_portal%2FDAP&Action=Navigate&P0=1&P1=eq&P2=%22Line%20Listing%20Objects%22.%22Substance%20High%20Level%20Code%22&P3=1+42325700
AstraZeneca:
https://dap.ema.europa.eu/analytics/saw.dll?PortalPages&PortalPath=%2Fshared%2FPHV%20DAP%2F_portal%2FDAP&Action=Navigate&P0=1&P1=eq&P2=%22Line%20Listing%20Objects%22.%22Substance%20High%20Level%20Code%22&P3=1+40995439
Janssen:
https://dap.ema.europa.eu/analyticsSOAP/saw.dll?PortalPages&PortalPath=%2Fshared%2FPHV%20DAP%2F_portal%2FDAP&Action=Navigate&P0=1&P1=eq&P2=%22Line%20Listing%20Objects%22.%22Substance%20High%20Level%20Code%22&P3=1+42287887

> 21). Neutralizing antibody levels after vaccination and at diagnosis of the cases were lower than those in the matched uninfected controls. There was no correlation between vaccine-induced neutralizing antibody levels and viral loads or the development of symptoms. . . . Breakthrough Delta variant infections are associated with high viral loads, prolonged PCR positivity, and low levels of vaccine-induced neutralizing antibodies, explaining the transmission between the vaccinated people (Chau et al., 2021).

In the case of vector DCRT-injections, this occurs within three months of the last vaccination, whereas for mRNA DCRT-injections, the waning effect is only slightly delayed (Mallapaty, 2021). It can't be excluded in the long run that this novel class of DCRT-injections will fail altogether due to continuously mutating subspecies. From this perspective, mass vaccination does not make sense at all as a large part of the population is already sufficiently protected by natural infections (Reiss and Bhakdi, 2020).

5.0 Natural Immunity Is Better

As early as 2020, Gomes et al. reached the conclusion that people who have natural immunity are not susceptible to the virus and therefore do not become sick. Rather, by realistic modelling of available data, a maximum of 7-18 % of the population will become infected with SARS-CoV-2, implying that herd immunity is achieved already at that level. Hence, indifferent mass vaccination must also be evaluated from this perspective, as it erodes herd immunity (particularly, as vaccinating young individuals adversely affects their innate immunity). This is especially relevant since lasting immunity to COVID-19 is suggested with infections without symptoms and even after mild illness; i.e., the normal rise in antibody levels is a consequence of infection. Antibody-producing cells are found even 11 months after the onset of initial symptoms, demonstrating that SARS-Cov-2 infections elicit a strong immune response in humans (Turner et al., 2021). As Coronaviruses have been around for decades, about one-quarter of people have antibodies from such precursor versions that can bind to the SARS-CoV-2, thereby neutralizing it quite efficiently, thus herd immunity has already been established years ago (Jones, 2020). On top of that, it has been shown that patients with IGA deficiency do not have a worse prognosis than healthy individuals (Naito et al., 2020). This, in turn, would indicate that lymphocytes are responsible for the immune reaction more so than the antibodies, which calls into question vaccination which should induce them.

5.1 Still Being Overlooked Though Known to Be Superior

Throughout the management of the current pandemic, natural immunity has been more or less neglected. The USA, so far, does not recognise any immunity through natural infection, even though the CDC itself admits some effectiveness of natural immunity after infection. Cohort studies indicate an 80%–90% reduction in incidence for at least 6 months after infection among antibody-positive persons (CDC, 2021b). Still, the CDC recommends vaccination of this group also without further stipulations (CDC, 2021c). The question has to be raised why this is the case. Rooted in a firm push-back against the way Sweden and Great Britain were handling the pandemic in the beginning, and subsequently against any quest for so-called "herd immunity" without vaccines of some kind, the John Snow Memorandum proclaimed the danger of trusting natural immunity and dismissed any public health value in it (Alwan et al., 2020). Even the epidemiological term "herd immunity" itself started to be frowned upon and politically charged, which resulted in a general distrust of natural immunity. Fortunately, the EU policies recognize natural immunity to some degree. Proof of a COVID-19 infection through a positive PCR test, or in some countries with a more trustworthy serological antibody count, results in a "recovered" status for a set

number of months and subsequently requires no shot — by policy in some EU-states — but at least one dose of some DCRT-injection remains a general requirement for a person to be considered "fully vaccinated" (EC, 2021b). Nonetheless, it is noteworthy that the EU policies acknowledge natural immunity to some degree.

5.2 Infected Persons Not Helped by DCRT-Injections

When immunity is acquired through infection, vaccination seems to bring little or no benefit, but it does bring with it risks associated with the side effects and possible long-term reactions the DCRT-injection may cause (Bock, 2021). Menni et al (2021) found in their study, that systemic side effects after vaccination were more common in individuals with previous infections than among those without known infection. This again shows the problem with the undifferentiated, blanket approach of the current DCRT-injection campaign. It does not reflect a thoughtful risk-benefit-analysis and exposes a large group of the population to a DCRT-injection they likely do not need, and exposes them to a higher risk of adverse side effects while at the same time using up DCRT-injection doses that could be beneficial to risk groups.

5.3 The Fatality Rate for COVID-19 Greatly Over-Estimated

Relating all these aforementioned aspects to the hypothesized claims that the pandemic will result in outstanding numbers of fatalities, it is further corroborated that SARS-CoV-2 is not the "deadly" virus as initially proclaimed, because, in the vast majority of cases, it did not even lead to severe illness and/or serious sequelae in healthy individuals. Moreover, SARS-CoV-2 under normal circumstances does not come into contact with the bloodstream. In the case of an intramuscular injection, however, such a transmigration occurs rather frequently (Hasset et al., 2019). In that case, affected endothelial cells could be stimulated to synthesize the genetic material and present the spike protein via the MHC-I pathway on their cell surface. In capillaries, where blood flow velocity is rather low, this can easily result in Lymphocyte interaction (Chen et al., 2020), leading to tiny, localized blood clots, which ultimately result in microthrombosis even up to four weeks following vaccination (Hafeez et al., 2021). In the case of a previously acquired COVID-19 infection, CD8 lymphocytes are already present in the blood of the affected individual. Thus, the risk of cross-reactions after vaccination are real (Grifoni et al., 2020; Sekine et al., 2020; Nelde at al., 2020;). Since cases of thrombocytopenia have already been described (Zhang et al., 2020c; Lippi et al., 2020), this is a serious development that is cause for concern, especially in the case of RNA vaccination (Grady, 2021). Therefore, the need to receive a SARS-CoV-2 jab is uncalled for (Reiss and Bhakdi, 2020).

5.4 DCRT-Injections for Children and Infants?

Given the emergency approval status granted to these novel DCRT-injections, anyone exposed to one of them needs to be made aware that he or she is participating in a global field trial equivalent to a phase III-traditional vaccine safety study.[3] Although as troubling as compulsory vaccination of medical personnel is — as it has been enforced by law in some EU-countries such as Italy (GU,

[3] Why was Israel able to provide this new vaccine to its population so quickly, starting as early as January 2021? The *Real-World Epidemiological Evidence Collaboration* signed by Pfizer and the Israeli Ministry of Health provides vaccines for its entire population, and in return the manufacturer receives an undisclosed payment along with the data on the vaccine's safety and efficacy, making Israel *de facto* the first large-scale field laboratory (Birnhack, 2021).

2021) — even more threatening is the currently planned expansion of the vaccination program to include children, infants, and pregnant women. The latter seems particularly strange because hardly any COVID-19 cases have been documented in children so that the risk of mortality in those groups is almost zero from any circulating virus (Ioannidis 2020). The idea to include this share of the population in the vaccination program is a clear indication that authorities don't understand this "pandemic" at all. Unfortunately, this will no longer be the case once children and the unborn babies of pregnant women who happen to be exposed to one or more shots of any DCRT-injection. It is reasonable to suppose that in children the spike protein can i) bypass the innate immune system, ii) enter the bloodstream, and, given the encapsulating LNP layer, iii) be even more toxic in children than adults. In such a scenario, the risk-benefit ratio becomes unreasonable (Kostoff et al., 2021). A study published a year ago emphasizes the risk of contracting acute and chronic conditions during the first 12 months of post-partum life when all the recommended traditional vaccines are administered (Hooke and Miller, 2020). Since COVID-19 is not a childhood disease — as it primarily affects the elderly — vaccination in the age-group <40 is not at all justified. Given what is already known of the DCRT-injections deployed in recent months, health specialists and parents should be cautious. On top of that and according to the hygiene hypothesis, young children should also refrain from wearing masks or being engaged in excessive hygiene, as such practices are associated with epigenetic hyperexpression of various genes, which inevitably leads to a weakening of the immune system that can persist for decades (Olszak et al. 2012).

5.5. Bossche Says Vaccination During a Pandemic Cannot Work

At a recent plenary lecture at an international vaccine conference, Vanden Bossche (2021) expressed concern about mass vaccination during a pandemic given the obvious fact that traditional vaccines, as well as the experimental DCRT-injections, are all designed for prophylactic use. They do not have the power to kill a disease agent but rather contain all or part of one, or some product of a pathogen, that is supposed to stimulate antibody production against the actual cause of some targeted disease. As such, according to Vanden Bossche, vaccines of any type are not an efficient way to control an ongoing pandemic. They may be sensibly deployed to prevent one in the future, but not to halt one already in progress. He therefore advised that vaccination should never be used on a large scale where the population has already been exposed to widespread infection and the challenges to the natural immune functions already under stress.

His concerns are further supported by observations that the diversity of SARS-CoV-2 antibodies naturally produced is dampened in the population by mass vaccination (Niesen et al., 2021). That result was also observed by Chau et al. (2021) who found that "neutralizing antibody levels after vaccination" were lower in vaccinated health care workers who became infected with a "Delta" variant which they carried at levels 251 times higher than persons infected with a prior, and distinct variant. The implication is that vaccinated persons may not only have suppressed antibody production against a novel variant of the disease condition that the vaccine supposedly protects them from, but, given the impact of the DCRT-injection itself — they got two doses of the Astra-Zeneca adenovirus, viral vector vaccine (the type depicted at the right hand side of our Figure 2 on page 180) — they may become a reservoir for and the source of a new variant of the targeted disease agent. Significantly, the health workers who had experienced the "breakthrough Delta variant infection" all became carriers of a variant that was "phylogenetically distinct from the contemporary Delta variant" that had previously proved to be more infectious than the "Alpha" variant of SARS-CoV-2.

5.6 Artificial Exposure to Viruses Speeds Mutant Production

Regardless of the proclaimed high efficacy by DCRT-injection producers, Bossche's expressed concern was rooted in the fact that vaccination on a large scale both accelerates and amplifies viral mutation rates. That is to say, new variants compared to the original strain have a better chance to increase their reservoir (see the Chau et al. study) thereby augmenting the viral replication capacity and spread of the new variants. All of this would turn the current global vaccination campaign into a program for advancing and amplifying the disease rather than reducing and dampening it. Although viruses cannot "think" and plan, the humans manipulating them and the DCRT-injections impacting their downstream transformations and replications, with regard to the qS-c theory, really can account for a change in viral competencies within an organism to more rapidly produce and promote infective variants. Such programmed "mutants" are, according to the findings of Chau et al., better able to resist the antibodies produced by multiple exposures to a DCRT-injection — a finding first reported by Farinholt et al. (2021). Moreover, recent data seem to even attest an opposite effect evidencing an increased risk of infection by the Beta, Gamma, or Delta variants after full vaccination, regardless of the vaccine used (Andeweg et al., 2021).

5.6 Explaining So-Called "Breakthrough" Infections

In addition, one should not forget that any vaccination is an "artificially induced infection" more suddenly impacting the whole organism. It is quite unlike the sigmoidal progression of a natural infection, and the vaccine, especially one of the DCRT varieties, does not act at the normal sites of a natural infection (nose, throat, lungs). Contrary to natural infections, which yield short-lived antibodies to the common cold viruses, for instance, and life-time natural immunities in others (to measles, chicken-pox, and so forth), DCRT-injected individuals may be building up replicants of some infectious agent indefinitely and with unknown long-term consequences. The results of Chau et al. as well as Farinholt et al. suggest that the antibodies generated to suppress whatever part of the SARS-CoV-2 virus the DCRT-injection generates in great supply (assuming it works as intended, as it seemed to in health workers studied by Chau et al.) can stress natural immunity and consequently actually promote and speed up the generation of new variants of whatever infectious agent, or whatever part of one, the DCRT-injections introduce into the body's genetic systems during a period of weakened immunity. All this can potentially render the vaccinated individuals themselves more susceptible to infections by new variants — the so-called "breakthrough" mutants — while at the same time the vaccinated individuals, as seen by Chau et al., become potential "super-spreaders" because they are producing a great deal of the new SARS-CoV-2 viral material. This threat scenario played out when DCRT-injected health workers were found to have 251 times more viral load of the delta strain of SARS-CoV-2 than their unvaccinated counterparts.

6.0 The "Adjuvant Effect" of LNP Encapsulated DCRT-Injections

It appears that the adjuvant-effect of DCRT-injections is powerful. Whether it involves any named "adjuvant" in addition to the NLP carrying the mRNA into cells or the DNA induced production of some variant of the programmed disease component is unknown (Chung et al., 2020), or at least is, according to Chung et al. (see the last paragraph before their "Conclusion" on p. 15532), undeclared by Pfizer and Moderna manufacturers. They do not name any specific adjuvants unless polysorbate and PEG are counted as such. However, as already noted, the mRNA and viral vector DNA products, presently being widely used in the world wide DCRT-injection experiment,

contain viral products encapsulated within the LNPs that can *themselves* act as adjuvants (Kim et al., 2021).

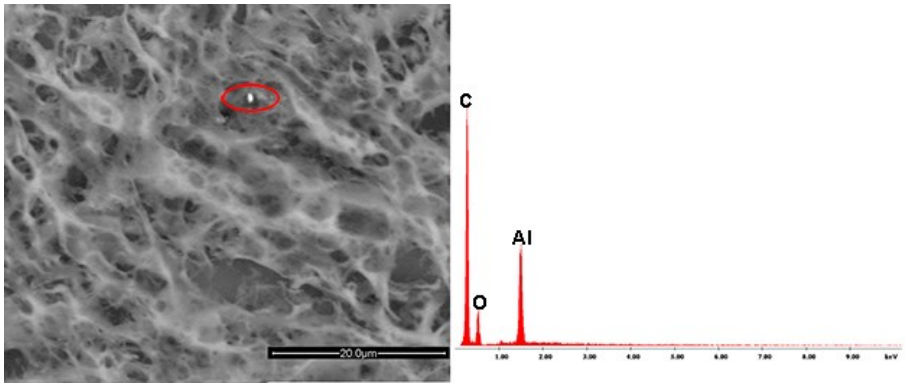

Figure 5a. Presence of aluminum compounds in the brain of deceased babies. Aluminum particle most likely aluminum-hydroxide.

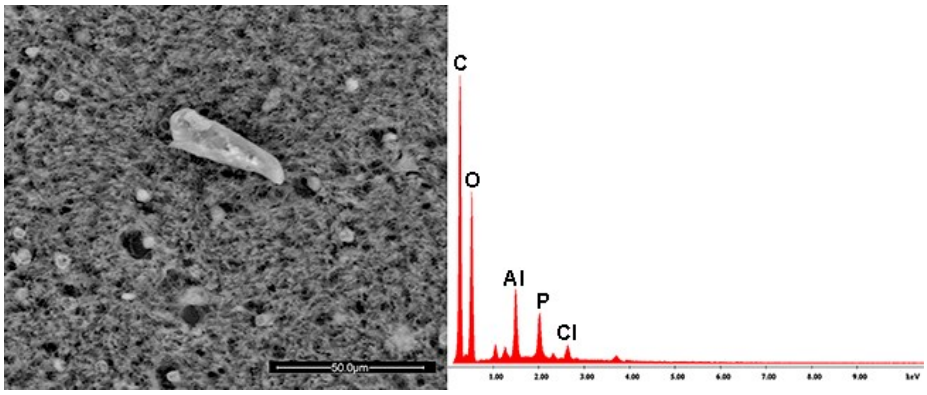

Figure 5b. Debris of aluminum-phosphate compounds commonly used as adjuvants in vaccines.

6.1 The Long and Perilous History of Adjuvants

The inclusion of well-known adjuvants consisting of aluminium-hydroxide or aluminium phosphate particles — which are easily detectable (Gatti and Montanari, 2015), and are known to cause adverse effects (Petrik et al., 2007; Tomljenovic & Shaw, 2011; Shaw et al., 2014; Butnaru & Shoenfeld, 2015; Gherardi et al., 2019; Crépeaux et al., 2020) — is particularly relevant for children up to the age of five who will typically have already been exposed to multiple doses of vaccines containing such adjuvants. All this, before potentially being exposed to DCRT-injections that are known to have deleterious effects on the immune systems of healthy adult individuals, much less can those injections be regarded as safe for use in children with lower body weight and more limited resources for ridding the body of toxicants through liver, kidney, and lymphatic functions. This younger age group is known already to be prone to greater harm by aluminum toxicity compared to older, larger, and more mature cohorts (Lyons-Weiler et al., 2020). As an aside, it is noteworthy that the neurotoxic potential of the aluminum-nanoparticles (Gherardi et al., 2001; Win-Shwe and Fujimaki, 2011; Cerpa-Cruz et al., 2013) could easily be avoided in currently "mandated" childhood vaccines by substituting extracts from medical plants that are biologically compatible with human boides (Sander et al., 2019) whereas the aluminum adjuvants are absolutely not (Burrell & Exley, 2010; Mold et al., 2016; Exley, 2017; Masson et al., 2017; Crepeaux et al.,

2020). There is no known biologically compatible uptake of aluminum into living systems (Shaw, Seneff, et al., 2014). As authorities are increasingly insisting on the use of DCRT-injections in younger and more vulnerable populations of children, even infants, there exists an urgent need to take account of known interactions of the polysorbate and PEG excipient/adjuvants in those experimental injections being added on top of the toxic burden of previous injections of aluminum adjuvants into individuals known to be more susceptible of immune system damage than the many adults who have already been injured (Wilson, 2021).

6.2 Blaylock's "Cytokine Storm" Playing Out

Figure 5 contains two images along with elemental analysis taken with a field-emission source operated in environmental SEM mode equipped with electron-backscatter diffraction camera and X-ray energy drift spectrometer (EDS), which reveal the xenobiotic particles in brain tissue samples from prematurely deceased newborns. A similar investigation that likewise used environmental electron microscopy (ESEM) to study the composition of mRNA and vector vaccines revealed that theses DCRT-injections contain components that are not mentioned in the instruction leaflet (TSC, 2021). The identified substances are known for their bio-incompatibility by adversely affecting blood circulation, and vascular endothelium, contributing to the formation of thrombi, as well as increasing the risk of hemorrhaging. Nanoparticles such as graphene, regarded themselves as adjuvants (Chung et al., 2020) are known to induce pro-inflammatory cytokine expression — consider Blaylock's (2021) "cytokine storm" (also see Fleming, 2021) — and in combination with PEG supposedly to improve elimination from the body (Palmieri et al., 2019). However, the DCRT-injections are actually designed to disperse the LNPs and their payloads throughout the body (Kostoff et al., 2021). Graphene oxide used to induce a biomolecular corona can be toxic as it causes LDH leakage, results in decreased levels of glutathione and associated peroxides, supresses mitochondrial membrane potential, slows ATP synthesis, and increases DNA damage (Gurunathan et al, 2019). Such nanomaterials are known to cross the blood brain barrier, enter the brain, and potentially induce strokes, and/or cerebral hemorrhages, while also damaging the endothelium of the heart muscle triggering a rise in myocarditis (Mevorach et al., 2021) and pericarditis cases among the young (Rose et al., 2021), predominantly affecting males (Mevorach et al., 2021). Indeed, both peri- and myocarditis are the most commonly observed adverse effects among mRNA-based DCRT-injections amounting to 79.2% and 87.2% respectively (Hajjo et al., 2021).

7.0 Socio-Political Implications and Demographics

Several governments within the EU are still concentrating on and intensifying DCRT-injection campaigns for people aged 65 years or older (EDCD, 2018). Italy is one of various COVID-19 epicenters and is not an exception to the continued emphasis on the elderly population (Madl et al., 2012). Some 20.3% of the residents in the COVID-19 hotspot province of Bergamo were supposedly infected with COVID, with a population of 1,109,933 inhabitants has 120,287 registered inhabitants in its provincial capital, all of them ≥65 years (CI, 2020) and more than half of them recipients of DCRT-injections. Also, during the 2019-2020 season 185,000 doses of influenza vaccine were ordered by the Bergamo authorities to offer free vaccination for individuals in this age group (BN, 2019a). In the same period some 34,000 inhabitants of Bergamo and Brescia were also exposed to meningitis vaccination (BN, 2019b) — this in spite of the fact that meningitis vaccination is associated with complications when administered to individuals showing flu-like symptoms (Wood et al., 1995; Liu et al., 2017). Such adverse interactions are no surprise

having been documented on several occasions (Cowling et al 2012; Wolff, 2020). Italy was among those EU-member states with a vaccination rate in the 65 and up age group amounting to 52.7% — at least this was the case during the 2019 flu-season (Eurostat, 2020). So the question arises, did this older population in Bergamo, especially in the capital city of that province, experience such a high rate of COVID infections because of the high rate of exposure to artificially injected pathogens?

7.1 Injection and Infection Rates

Only Spain, Belgium, Ireland, the Netherlands, and the UK score higher than Italy in the percentage of persons vaccinated and have likewise been hit hard during the COVID-19 waves as seen in a preprint article (EBMPHET, 2020) relating COVID-19 incidence to vaccination coverage rates (VCRs). According to that paper, the UK, the Netherlands, Belgium, Spain and Italy (among other countries) reveal a statistically significant ($p < 0.05$) positive correlation between VCR and the incidence of SARS-CoV-2 infections, as well as mortality in those aged 65 and up. Similar correlations between VCR and case fatality rate (CFR) have been noted for Europe in general. The editor of the *British Medical Journal* (Doshi, 2020a, 2020b) highlights problems associated with current DCRT-injections as applied in elderly population that have not been properly addressed: for one, he points out that none of the vaccine trials has been designed to achieve a significant reduction in hospital admissions, intensive care unit treatments, or deaths. Also, he notes that in the absence of sufficient data analysis for persons in the over-65 age bracket, they should not be forced to receive the experimental DCRT-injections. Accordingly, we are prompted to ask why are such experimental DCRT-injections being pre-financed and produced with outrageously aggressive government funding while the privately owned companies that are developing and producing the DCRT-injections are raking in profits in the billions of dollars and are protected from any kind of accountability to the general public — the people footing the bill?

7.2 Evident Design Flaws Ignored?

The current global use of the new technology DCRT-injections, all of them operating in the US under emergency use authorization (EUA) and elsewhere under some equivalent emergency provision, was already beginning to reveal major design flaws in the form of dramatic side effects (Salah and Mehta, 2021) even when only a small percentage of the world's population had been vaccinated (EMA, 2021b).[4] Documented cases of hypothyroidism (Kaur et al., 2021) and premature deaths (EudraVigilence, 2021; VAERS, 2021 — see also Figure 1) have not been properly acknowledged or addressed by authorities. Although several countries in Europe as well as the USA halted and/or restricted use of DCRT-injections to certain population groups after repeated cases of cerebral venous sinus thrombosis (CVST) were documented in combination with low levels of blood platelets (thrombocytopenia — see Schuchat, 2021; Nicolas, 2021; EMA, 2021a), the current push for world wide mass vaccination has overwhelmed reasonable constraints. While any temporary moratorium on the problematic DCRT-injections would certainly be recommended by persons looking thoughtfully at findings by independent researchers who do not

[4] Given the steady rise in confirmed myocarditis cases (Gargano et al. 2021) it is very likely that the current class of gene-based DCRT-injections could lose their currently tentative EUA approval; experience from the past with cyclo-oxygenase-2 (COX-2) inhibitors associated with an increased risk of thrombotic events (Bresalier et al. 2005) have resulted in legal battles in which the producers of the drug was forced to release billions of dollars in compensation.

have conflicts of interest causing them to prefer certain outcomes above others, all of the foregoing causes us to raise the question of whether such untested DCRT-injections should be used in any kind of preventative care. When is it reasonable to experiment with human genetics using procedures known to produce conditions such as thrombocytopenia, myocarditis, pericarditis, not to mention a host of autoimmune diseases, and a greater number of deaths reported under the VAERS system than for all the previous vaccines in all the prior years on record combined (Figure 4)?

Conclusions

Genetic DNA vector or mRNA injections, especially those termed DCRT-injections in this paper, involve substantial risks that cannot be properly assessed without cumulative long-term data, and yet these so-called "vaccines" were associated with significant side effects even while they were still in their Warp Speed developmental phase before 2021. The mass use of these rapidly approved DCRT-injections raises many questions — foremost among them is why adequate safety testing has not been undertaken and why there has been no open public discussion, much less the sort of debate that Robert F. Kennedy, Jr. has persistently invited on behalf of the Children's Health Defense organization. The prevailing tunnel vision, disregarding all warning signs being pointed out consistently by independent researchers who have no vested interest in outcomes — other than wanting themselves and their children to be safe from medical harms — is a dangerous social phenomenon. Such single-minded pursuit of monetary profits and the usurpation of human rights and freedoms — have no place in scientific circles and especially in medical research.

While the processes of human protein biosynthesis are well understood, the introduction of the DCRT-injections aimed at manipulating human genetic systems at the level of active mRNA and nuclear DNA may have already unleashed adverse potentials that are beyond anyone's control. The precautionary principle should be paramount here, and as always, the potential to do harm must be weighed against any promised benefits. The thrombosis cases — along with a host of other disease conditions, life-threatening disorders, and many deaths that are directly attributable to DCRT-injections have already occurred in Europe and the USA — illustrate the drama playing out in real time with the DCRT-injections as the main protagonists while various governmental power-brokers, corporate media and marketing moguls, as well as medical experts pull the strings. Even the classical inactivated components in traditional vaccines are not without risks, especially from the problematic adjuvants, excipients, animal proteins, etc., that are known to pose short-term and long-term threats. However, the DCRT-injections, because of their direct involvement in genetic re-writing turned loose inside human bodies, ups the ante exponentially as Mae-Wan Ho pointed out over the last couple of decades in many of her insightful publications (but see Ho, 1998, 2013, 2014). Moreover, the use of a prophylactic strategy *after a world-wide pandemic is well underway* is like closing the barn door after all the horses are long gone.

DCRT-injections are *de facto* unsuitable as tools to prevent what has already happened. It has been feared that mass vaccination is only speeding up SARS-CoV-2 diversification and, thus, ensuring its escape from all existing preventive measures. Must there be an unending series of booster shots trying to chase down the SARS-CoV-2 variants that are appearing much faster than the chasing shots and boosters can be produced? More importantly, how will the hopelessly outdistanced boosters ever catch up with the diversity of SARS-CoV-2 variants flying like bats from a bottomless pit? In view of all the risks, what compensating benefits can world-wide DCRT-injections (or some other variety of genetic modifications) really offer? Where are the benefits?

One shot was not enough. Two were certainly not more effective, but were — according to research by Bauer with millions of cases and by Cole with thousands (Wilson, 2021) — more harmful than one, so how can a series of three shots, four, or an unending series of "boosters" set things right? Also, as Robert F. Kennedy, Jr. has observed: what ever happened to the known fact that our natural immune defenses can defeat more than 99% of the infectious diseases to which we are exposed? Why not concentrate on enhancing natural immunity?

Many age groups are at minuscule risk from COVID-19, and even with high SARS-CoV-2 infection rates and the multiple variants of the virus that have already been identified, COVID-19 does not appear to have been significantly more of a risk factor than ordinary flu viruses. Even with all the engineering that went into promoting this world wide "pandemic" (see Fleming, 2021; also Kennedy, 2021), our natural immune defenses seem capable of handling everything it has thrown at us. Hundreds of millions have even survived, so far, and overcome the extra-special risks thrown at them by injections of DCRT-injections that were schooled by the decades of research that went into the creations of SARS-CoV-2 thanks to Fauci, Gates, the Wuhan Laboratory, and all its collaborators in the USA (Fleming, 2021; Kennedy, 2021). Does the global push for mass vaccination make sense in the fight against the COVID-19 pestilence in light of the known risks of DCRT-injections? Is the relative low risk to individuals a sufficient basis for shutting down whole countries, the entire world? There is also an urgent need for honest and unbiased data collection and analysis of naturally occurring immunity in the population. Artificial immunization is certainly a valuable tool if done properly, but it requires a solid scientific basis, and in no way can justify running rough shod over human rights about what goes into our own bodies. The current vaccination push, as well as the "zero-covid" strategy is so far from being any kind of scientific necessity that it can only qualify as a political preference based on the marketing of pharmaceuticals (Kulldorff et al., 2020; Broudy, 2021; Broudy and Arakaki, 2020; Broudy and Hoop, 2021).

The need for a more informed approach to the pandemic is evident. Consideration of natural immunity in crafting public health policies is essential and cannot reasonably be seconded to DCRT-injections on account of the obscene profits they offer to the backgrounded power-brokers like Fauci, Gates, and their collaborators. Natural immune powers built into human beings by our Creator along with certain "unalienable rights" (according to the American Declaration of Independence) are as real as our bodies are, and are valid wedges with which to chock the wheels of the fearful promoters of this pandemic — witness Event 201 and its participants documented and recorded by Johns Hopkins Bloomberg School of Public Health et al., (2019) — before their arguments can possibly take flight again. We need research, reasoned analysis, and level-headed debates to put the fear of COVID-19 into clear perspective and to put the quietus to the absurdly false claim that DCRT-injection is an absolute must. Doing this will ease financial pressure on developing countries that are currently being driven toward an unnecessary and incredibly costly DCRT-injection campaign. An open, evidence-based discussion of COVID-policies is most urgently needed to stop the drift towards politically influenced and market-driven management of an issue,[5] that is scientific in nature.

[5] The continuing global pandemic is important for investor confidence. There is concern about future demand as the latest wave of infections declines. Investors worry that the pandemic could be over in 2022, and what then? (Blankenhorn, 2021).

An Executive Summary and Conclusions

The unprecedented rapid emergency use approval (EUA) of COVID-19 vaccines is not only surprising but involves innovative therapies and novel constituents (Broudy and Kyrie, 2021) that have not been adequately studied or tested for safety. According to Seneff and Nigh (2021) some of the first-time novelties include:

1. using PEG (polyethylene glycol), polysorbate and lipid nanodroplets (LNP) in an injection;

2. using mRNA/vector therapeutic technologies — ones that have been tested only for a few months — against an infectious virus or parts of it;

3. requiring the involvement of unelected public health officials effectively to screen adverse reactions before they are reported to the public;

4. enforcing public implementation of the therapies based on preliminary and relatively uncriticized efficacy data coming exclusively from the manufacturers with vested interests in the marketing of the therapeutic injections (see Kennedy, 2021 and Fleming, 2021);

5. no clear peer-reviewed published reports (or experimentally tested claims) about the power of the promoted therapies to reduce infections, transmissibility of the targeted disease agents, or the prevention of disease or deaths;

6. using a coronavirus (or piece of such a virus) in a genetic therapy designed to directly impact protein manufacturing in human beings that is normally under the control of their own genetic systems;

7. administering injections of genetically modified polynucleotides in the general population;

all of which is leading to both a quantitative and qualitative accumulation of side effects (Kostoff et al., 2021), which can even be lethal due to an:

1. overreacting inflammatory response (systemic inflammatory response syndrome, SIRS);

2. spike proteins interaction with ACE2 receptors on cell membranes including skin, lungs, blood vessels, heart, mouth, gastrointestinal tract, kidneys, and brain;

3. spike protein interactions with platelets and/or endothelial cells lining blood vessels;

4. immediate/delayed release of histamine from mast cells and basophils (mast cell activation syndrome);

5. lymph node swelling in various areas of the body affecting blood flow and altering pain perception.

The portfolio of adverse reactions (Kostoff et al., 2021) already documented and accessible via the VAERS (2021) and EudraVigilence (2021) databases include the following symptoms/biomarkers:

- Cardiovascular (blood creatine phosphokinase increased, cardiac imaging procedure abnormal, echocardiogram abnormal, electro- cardiogram abnormal, heart rate increased, myocarditis, palpitations, pericarditis, tachycardia, troponin I increased, troponin increased, fibrin D-Dimer increased, platelet count decreased, blood pressure increased, bradycardia, brain natriuretic peptide increased, ejection fraction decreased, migraine);

- Gastrointestinal (abdominal pain, diarrhoea, vomiting, alanine aminotransferase increased, aspartate aminotransferase increased);

- Neural (gait disturbance, mobility decreased, muscle spasms, muscle twitching, seizure, tremor, Bell's Palsy, dyskinesia);
- Immune (C-Reactive Protein increased, red blood cell sedimentation rate increased, white blood cell counts increased, inflammation, anaphylactic reaction, pruritis, rash, lymphadenopathy);
- Endocrine (heavy menstrual bleeding, menstrual disorder).

Personal accounts of adverse effects in an oral history format can be accessed via the testimonials project (Livny, 2021).

Conflicts of Interest

The authors have no conflict of interest to declare.

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