PASCAS CARE

Coronavirus Covid-19 Treatment

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PASCAS INTRODUCTION:

Documents assembled by Pascas are provided for your individual assessment and exploration. The contents are sourced from a variety of avenues and publications. Every endeavour is made to determine that the contents are of the highest level of truth and veracity. At all times we ask that you go within yourself, to ascertain for yourself, how the contents resonate with you.

Pascas provides these notes and observations to assist us all in the development and growth of our own pathways and consciousness. Pascas does not hold these contents as dogma. Pascas is about looking within oneself. Much of what we are observing is new to us readers and thus, we consider that you will take on board that which resonates with you, investigate further those items of interest, and discard that which does not feel appropriate to you.

Kinesiological muscle testing, as developed by Dr David R Hawkins and quantified by his Map of Consciousness (MOC) table, has been used to ascertain the possible level of truth of documents. Such tested calibration levels appear within the document. We ask that you consider testing same for yourself. The technique and process is outlined within Pascas documents, such as Pascas Care – Energy Level of Food. From each person's perspective, results may vary somewhat. The calibration is offered as a guide only and just another tool to assist in considering the possibilities. As a contrast, consider using this technique to test the level of truth of your local daily newspaper.

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The sources of contents are noted throughout the document. In doing so, we acknowledge the importance of these sources and encourage our readers to consider further these sources. Should we have infringed upon a copyright pertaining to content, graphics and or pictures, we apologise. In such cases, we will endeavour to make the appropriate notations within the documents that we have assembled as a service via our not for profit arm, to our interested community.

We offer all contents in love and with the fullness of grace, which is intended to flow to readers who join us upon this fascinating journey throughout this incredible changing era we are all experiencing.

Aspiring to Living Feelings First, John.

"Never can one man do more for another man than by making it known of the availability of the Feeling Healing process and Divine Love." JD

Coronavirus Covid-19 Treatment

To be read in conjunction with this document is Pascas Care Letters – Etheric Spirit Body and Pascas Care Coronavirus Covid-19 Treatment Protocols.

Kindly go to www.pascashealth.com then Library Download page, and in the Pascas Care Letters section and then the Medical section, click on the following to open PDFs:

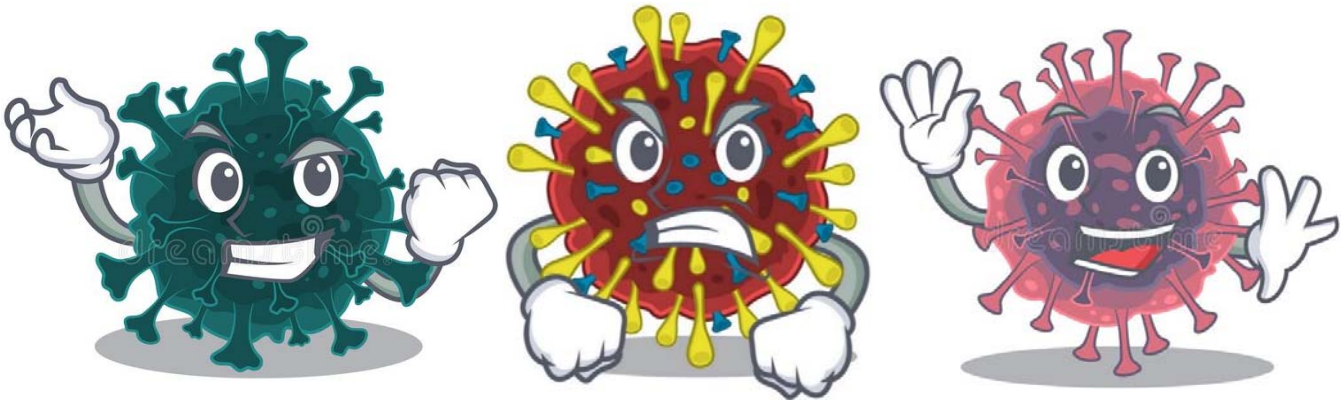
- Pascas Care Letters Etheric Spirit Body.pdf
- Pascas Care Coronavirus Covid-19 Treatment.pdf
- Pascas Care Coronavirus Covid-19 Treatment Protocols.pdf
- Pascas Care Coronavirus Covid-19 Senator Roberts Australia.pdf
- Pascas Care Coronavirus Covid-19 Vaccine Deaths.pdf

Our natural immunity is by far our best protection against all ailments. Appropriate vaccines can and do enhance your protection.

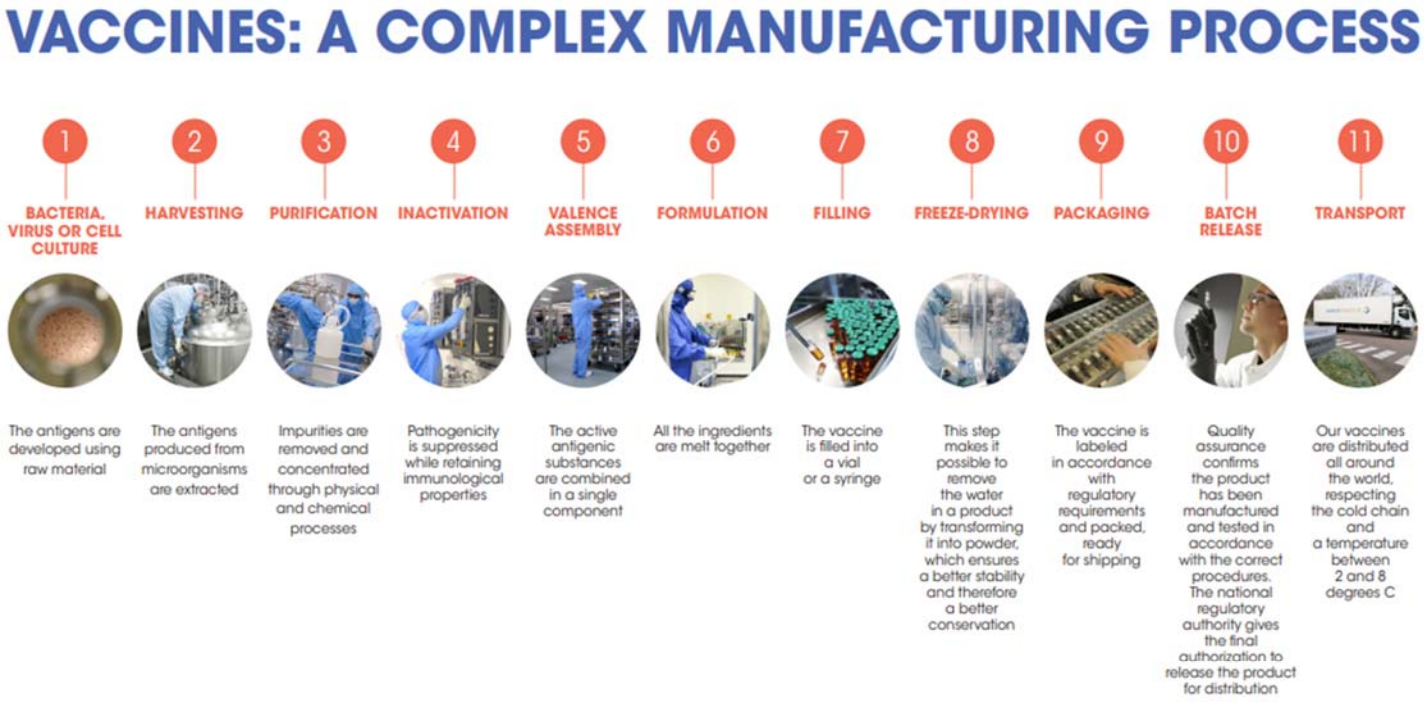
There are treatments for coronavirus Covid-19 that have been demonstrated around the world to be efficacious. With all medical issues and treatment, at all times consult with your professional health carers and providers.

Long term, our personal Feeling Healing is the ultimate pathway to a healthy body.

Meanwhile, vaccine, pharmaceutical and nutraceutical manufacturing can be strategically established in Australia (Toowoomba), India and Africa (central east coast), Central Americas or northern South America, Thailand (Chiang Mia), all interacting as Scientific Centres for Advancement of Technology, with regional distribution centres such as Tari in Papua New Guinea, Lucknow in India, etc. This is all to ensure global availability of necessary medical supplies under all circumstances. Long term strategic assets are best located between 28°north and south latitudes, towards the east on continents and at altitudes of several hundred metres.



NOTE: Consult your professional health care providers and medical doctors.



On average, it takes between 12-36 months* to manufacture a vaccine before it is ready for distribution.

Vaccines are complex biological products with lengthy manufacturing and control processes. The quality controls represent up to 70% of the full manufacturing duration.

Successful manufacturing of high-quality vaccines requires international standardization of starting materials, production and quality control testing, and the setting of high expectations for regulatory oversight of the entire manufacturing process from start to finish, all while recognizing that this field is in constant change[1].

All the components, manufacturing processes, testing methods, their reagents and standards have to comply with the standards defined for Good Manufacturing Practices (GMP). These strong quality requirements involve ad hoc pharmaceutical quality systems, quality assurance measures and procedures, several quality controls at each stage and an adequate infrastructure and separation of activities to guarantee vaccine identity, purity, sterility, efficacy and safety.

*Complex multivalent vaccines can have production lead times of more than 36 months.

Vaccines Manufacturing

On average, it takes between **12-36 months* to manufacture a vaccine.**

Vaccines are complex biological products with lengthy manufacturing and control processes. Quality controls are applied all along the manufacturing process and represent up to 70% of the manufacturing time. Quality assurance ensures that vaccines are produced following the highest standards.[1] All components, manufacturing steps, controls tests including reagents and standards, distribution steps comply with good practices such as Good Manufacturing Practices (GMPs), Good Laboratories Practices (GLPs) and Good Distribution Practices (GDPs).

Raw material reception

2 weeks on average
(it can range from several days to a few months)
Raw material are either used in key production steps as fermentation, purification or as an integral part of the vaccine. Up to 160 raw materials could be used to produce some vaccines.

Coupling & Formulation

2 weeks
During the formulation, the antigen is coupled with stabilizers, preservatives, adjuvant to enhance the immune reponse, facilitate vaccines administration & ensure vaccine stability in time.

Packaging & lot release

18 weeks
Due to the diversity and complexity of regulatory requirements, across EU Member States and globally, vaccine syringes or vials are each time labelled and packed in a country-specific format (label, leaflet, carton). Following quality assurance confirmation that the product has been manufactured and tested in accordance with ad hoc procedures, a final authorization is given to release the product for distribution.

Distribution

Finished product is delivered to distributers, wholesalers, pharmacies or directly to local health authorities, ensuring all Good Distribution Practices are respected.

Active ingredient manufacturing

12 months
Generation of the antigen** (active ingredient) is the most critical step in the production of high quality, safe and efficacious vaccines.

Filling

8 months
Vaccines are filled aseptically, in a vial or a syringe, to endure sterility. Vials are closed using sterile stoppers and crimped to maintain sterility. Unstable liquid vaccines are lyophilized. During this step, water is removed from the liquid to allow stability. In this case, the vaccine will have to be reconstituted just before injection.

Shipment

2 weeks (up to 4 weeks in case of cross region transfer)
Maintenance of the cold chain for vaccines (temperature: +2C to +8C) is essential for preservation of most vaccines.

- Testing done by manufacturer
- Testing done by the exporting country
- Testing done by the importing country

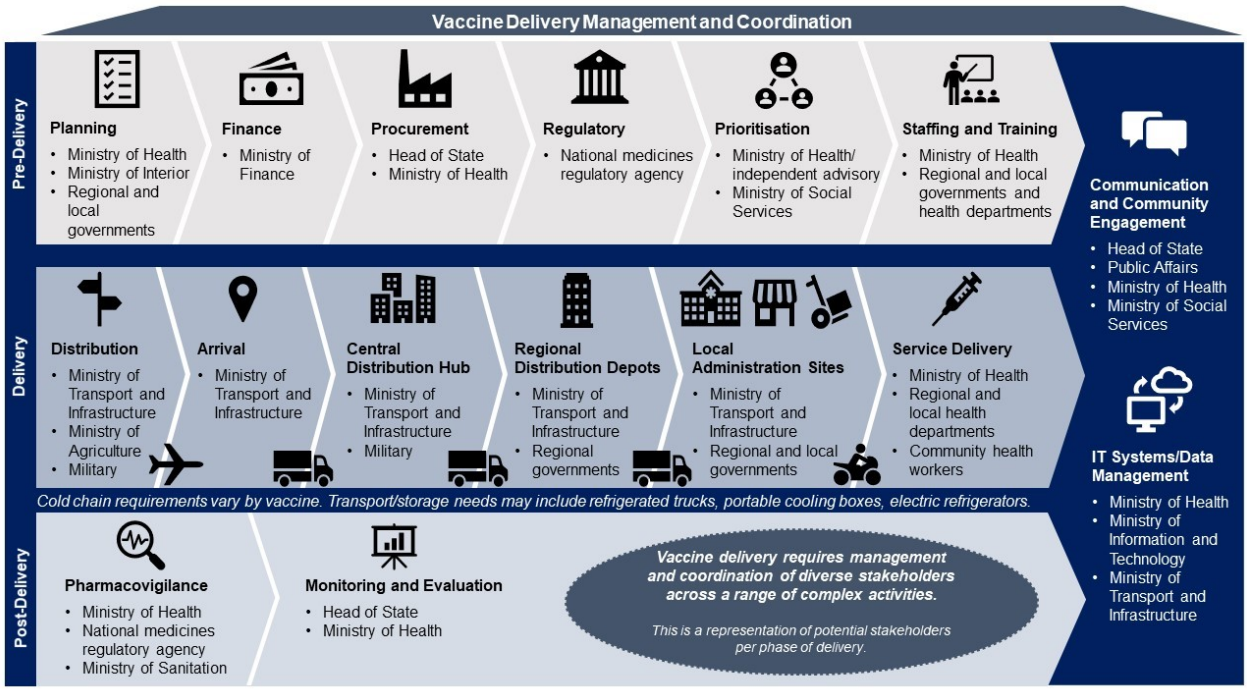
* Complex multivalent vaccines can have production lead times of more than 36 months.

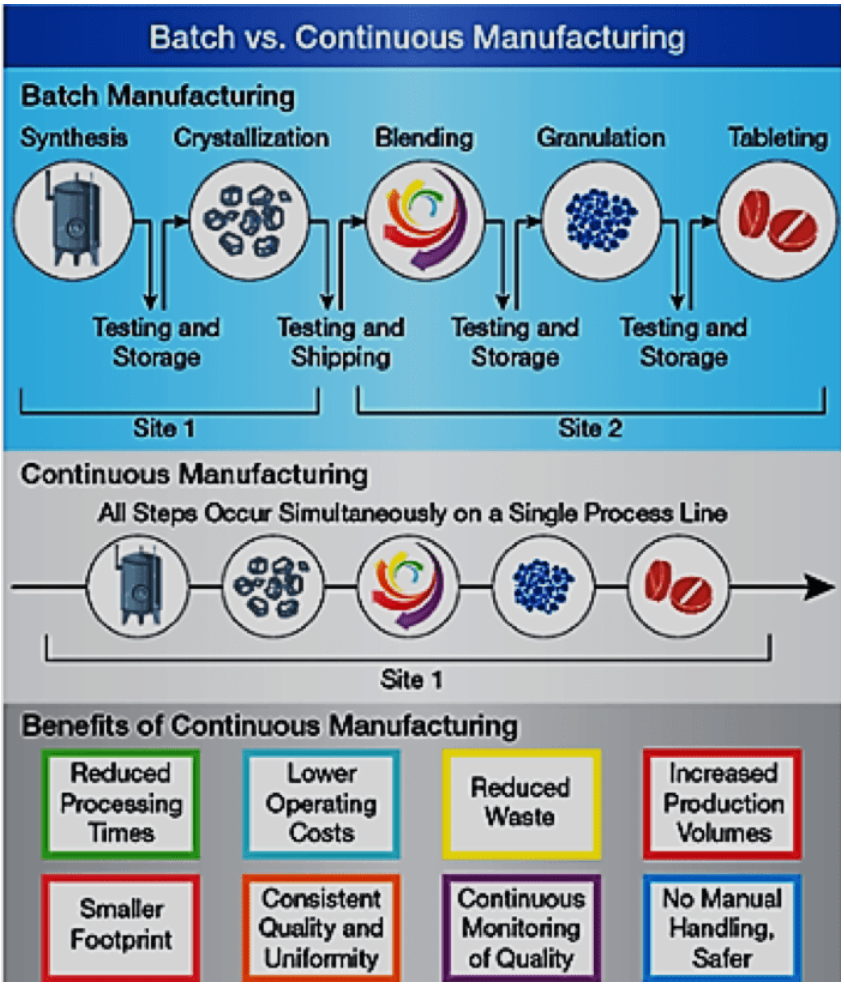
** Antigen is a live (e.g., viruses and bacteria) or inactivated substance capable of producing an immune response.

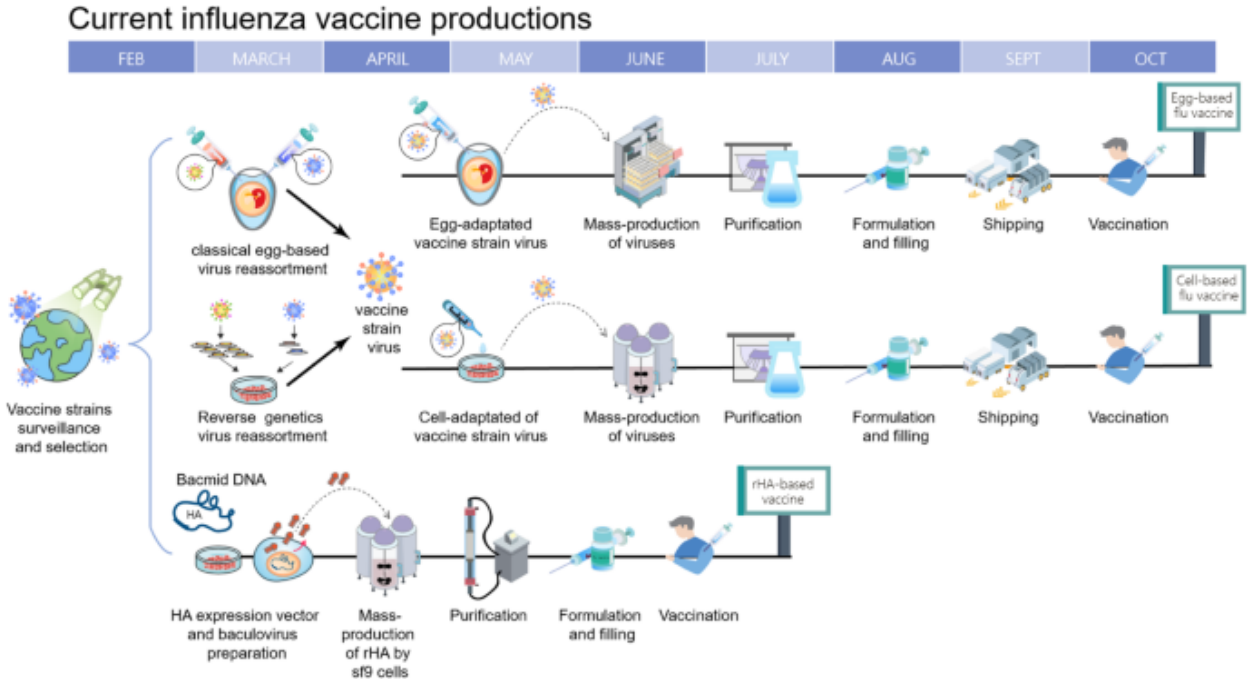
[1] World Health Organization. Immunization Standards. Vaccine quality. Available at:http://www.who.int/immunization_standards/vaccine_quality/en/. Accessed April 8, 2016

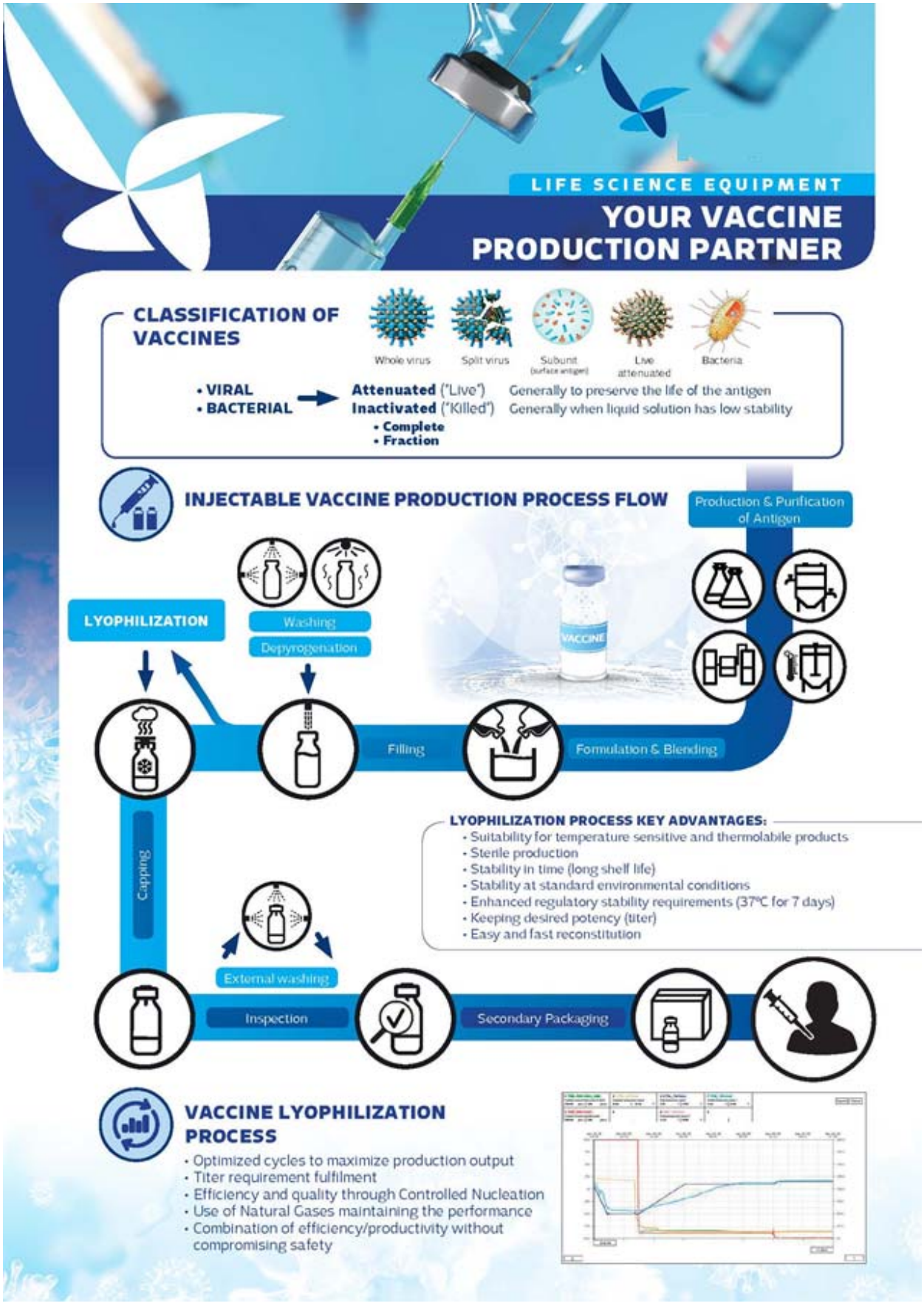
Vaccines Europe
An industry for healthy lives

VaccinesEurope @VaccinesEurope www.vaccineseurope.eu


Vaccine Delivery Management and Coordination
Pre-Delivery
Planning
• Ministry of Health
• Ministry of Interior
• Regional and local governments
Finance
• Ministry of Finance
Procurement
• Head of State
• Ministry of Health
Regulatory
• National medicines regulatory agency
Prioritisation
• Ministry of Health/ independent advisory
• Ministry of Social Services
Staffing and Training
• Ministry of Health
• Regional and local governments and health departments
Delivery
Distribution
• Ministry of Transport and Infrastructure
• Ministry of Agriculture
• Military
Arrival
• Ministry of Transport and Infrastructure
Central Distribution Hub
• Ministry of Transport and Infrastructure
• Military
Regional Distribution Depots
• Ministry of Transport and Infrastructure
• Regional governments
Local Administration Sites
• Ministry of Transport and Infrastructure
• Regional and local governments
Service Delivery
• Ministry of Health
• Regional and local health departments
• Community health workers
Cold chain requirements vary by vaccine. Transport/storage needs may include refrigerated trucks, portable cooling boxes, electric refrigerators.
Post-Delivery
Pharmacovigilance
• Ministry of Health
• National medicines regulatory agency
• Ministry of Sanitation
Monitoring and Evaluation
• Head of State
• Ministry of Health
Vaccine delivery requires management and coordination of diverse stakeholders across a range of complex activities.
This is a representation of potential stakeholders per phase of delivery.
Communication and Community Engagement
• Head of State
• Public Affairs
• Ministry of Health
• Ministry of Social Services
IT Systems/Data Management
• Ministry of Health
• Ministry of Information and Technology
• Ministry of Transport and Infrastructure


Batch vs. Continuous Manufacturing
Batch Manufacturing
Synthesis
Crystallization
Blending
Granulation
Tableting
Testing and Storage
Testing and Shipping
Testing and Storage
Testing and Storage
Site 1
Site 2
Continuous Manufacturing
All Steps Occur Simultaneously on a Single Process Line
Site 1
Benefits of Continuous Manufacturing
Reduced Processing Times
Lower Operating Costs
Reduced Waste
Increased Production Volumes
Smaller Footprint
Consistent Quality and Uniformity
Continuous Monitoring of Quality
No Manual Handling, Safer


Current influenza vaccine productions
FEB
MARCH
APRIL
MAY
JUNE
JULY
AUG
SEPT
OCT
Vaccine strains surveillance and selection
classical egg-based virus reassortment
Egg-adaptated vaccine strain virus
Mass-production of viruses
Purification
Formulation and filling
Shipping
Vaccination
Egg-based flu vaccine
vaccine strain virus
Reverse genetics virus reassortment
Cell-adaptated of vaccine strain virus
Mass-production of viruses
Purification
Formulation and filling
Shipping
Vaccination
Cell-based flu vaccine
Bacmid DNA
HA
HA expression vector and baculovirus preparation
Mass-production of rHA by sf9 cells
Purification
Formulation and filling
Vaccination
rHA-based vaccine


LIFE SCIENCE EQUIPMENT
YOUR VACCINE PRODUCTION PARTNER
CLASSIFICATION OF VACCINES
Whole virus
Split virus
Subunit (surface antigen)
Live attenuated
Bacteria
• VIRAL
• BACTERIAL
Attenuated ("Live") Generally to preserve the life of the antigen
Inactivated ("Killed") Generally when liquid solution has low stability
• Complete
• Fraction
INJECTABLE VACCINE PRODUCTION PROCESS FLOW
Production & Purification of Antigen
LYOPHILIZATION
Washing
Depyrogenation
VACCINE
Filling
Formulation & Blending
Capping
External washing
Inspection
Secondary Packaging
LYOPHILIZATION PROCESS KEY ADVANTAGES:
• Suitability for temperature sensitive and thermolabile products
• Sterile production
• Stability in time (long shelf life)
• Stability at standard environmental conditions
• Enhanced regulatory stability requirements (37°C for 7 days)
• Keeping desired potency (titer)
• Easy and fast reconstitution
VACCINE LYOPHILIZATION PROCESS
• Optimized cycles to maximize production output
• Titer requirement fulfilment
• Efficiency and quality through Controlled Nucleation
• Use of Natural Gases maintaining the performance
• Combination of efficiency/productivity without compromising safety

YOUR VACCINE PRODUCTION PARTNER

LIFE SCIENCE EQUIPMENT

VACCINE PRODUCTION EQUIPMENT

Downflow booths

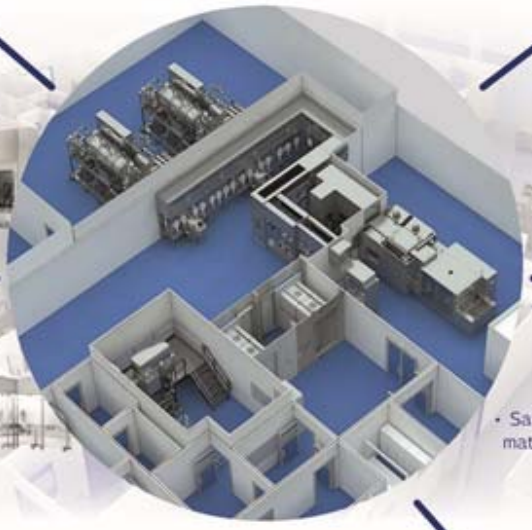
- Grade A (ISO 5) Unidirectional laminar airflow and negative pressure for product, operator and environment protection
- Standardized models and also tailor-made solutions
- Bag-In Bag-Out filtration system option
- Several standard accessories (containment screens, work benches,...)

Sterilizers

- Dry heat sterilizers for depyrogenation
- Moist heat sterilizers for infeed sterilization, decontamination (dedicated effluent discharge/CIP) and terminal sterilization
- Automatic Loading/Unloading integrated solutions

Isolators / c-RABS o-RABS

- Grade A (ISO 5) unidirectional laminar airflow
- Physical barrier for product protection
- Isolator suitable for product & operator protection
- Customized solutions to integrate with the complete line
- Bio-decontamination systems available



Pass-Boxes

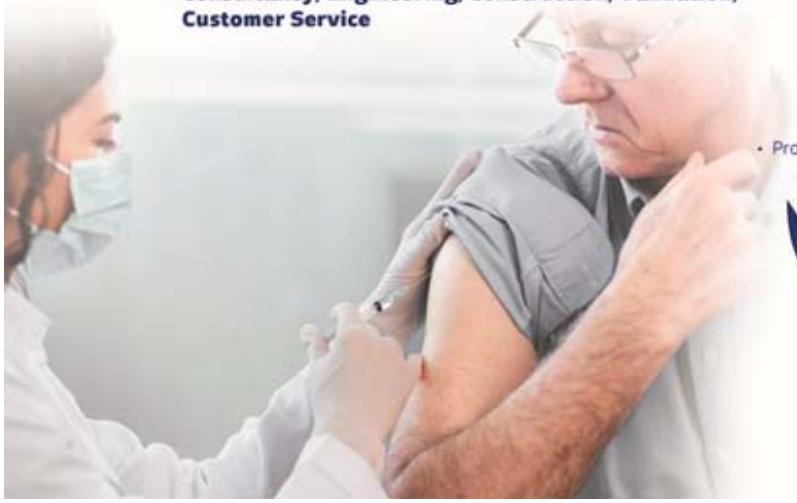
- Safe pass-through for transfering materials between classified areas
- Standardized models and tailor-made solutions
- Bio-decontamination systems available

Lyophilizers

- Automatic Loading/Unloading integrated solutions
- Cleaning and Bio-decontamination (CIP/SIP) cycles
- Product, operator and environment protection
- Effluents suitable treatment

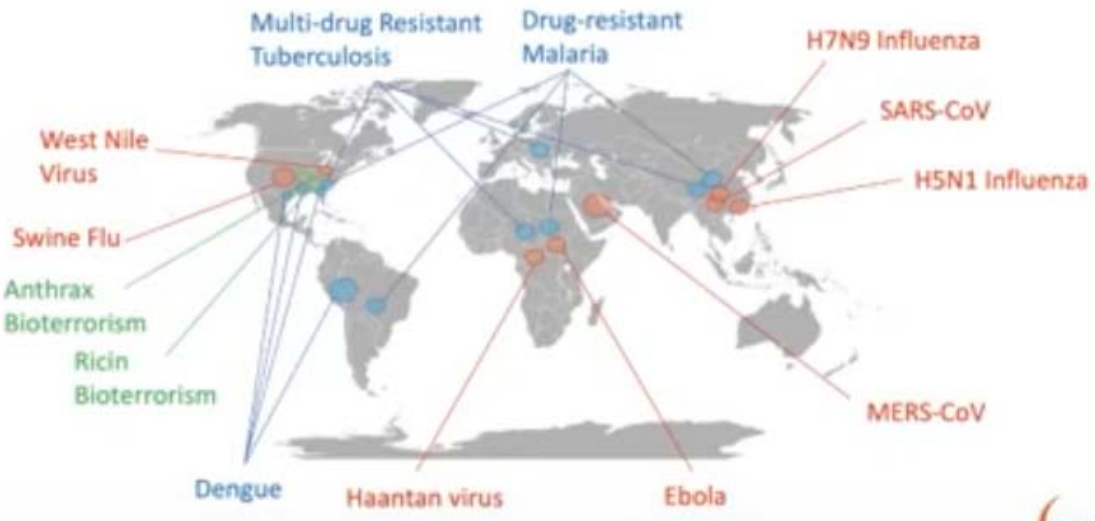
OTHER TELSTAR SERVICES :

- **Complete line solutions**
- **Lyophilization and Sterilization cycle optimization/ development services**
- **Calibration services**
- **Consultancy, Engineering, Construction, Validation, Customer Service**

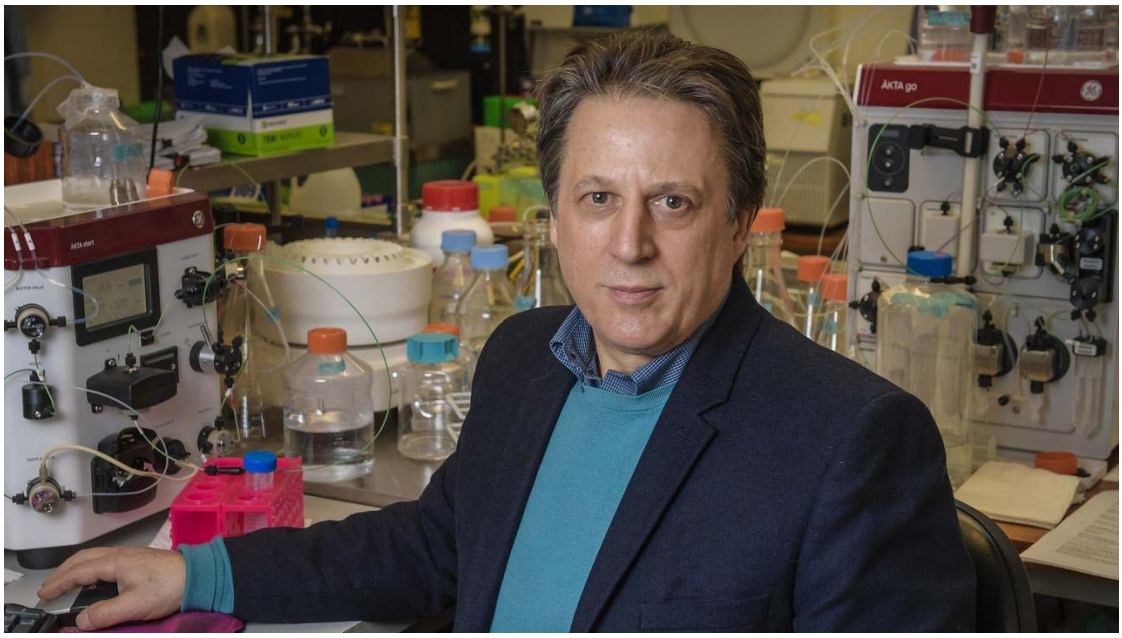


Track-record in Pandemic Vaccines

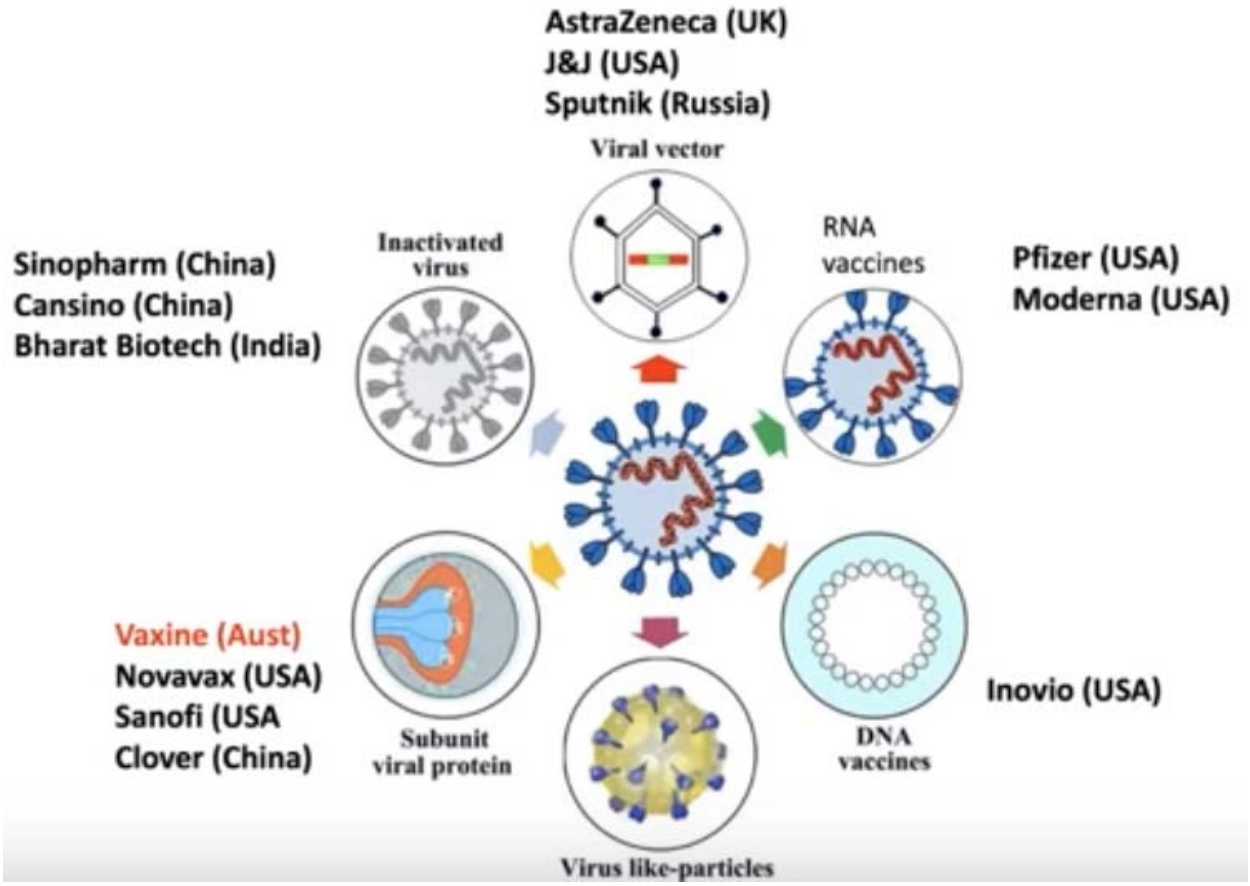
- Flinders-based team has led 12 human clinical trials (> 2000 subjects) since 2008, many of pandemic vaccines
- Developed first pandemic vaccine in world to enter human trials during 2009 swine flu pandemic
- Successful SARS and MERS vaccine

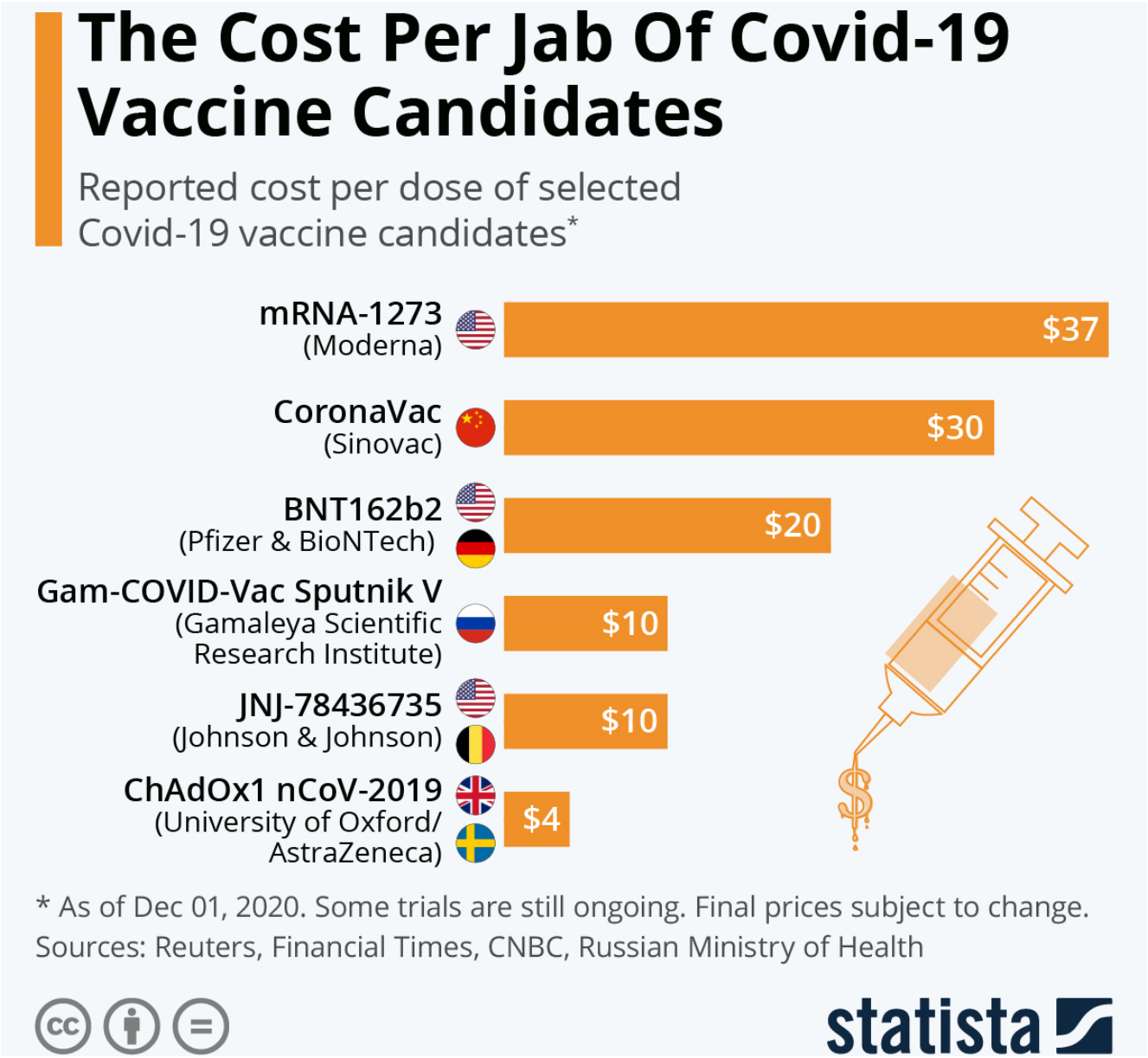


vaxine



COVID-19 vaccine approaches





The cost of producing vaccines in developing countries was estimated to be on average US$ 2.18 per dose, ranging between US$ 0.98 and US$ 4.85 for different vaccine types and formulations. Vaccine costs-per-dose decrease as production scale and scope increase. Cost-per-dose is mainly driven by fixed costs, but at a scale of production over 20 million doses per year it becomes driven by variable costs. Under the three hypothetical scenarios used, costs-per-dose of vaccines produced by developing countries were around 47% lower than vaccine prices in developing-country markets and 84% lower than prices in industrialized-country markets.

Studies of mRNA production techniques, carried out by Public Citizen with engineers at Imperial College, analysis suggests that it could cost US$9.4 billion to produce 8 billion doses of the Pfizer/BioNTech vaccine —US$1.18 per vaccine and for Moderna it would cost US$22.8 billion to produce 8 billion doses —US$2.85 per vaccine.

Coronavirus Covid-19: Evidence of mRNA and Treatment of Covid-19

Professor Nikolai Petrovsky – Covax-19
https://www.facebook.com/watch/live/?extid=NS-UNK-UNK-UNK-IOS_GK0T-GK1C&ref=watch_permalink&v=567063294359030

3 November 2021

https:// **Professor Nikolai Petrovsky – Vaccine Adverse Events, Mandates and Secrecy in Australia**

22 October 2021

https://www.youtube.com/watch?v=yL_2Rq1zoRg 23 June 2021

Professor Nikolai Petrovsky – Vaccines and biodefense: COVID-19, flu and beyond

Professor Nikolai Petrovsky is the Director of Endocrinology (Flinders Medical Centre – Adelaide, South Australia), Professor of Medicine (Flinders University), Vice President of the International Immunomics Society, Founder of Vaxine and the creator of COVAX-19 and Spikogen.

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Evidence of mRNA-Based Vaccine Traveling from Injection Site (Paper Review)

https://moderndiscontent.substack.com/p/evidence-of-mrna-based-vaccine-traveling?token=eyJ1c2VyX2lkIjo1MDg4NzI4MCwicG9zdF9pZCI6NDMxMzQxNjQsIl8iOiI3VE5JUSIsImlhdCI6MTYzNTUzNjk4MSwiZXhwIjoxNjM1NTQwNTgxLCJpc3MiOiJwdWItNDczMDUyIiwic3ViIjoicG9zdC1yZWFjdGlvbiJ9.9WT5t3_rv2D3e7W6cq0kRvWBDWF1gaaV3GpgKWCa84U

A recent study contradicts a common establishment narrative about COVID vaccines.

26 October 2021

One of my biggest gripes with the way this pandemic has been managed was with the lack of consistency with testing procedures. I have lamented the fact that PCR tests only examine the nasal environment while intramuscular (IM) vaccines only elicit systemic immunity and not mucosal immunity.

And there is good reason to assume so; previous vaccination procedures have argued that IM injections do not stimulate mucosal memory, the site of the initial infections, which explains why so many people who are vaccinated can still test positive with a nasal swab.

The only way that an IM injection could stimulate the mucosal immune system would be if the vaccines (or its contents) were to travel outside of the site of injection, and on this front the vaccine industry, as well as the FDA and NIH, have insisted such a thing should not occur.

Well, it seems now there may be evidence to the contrary.

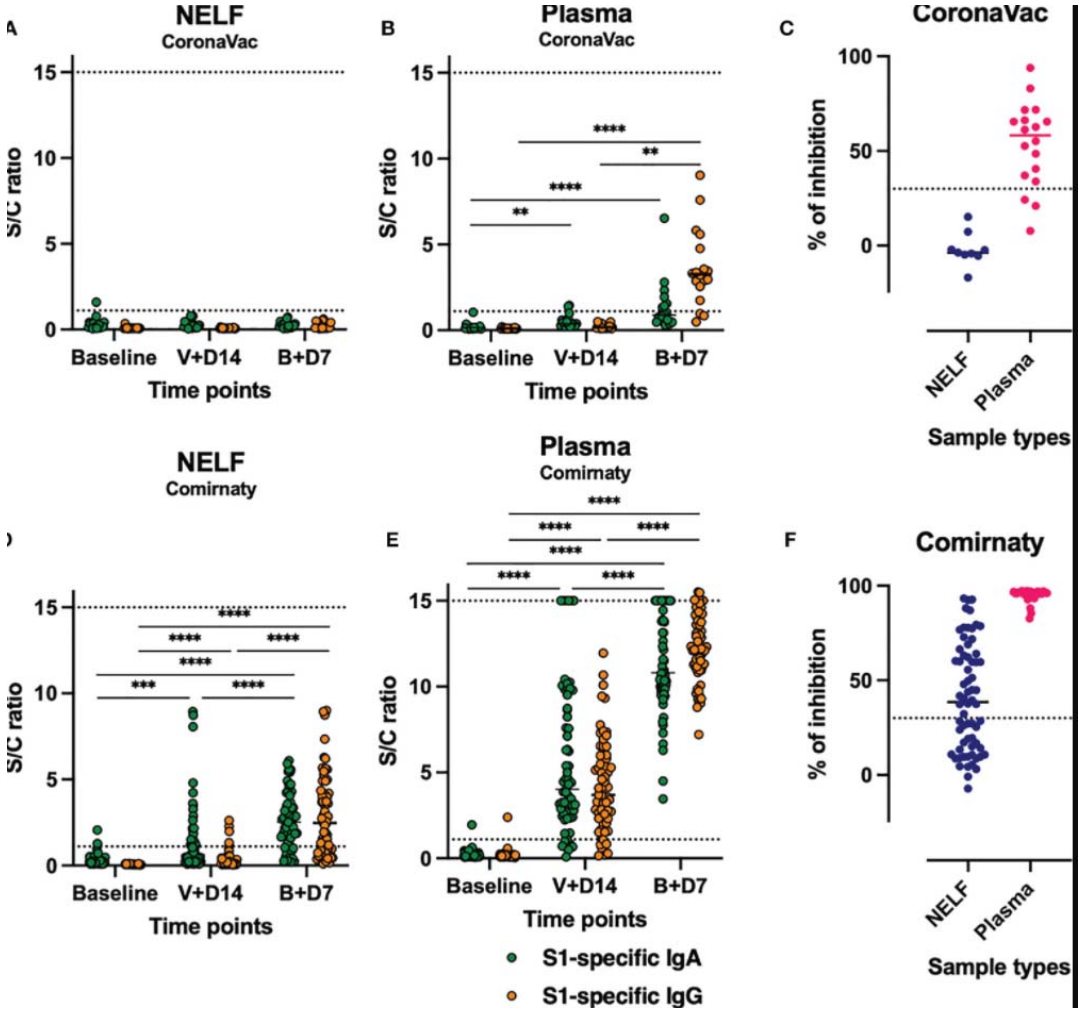
A few days ago one of my Subscribers (*chavoc*) pointed out a study that indicated mucosal immune response after an intramuscular (IM) injection with Comirnaty, with another (*UM Ross*) indicating that this would mean the lipid nanoparticles can travel (which we were assured is not possible).

So let's examine this study and see what it points to.

The study that *chavoc* provided was a study by Chan et. al. 2021 and it's a very recent study (from mid-October). In this study the researchers examined whether 2 different vaccines (the mRNA-based Comirnaty and the inactivated virus CoronaVac) would be able to stimulate a mucosal immune response.

Note that the authors did not indicate the dosage (we'll have to assume the approved dosage from the manufacturer-i.e. 30 ug for Comirnaty/dose) and that there were nearly 1/3 fewer participants in the CoronaVac arm of the study, so make sure to keep this in mind. Also, if the paper mentions a booster, it is referring to a 2nd dose not a 3rd dose as we have been describing them.

Surprisingly, the mRNA based vaccine was able to stimulate a mucosal immune response while the inactivated virus could not.

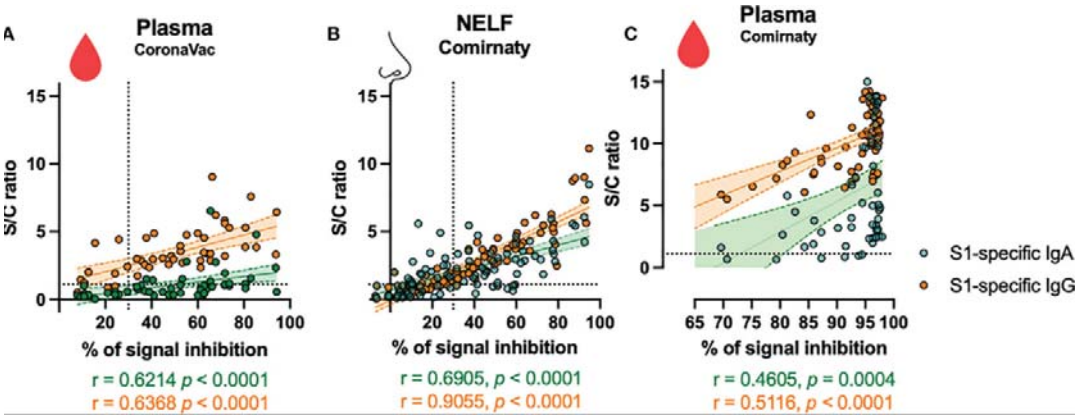


Taken from Chan et. al. 2021. Comirnaty (mRNA) was able to induce the mucosal immune system while CoronaVac (inactivated virus) did not. NEFL = nasal epithelial lining fluid (just think nose/mucosal), Plasma = blood.

The researchers noted (emphasis mine):

> **None of the CoronaVac recipients developed detectable NELF S1-specific IgA and IgG (Figure 2A)** by day 7 ± 2 after the booster. **In comparison, most subjects who received Comirnaty developed NELF S1-specific antibodies.** The increase in S1-specific IgA and IgG levels at the three time points was significant by Friedman test, followed by Dunn's multiple-comparison test (Figure 2D). Moreover, S1-specific IgA appeared earlier than IgG in NELF. More subjects developed NELF S1-specific IgA (39/65, 40%) than IgG (5/65, 8%) (see Supplementary Figure E1B, blue dots, in the supplementary materials) by 14 ± 2 days after the first dose. These further increased to 82 and 68%, respectively, by 7 ± 2 days after the booster (see Supplementary Figure E1C, blue dots in the supplementary materials).

Those who were administered Comirnaty also showed strong neutralizing antibodies as detected by NELF samples, once again indicating strong mucosal immunity stimulation.



Taken from Chan et. al. 2021. "**Figure 4** Correlation of S1-specific Igs to the percentage of signal inhibition in the surrogate ACE-2-based neutralization readout. The correlation coefficients of the levels of the **(A)** plasma of CoronaVac subjects, **(B)** nasal epithelial lining fluid (NELF), and **(C)** plasma of Comirnaty subjects at 7 ± 2 days after the booster with the NAb are superimposed on the panel with the trend lines estimated with the use of simple linear regression."

On the surface this seems great, and would exactly align with what I have stated; in order to prevent transmission and reduce viral load the vaccines need to induce mucosal immunity. So all is well right?

Well no, and actually this is extremely concerning.

Over the course of the vaccine rollout we were constantly told that there was no way that these vaccines (or spike protein) moved outside of the site of injection. In fact, those who questioned this possibility were made to seem hysterical.

So then how do we explain these results? Surely the vaccines, who supposedly remain within the intramuscular region of the injection site are also somehow able to stimulate the mucosal immune system as well?

Here are the authors' proposal (emphasis mine):

> **It is commonly believed that intramuscular vaccines do not induce mucosal immunity effectively (19). The mucosal immunity of the upper respiratory tract is partly compartmentalized and usually initiated in the nasopharynx-associated lymphoid tissue (NALT) in all age groups and bronchus-associated lymphoid tissue (BALT) in children and adolescents or adults upon disease induction (20).** These upper respiratory tract-associated lymphoid tissues generate IgA-producing mucosal B cells that express the homing receptor, e.g., a4ß1, CCR10, CD62L, and LFA-1 (21, 22). These homing receptors allow the B-cells to traffic efficiently to the mucosal effector site, the respiratory tract in this case, where their ligands, VCAM-1 and CCL28, are strongly expressed. **The IgA-producing mucosal B cells differentiate into polymeric IgA-secretory plasma cells and contribute to the production of the polymeric IgA (in dimers or tetramers) in the lamina propria** as opposed to serological IgA (predominantly monomers), which is produced within the bone marrow, spleen, and lymph nodes (23). The dimeric IgA is formed by linked two IgA molecules by a joining chain (J-chain), while the J-chain binds to the polymeric immunoglobulin receptor (pIgR), which transports the dimeric IgA from the basolateral to the apical surface of the epithelium by transcytosis. **Therefore, the SIgA present in secretions is typically produced within mucosal tissues. This raises important questions about the route that mRNA lipid nanoparticles need to take from the intramuscular**

> **injection site to the NALT (and BALT) and the biological mechanisms that underlie this process.**
>
> An *in vivo* investigation in the biodistribution of the lipid nanoparticles carrying influenza virus mRNA found that, after intramuscular administration, the concentration of mRNA lipid nanoparticles decreases along the disseminating route from the injection site. **The expression of mRNA can be detected in distal tissues, including the lung, though the concentration was 1,000-fold lower (24).** We postulate that the number of mRNA lipid nanoparticles that reach the nasal mucosa after Comirnaty injection might be sufficient for NALT stimulation. **However, the mechanisms underlying this process and the factors that affect the consistency of this effect require further investigation.**

As indicated, there is some evidence that the lipid nanoparticles are able to travel to other sites, albeit in very low amounts. This would explain the high variability in antibody levels (as indicated by the graphs).

So there is evidence that goes against the narrative that we have been fed; **yes, the vaccine is able to travel!**

But remember, in order to produce anti-spike antibodies the mRNA must travel as well.

In this case we are left with 2 possibilities: either the lipid nanoparticle itself is able to travel to other sites where it may be picked up by cells and produce spike proteins, or the spike proteins are produced locally and spread throughout the body.

Remember that this is not occurring with the inactivated virus vaccine (as indicated by the data), which may support the idea that the lipid nanoparticle is the compound that is moving around *(this same issue may not be occurring with the Adenovirus vaccines, and similar studies should be conducted with those vaccines as well).*

Unfortunately, the low sample size in the CoronaVac cohort may be masking any mucosal immune response that would contradict this position, although you would expect at least *some* evidence that the mucosal immune system is stimulated in those groups (if at all possible), and yet that clearly does not seem to be the case.

The differences also can't be explained by differences between the vaccine delivery systems (as of now) as indicated in this Hasset et. al. 2021 paper, the optimal LNP size is similar to that of SARS-COV2 (~100 nm) and that the cationic nature of the LNPs are intended to direct cellular uptake.

As of now, it's hard to indicate why this would be occurring, but the idea that it is occurring is alarming in general.

Similar to molnupiravir, we are being misled about the possible adverse events with respect to many of these COVID treatments, and yet any dissenting voice is being silenced.

We need more evidence and more science, not validation by bureaucrats and pharmaceutical giants that what they are doing is working, and, more frustratingly, that what they are doing is "following the science".

The researchers note as much as well:

> The unexpected mucosal response in mRNA vaccine recipients raises the concern about which other organs/tissues may be affected and whether such reactions may cause unintended side effects with adverse outcomes. **Our study, therefore, highlights the necessity of further studies to determine the distribution of mRNA lipid nanoparticles in humans.**

Without transparency and rigorous scientific evidence, we are absolutely doing ourselves no favours. Now that there are talks of boosters and vaccinating children as young as 5, there's not doubt that we may bear witness to the consequences of not following actual science, and many people may end up paying the price because of it.

The media and federal regulatory bodies have not afforded us any reason to trust them, and here we should hold steadfast with the notion that we were told that either the spike or the lipid nanoparticle should not be distributed within the body.

So not only do we need to be concerned that we may be deceived, we also need to be concerned that this will once again become a position that health officials could possibly flip-flop on.

So I'll leave you with 2 possible news titles, and I would like you to guess which one is likely to be used:

- "There's evidence the mRNA vaccine may be distributed within the body-and why that's a good thing!"
- Contrary to previous statements, concerning evidence indicates the mRNA vaccines may be distributed within the body."

I know which one I want, but unfortunately we all know which one we're likely to get.

Pathway Forward

Hippocratic Oath

New Feelings Way: learning how to live true to ourselves by living true to our feelings.

We are to express our feelings, both good and bad, at all times, and to long for the truth of them.

By living true to ourselves true to our feelings, we are living true to God. It's that simple.

Golden Rule: that one must always honour another's will as one honours one's own.

The Golden rule is: Never interfere with another's will.

God's Divine Love: Pray for it, ask for it, and receive it.

To liberate one's real self, one's will, driven by one's soul, moves one to embrace Feeling Healing, so as to clear emotional injuries and errors. With the Divine Love, then one is also Soul Healing. We are to feel our feelings, identify what they are, accept and fully acknowledge that we're feeling them, express them fully, all whilst longing for the truth they are to show us.

COVID-19 and the mRNA Vaccine Legacy

https://www.emjreviews.com/innovations/article/covid-19-and-the-mrna-vaccine-legacy/

09 February 2021

Author: Rachel Donnison, Editorial Assistant

FREQUENTLY pitted as the only way of eradicating the coronavirus disease (COVID-19) that arises from severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the world is holding its breath as the first vaccination programmes of 2021 are rolled out in the UK, Germany, Italy, Poland, Denmark, and many other countries in Europe and further afield.

2020: A YEAR OF ACCELERATED VACCINE DEVELOPMENT

Of the 320 COVID-19 vaccine candidates in development,[1] the first to gain both U.S. Food and Drug Administration (FDA) and Medicines and Healthcare products Regulatory Agency (MHRA) approval was the BNT162b2 mRNA vaccine, produced jointly by the pharmaceutical giant Pfizer and biotechnology company BioNTech.[2,3] This was the first time an mRNA vaccine has ever received approval by either regulatory board. In another example of a pharmaceutical and institutional partnership, the FDA-approved SARS-CoV-2 vaccine produced by Moderna and the National Institute of Allergy and Infectious Diseases (NIAID) also utilises mRNA to generate immunity.[4] A more traditional form of a vaccine created against SARS-CoV-2 is the adenovirus vector-based ChAdOx1 nCoV-19 vaccine, developed by the joint efforts of the University of Oxford, Oxford, UK, and the multinational pharmaceutical company AstraZeneca.[5] This has recently been approved for use in the UK by the MHRA and is presently being rolled out across the country with the hope of vaccinating 15 million of those at highest risk by mid-February.

Imperial College London, London, UK, have also entered the race to end the current pandemic, offering their self-amplifying RNA vaccine, which is currently in Phase I clinical trials.[6]

Breaking away from traditional methods, COVID-19 vaccines have revolutionised vaccine development, as the use of mRNA has seen unprecedented uptake by developers. But how much do we know about these vaccines, and what efficacy and safety benefits do they offer over traditional vector-based vaccines?

HISTORY OF mRNA VACCINES

mRNA molecules carry the genetic code of a specific encoded protein from the DNA in the nucleus to the cytoplasm, where the protein is then formed. Manufactured as a potential vaccine, mRNA offer many safety advantages over their double-stranded counterpart; namely that they do not interact with the host's genetic material, excluding the potential negative effects of genomic integration. When used as a platform for vaccine development, their noninfectious, nonintegrating properties make the risks posed by infection or mutation low, and because it is degraded by natural cellular processes it can be easily regulated to lower immunogenicity.[7]

In 1989, the discovery of a successful method of mRNA *in vitro* transfection, whereby mRNA injected into mice resulted in the encoded protein's production, led to the first suggestions of using mRNA as a therapeutic.[8] Over the next 30 years, mRNA was largely side-lined because of technological issues with stability, induction of host immune response (immunogenicity), and inefficient *in vivo* delivery.[7] Despite these barriers, mRNA offers high yields of *in vitro* transcription reactions, rendering them rapid, cost-effective, and scalable for mass production.[9] For context, DNA vaccines require producing cell lines and subsequent clinical grade protein production, which typically takes over a year, whereas nucleic acid mRNA vaccine manufacture can occur in a few weeks.[9]

mRNA VACCINES ARE NOT NOVEL

Though only two mRNA vaccines have been approved by the FDA, there are several in clinical trials for protection against Chikungunya virus,[10] HIV,[11] and rabies,[12] and there is much to be learnt from animal coronavirus vaccines.[13] The results so far are promising, though the only results to be published in the peer-reviewed literature, as of yet, are for the first rabies mRNA vaccine; the vaccine induced functional antibodies in all 101 participants when injected intradermally or intramuscularly, though many (78%) experienced limited systemic adverse events.[14]

Fast forward to 2019, and the chaos induced by COVID-19 forced many immunologists to rethink the DNA-based vaccine status quo; in the case of an emerging novel virus, it is not simply a question of therapeutic effectiveness, but also of rapid development and large-scale deployment.

However, despite the many immunological advantages, the necessity of storage at -70 °C has already caused issues with the Pfizer/BioNTech vaccine, particularly in low- and middle-income countries where such freezing facilities are limited. This has led to the development of the COVID-19 Vaccine Global Access Facility (COVAX), which aims to ensure fair allocation of vaccine supply; to end this pandemic, it is not enough to eradicate the virus locally, there must be a global approach.[15]

Clinical data have also been released on the Pfizer/BioNTech and Moderna/NIAID mRNA vaccines, as summarised below.

REGULATOR-APPROVED mRNA VACCINES AGAINST COVID-19

Pfizer/BioNTech BNT162b2

In response to the rising COVID-19 cases worldwide in early 2020, Pfizer and BioNTech initiated a joint co-ordinated programme of four potential RNA-based COVID-19 vaccine candidates. Following clinical studies in both Germany and the USA, two of the four were taken forward on the strengths of their ability to elicit high SARS-CoV-2 neutralising antibody titres:[16] the first was BNT162b1, which encoded the SARS-CoV-2 receptor–binding domain, and the second was BNT162b2, which encoded the SARS-CoV-2 full-length spike protein that is used by the virus to invade host cells.[16] In the Phase I trials of both variants, the BNT162b2 vaccine was selected for continuation to Phase II/III based on its associated lower incidence and severity of systemic reactions, particularly in older participants.[17] Phase III trials of the BNT162b2 vaccine, which enrolled 43,548 participants, showed a 95% effectiveness in preventing COVID-19 in a two-dose regimen, with similar efficacy across subgroups defined by age, sex, race, ethnicity, BMI, and comorbidities.[18] In terms of safety, the most reported systemic events

were headache and fatigue: 59% and 52%, respectively, in those aged 16–55 years, compared with 51% and 39% in those aged >55 years; however, headache and fatigue were also reported by placebo participants (23% and 24%, respectively).[18]

Moderna/NIAID mRNA-1273

Also utilising the SARS-CoV-2 spike glycoprotein is Moderna/NIAID's mRNA vaccine contender. The lipid nanoparticle-encapsulated mRNA vaccine focusses on the SARS-CoV-2 pathway of viral entry: the spike protein is the major surface protein on the CoV virion, making it the logical primary target for neutralising antibodies.[19] After successful antigenicity by mRNA-1273 *in vivo*, human Phase I clinical trials began in March 2020, just 66 days after the SARS-CoV-2 viral sequence was published.[20] Tested in 45 volunteers, antibody responses were recorded in all participants and no trial-limiting safety concerns were identified; >50% of participants reported mild symptoms, such as fatigue, chills, headache, myalgia, and pain at the injection site.[20] With the regulator's permission, Phase II/III trials were approved and an interim analysis in November 2020 showed an effectiveness of 95% in the >30,000 USA participants enrolled.[21] In contrast to the Pfizer/BioNTech vaccine that needs to be stored at -70 °C, the Moderna/NIAID vaccine will remain viable after freezing in a conventional freezer for up to 6 months, and once thawed can be placed into a standard refrigerator for 30 days.[22]

2021: ANOTHER UNPRECENDED YEAR?

https://wexnermedical.osu.edu/blog/covid-19-vaccine-long-term-side-effects

Not only did both of the approved mRNA vaccines prevent symptomatic COVID-19 in their Phase III trials, but they also prevented severe cases of COVID-19; there were only 10 such cases with the Pfizer/BioNTech vaccine[18] and 11 with the Moderna/NIAID candidate.[21] Immunologically, both mRNA vaccines show similar efficacy (95%), though logistically the Moderna/NIAID vaccine is easier to store with current freezing systems. The results of the Imperial College London self-amplifying RNA vaccine trials will be much anticipated this year, and we can also expect to see results of DNA-based COVID-19 vaccine candidates, namely from Janssen/Johnson & Johnson, GlaxoSmithKline/Sanofi, and Altimmune. The challenge of emerging mutations in the genome of SARS-CoV-2 could potentially alter the efficacy of vaccines against COVID-19, although this is yet to be determined. "Unprecedented" has been a word used frequently since the onset of the pandemic, and the scientific innovation we have seen has been remarkable; we have seen the unprecedented speed of vaccine trials, unprecedented approval of an mRNA vaccine for human use, and unprecedented vaccine rollout. A process that can take more than 10 years reduced to just over 10 months will leave a legacy in vaccine development; the next time we are faced with an infectious disease of this scale, we will be thankful much of the leg work has already been done by those who came before us.

mRNA technology isn't brand-new, and mRNA degrades quickly in the body

The Pfizer and Moderna vaccines are both messenger RNA vaccines, or mRNA vaccines. RNA stands for ribonucleic acid, a molecule that contains the genetic blueprint for our cells to make proteins. Proteins are used by cells to perform our bodily functions.

mRNA vaccines had been studied for decades before COVID-19 emerged. The vaccine technology had

been studied in vaccines against other viruses, such as influenza, rabies and Zika, as well as in treatments for cancer.

Because of this, we know well how mRNA functions in a vaccine.

mRNA vaccines work like an instruction manual. For COVID-19 vaccines, that handbook tells the cell how to create a piece of a "spike protein" that's unique to SARS-CoV-2 (the virus that causes COVID-19).

The vaccine can't cause COVID-19 infection itself, because it doesn't carry the actual, live virus — the mRNA encodes only for the spike protein found on the surface of the virus. The spike protein is harmless by itself.

Once the body creates that spike protein using the mRNA instructions, the body quickly breaks down those mRNA strands and they dissipate within a few hours or days after injection. The mRNA never enters the nucleus of any cell (where the DNA is located), it doesn't affect any genetic material in the body, and the mRNA strands are removed from the body through everyday cellular processes.

OVERIVEW

We, in Australia, if not the greater part of the World, live in a most confusing time where we are all expected to give consent to a medical process, but are not given even the basic information for us to make a rational or reasoned decision. It would seem from both a Governmental and Department of Health viewpoint the only thing that is important is to take the JAB (coronavirus Covid-19 vaccine).

The Television and Press (2021) in particular hound us into taking the JAB. This is unprecedented. Never before has the press been so dogged at presenting only one side. It causes one to wonder who owns the press???

This is done in spite of the prolific number of adverse reports filed with CDC (Centres for Disease Control and Prevention) VAERS (Vaccine Adverse Event Reporting System) and TGA (Therapeutic Goods Administration**)** in Australia. Because both reporting systems are voluntary, the suggestion is that only somewhere between 1% and 10% of the adverse cases are reported!!!

Never before in our history has a vaccine, which evoked more than a few adverse reports and deaths, been allowed to continue to be administered. The present number of deaths from the Covid-19 vaccine, according to the internet, is over 17,000 in the USA alone. That's cases reported. Articles are available which show that in the history of vaccines, you can add all the previous deaths before the Covid-19 vaccines together and the sum is minuscule compared to the number of deaths from the current choice of Covid-19 vaccines.

In addition to this, in 2010 the definition of a pandemic was changed from the number of people hospitalised to the number of people who tested positive. The PCR (polymerase chain reaction – it's a test to detect genetic material from a specific organism, such as a virus) test was considered the Gold

Standard for testing. This was in spite of the advice by Dr Kary Mullis, the developer of the test, stating it could not be used the way it is presently used. Additionally in July 2021 the CDC issued a notice that the PCR test was to no longer be used because of unacceptably high false positives it produced. There is plenty of evidence to suggest it gives up to 80% false positives. It is not to be used after the 31st December 2021.

In spite of this statement by the CDC, posted on their web site, nothing is in the press!!! The Government is still lauding it as the Gold Standard for the testing for Covid-19 infection!!! Maybe, we really only have an administrative pandemic???

The next aspect of concern is contained in the article of 26 October 2021; Evidence of mRNA – Based Vaccine Travelling from Inspection Site.

The disturbing information is that the vaccines were approved for emergency use on the understanding of the FDA (Food and Drug Administration) and the NIH (National Institutes of Health) that the vaccine would not migrate from the injection site. Recent information advises that at least 75% of the vaccine does migrate from the injection site. This was never considered by the Drug Companies.

The consequence of the migration of the vaccines has not presently been evaluated. This is nothing less than a catastrophe. If we have been vaccinated with the present range of vaccines available in Australia, we are the preliminary trial group, no one has any idea of what will happen to us. This is probably why the vaccine development will not be concluded until 2028. If we've had the vaccine, we are Guinea Pigs for the pharmaceutical companies, and no one can indicate what is ahead for us. It really is just, fingers crossed and hope. People are encouraged to jump in with blind faith in the drug companies' expertise??

The vaccines do not stop one from being infectious, does not stop from contracting the existing virus's, give limited immunity to existing virus's and lesser to newer virus strains, and requires one to have their immunity re-boosted every eight months or so, which means people have to continue to dose themselves with a serums which cause complications at the time over the booster shot and ongoing.

This is made more difficult to accept when there is so much information about the success of a number of prophylactic (intended to prevent disease) treatments like Ivermectin and Hydroxychloroquine. Not only do they remove all the symptoms they actually kill the virus (host cell) and create immunity. They have been considered safe and have been for around 40 years. The press came out filing a false report with The Lancet, which The Lancet has subsequently advised was a fake paper with no credibility whatsoever. But the damage was done – why???

Why are Governments not protecting their people from this capricious attitude of the drug companies?

Fortunately there seems to be some light at the end of the tunnel. One such light is the work being done by **Professor Nikolai Petrovsky at the Flinders University Adelaide – South Australia**. They are developing a Covid-19 vaccine based on the more traditional approach. No messenger RNA and no nanoparticles. It's called Covax-19, which it seems, kills the virus and completely prevents shedding. It may also be effective against new variants of the virus. The hope is that it will be approved by the end of this 2021.

Archbishop Viganò Writes Stunning Letter on Vaccine Program

https://summit.news/2021/11/02/archbishop-vigano-writes-stunning-letter-on-vaccine-program/

Wednesday, 2 November 2021

Slams Pope for promoting jabs which contain material from aborted foetuses.

Archbishop Carlo Maria Viganò has written a stunning letter to America's bishops in which he makes several astounding claims about COVID-19 jabs and the Church's role in promoting vaccines.

Viganò asserts that vaccines normally go through years of rigorous testing, and that the lack of such a process in the case of COVID-19 jabs represents public health authorities conducting "experimentation on the entire world population."

The Archbishop referenced drug treatments that have proven effective in fighting COVID without the risks of vaccines, noting that such drugs have been discredited by global health bodies and the media.

"It must be reiterated that there are effective treatments which cure patients and allow them to develop permanent natural immune defences, something that the vaccines do not do," he wrote. "Furthermore, these treatments do not cause serious side effects, since the drugs that are used have been licensed for decades."

"International standards specify that an experimental drug cannot be authorized for distribution except in the absence of an effective alternative treatment: this is why drug agencies in the USA and Europe have prevented the use of **hydroxychloroquine, ivermectin, hyper-immune plasma, and other therapies** with proven effectiveness," he added.

Viganò goes on to state that the vaccines proving ineffective in preventing people from getting and passing on the virus means they can't even be called vaccines.

"In fact a "vaccine" is defined as a medicinal preparation aimed at inducing the production of protective antibodies by the organism, conferring specific resistance against a specific infectious disease (viral, bacterial, protozoal). This definition was recently changed by the WHO, because otherwise it would not have been able to include anti-Covid drugs, which do not induce the production of protective antibodies and do not confer a specific resistance against the SarsCoV-2 infectious disease."

The Archbishop went on to assert it was a moral "duty" to refuse inoculation given what we now know about the vaccine program.

"Worldwide, the number of deaths and grave pathologies following vaccination is increasing exponentially: in only nine months these vaccines have caused more deaths than all vaccines in the last thirty years. Not only this: in many nations – such as Israel for example – the number of deaths after vaccination is now greater than the number of deaths from Covid."

Viganò went on to assert it would be "immoral and unacceptable" for Catholics to take the vaccine given revelations by Pfizer executives that the jabs contain material from aborted foetuses.

The Archbishop expressed his fury at other members of the clergy and Pope Francis himself for facilitating a "crime against humanity" and "satanic action against God."

Viganò pulled no punches in outlining the wider agenda at play.

"I realize that it may be extremely unpopular to take a position against the so-called vaccines, but as Shepherds of the flock of the Lord we have the duty to denounce the horrible crime that is being carried out, whose goal is to create billions of chronically ill people and to exterminate millions and millions of people, based on the infernal ideology of the "Great Reset" formulated by the President of the World Economic Forum Klaus Schwab and endorsed by institutions and organizations around the world."

Viganò previously wrote to then President Donald Trump asserting that the COVID-19 pandemic is part of a plot to impose a "health dictatorship" and that Trump is "the final garrison" in stopping this agenda.

Last year, we also highlighted how Cardinal Raymond Burke warned that the COVID-19 pandemic is being exploited by proponents of "The Great Reset" to "advance their evil agenda."

Klaus Schwab's vision of a post-COVID world, and how the economy can work with nature – The Great Reset podcast

https://www.weforum.org/agenda/2020/07/klaus-schwab-nature-jobs-great-reset-podcast/

NOTE: Consult your professional health care providers and medical doctors.

Something Really Strange Is Happening At Hospitals All Over America

http://themostimportantnews.com/archives/something-really-strange-is-happening-at-hospitals-all-over-america

2 November 2021 *Authored by Michael Snyder via TheMostImportantNews.com,*

In a year that has been filled with so many mysteries already, I have another very odd one to share with you. **Emergency rooms are filled to overflowing all over America, and nobody can seem to explain why this is happening.** Right now, the number of new COVID cases in the United States each day is less than half of what it was just a couple of months ago. That is really good news, and many believe that this is a sign that the pandemic is fading. Let us hope that is true. **With less people catching the virus, you would think that would mean that our emergency rooms should be emptying out, but the opposite is actually happening.** All across the country, emergency rooms are absolutely packed, and in many cases we are seeing seriously ill patients being cared for in the hallways because all of the ER rooms are already full.

Let me give you an example of what I am talking about. The following comes from an article entitled ***"ERs Are Swamped With Seriously Ill Patients, Although Many Don't Have Covid"…***

Inside the emergency department at Sparrow Hospital in Lansing, Michigan, staff members are struggling to care for patients showing up much sicker than they've ever seen.

Tiffani Dusang, the ER's nursing director, practically vibrates with pent-up anxiety, looking at patients lying on a long line of stretchers pushed up against the beige walls of the hospital hallways. "It's hard to watch," she said in a warm Texas twang.

But there's nothing she can do. The ER's 72 rooms are already filled. Can anyone explain why this is happening?

If the number of COVID cases was starting to spike again, it would make sense for emergency rooms to be overflowing.

But at this particular hospital in Michigan, we are being told that some of **the main things that are being treated include "abdominal pain", "respiratory problems", "blood clots" and "heart conditions"…**

Months of treatment delays have exacerbated chronic conditions and worsened symptoms. Doctors and nurses say the severity of illness ranges widely and includes abdominal pain, respiratory problems, blood clots, **heart conditions** and suicide attempts, among other conditions.

That mention of "heart conditions" immediately got my attention, because I have been seeing this so much in the news recently.

For instance, a high school senior in Pennsylvania just dropped dead from "a sudden cardiac incident"…

The high school soccer manager 'greatly enjoyed' his team's championship victory Saturday. Later that evening, he was dead.

Now, late student Blake Barklage's high school is mourning his untimely death. As 6ABC in Philly reports, the tragedy occurred at La Salle College High School in Montgomery County, Pa.

In a letter to parents, the school announced that the senior died after **'a sudden cardiac incident'** Saturday night.

Elsewhere in the same state, an otherwise healthy 12-year-old boy just suddenly died because of an issue with his coronary artery…

As family and friends grieve, the cause of death is in for a 12-year-old taken way too soon while warming up for school basketball practice.

As TribLive in Pittsburgh reports, Jayson Kidd, 12, of Bridgeville, Pa., died of natural causes involving **his coronary artery**, according to the Allegheny County Medical Examiner's Office.

Heart problems kill elderly people all the time, but it is odd that so many healthy young people have been having these problems.

Over the weekend, Barcelona striker Sergio Aguero suddenly collapsed on the pitch during a match. He was later diagnosed with "a cardiac arrhythmia"…

Sergio "Kun" Aguero, a striker for the Barcelona soccer team, has been diagnosed with **a cardiac arrhythmia** after collapsing during Saturday's match against Alaves.

The 33-year-old Argentinian was examined by medical staff at the stadium before being taken to a nearby hospital where he is still waiting to undergo further examination.

Just two days later, a match in Norway was brought to a screeching halt after a player experienced "cardiac arrest" right in the middle of a match…

A football match in Norway's second division was halted on Monday after Icelandic midfielder Emil Pálsson suffered **a cardiac arrest** during play.

The 28-year-old Sogndal player suffered the attack as the game against Stjordals-Blink entered the 12th minute, his club said in a statement.

I have been seeing so many stories like this.

So why are so many young people suddenly having such serious problems with their hearts?

Can anyone out there explain this to me?

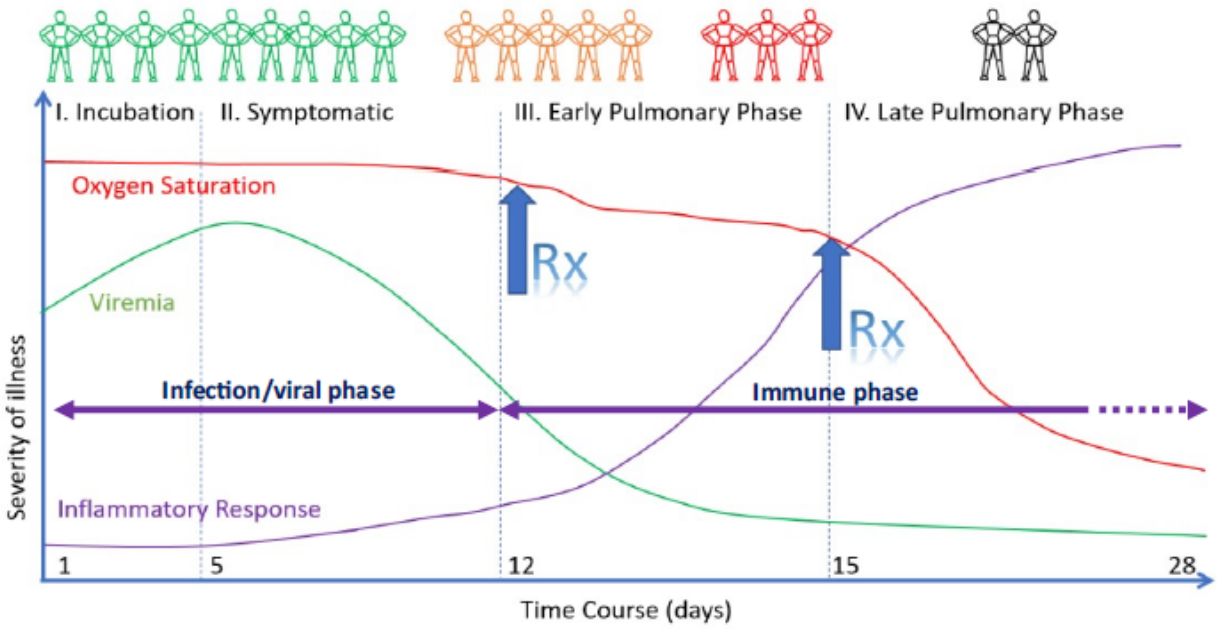
Covid Information, Protocols & Consultation Guidelines

General principles of the covid infection illness

- The virus 'incubates' in your body for 5-10 days before symptoms start.
- Just prior to and once symptoms start, you may be infectious for 7-14 days.
- See the graph below regarding the first *infection/viral phase*: it is rare for people to be very unwell during this phase.
- Almost all patients who die from covid die during the second phase, the '*immune phase'* (see graph below).
- Typical *immune phase* symptoms include shortness of breath, fatigue, muscle aches/pains, nausea, and sometimes diarrhoea.
- *Immune phase* symptoms usually start ***8-14 days after the onset*** of infection/viral phase symptoms.
- If the *immune phase* is not treated promptly, blood clots can form in the large and/or small blood vessels. Once there are widespread blood clots, there is an increased risk of widespread organ failure and death. Correct and prompt treatment of the *immune phase* is paramount to prevent these complications.
- In the USA and other countries, increasing numbers of covid patients suffering *immune phase* symptoms are being successfully treated at home. The aim is to treat all stages of the covid illness so that hospitalisation can be avoided.

Figure of the covid illness:

Figure of the covid illness:



KEY: Viremia = level of active/alive virus in the circulation (blood); **Pulmonary = Lung**

Our priority is to offer consultations to **symptomatic covid positive patients** and those at **high risk of severe covid illness**.

People considered at high risk of serious covid illness are those who are/have:

- Aged 65 and over
- Body Mass Index of 35 or more
- High blood pressure
- Heart disease
- Vascular disease
- Chronic lung disease
- Kidney disease
- Diabetes
- Cancer and immune deficiency problems

1. PREVENTION protocol

Supplements to be taken on a daily basis to help minimise risk of serious covid illness in the event you are exposed to the covid virus:

- **Vitamin D3** 2000 IU daily (chemist)
- **Zinc** chelate, picolinate or citrate 30-50 mg daily (chemist or online e.g. iHerb)
- **Vitamin C** 1-2 grams daily (tablets or chewables) - If loose bowels, take a little less (chemist)
- **Quercetin** 250-500 mg daily (online e.g. iHerb)
- **Optional: Melatonin** 6 mg if can tolerate at night (prescription, compounded, or online)

Avoid purchasing cheap, unreliable supplements from supermarkets
https://covid19criticalcare.com/covid-19-protocols/i-mask-plus-protocol/

Many Australians have low vitamin D and zinc levels. The people who are more likely to have a low vitamin D level are those who avoid exposure to sunshine, are obese, have dark skin, have autoimmune disease or a family history of low vitamin D.
People who are at risk for low zinc are those **aged 60 years and older**, **vegetarians**, and those who take **acid-blocking medications**. Vitamin D and zinc blood levels can be requested via your family doctor – there is usually a charge for these.

Supplementation with vitamin D and zinc is safe, however, we recommend that all patients over 50 get their vitamin D and calcium levels checked before starting the vitamin D.

The following studies are just a few of the clinical studies that provide evidence on the importance of these supplements in reducing the risk of severe covid illness:

Vitamin D
Vitamin D deficiency and the COVID-19 pandemic
https://pubmed.ncbi.nlm.nih.gov/32474141/

Vitamin C

Mini-Review on the Roles of Vitamin C, Vitamin D, and Selenium in the Immune System against COVID-19

https://pubmed.ncbi.nlm.nih.gov/33207753/

Zinc
Zinc and COVID-19: Basis of Current Clinical Trials
https://pubmed.ncbi.nlm.nih.gov/33094446/
Quercetin

The effect of quercetin on the prevention or treatment of COVID-19 and other respiratory tract infections in humans: A rapid review

https://pubmed.ncbi.nlm.nih.gov/32837891/

What about Ivermectin for prevention?

At the moment, the once-a-week Ivermectin prevention protocol (as per I-MASS protocol), is not practical for mass distribution given the few doctors able to or with knowledge to prescribe. Given all patients need a medical consultation before being prescribed ivermectin, we are obliged to restrict ivermectin prescriptions for prevention purposes to those at high risk for severe covid illness. Our priority otherwise, is to prescribe it for patients with proven and symptomatic covid infection.
For those not as high risk for severe covid illness, acquiring, then treating the infection (rather than *preventing* the infection), has the advantage of allowing the important process of obtaining natural immunity following infection.

Ivermectin can be taken to curtail covid infection severity in both vaccinated and unvaccinated individuals.

2. OUTPATIENT TREATMENT protocol

Early treatment of covid infection is paramount. Please don't delay in contacting us for a consultation if you have a **positive PCR test** AND **symptoms**. Starting treatment during the viral/infection phase is preferable to starting it later in the illness, but treatment of symptomatic infection at any time is important. NOTE: Prescription medication cannot be supplied for this outpatient protocol unless there is evidence of a positive covid test.

a. Early symptom treatment

When you suspect you may have been exposed to covid AND you have new onset symptoms including loss of taste/smell, fever, cough, runny nose, sore throat, abdominal pain, diarrhoea or shortness of breath, we recommend the following based on the I-MASK+ protocol:

- *Increase Vitamin D, Vitamin C, Zinc and Quercetin to twice a day dosing*
- Continue current dose of **Melatonin** or double if can tolerate
- **Use hydrogen peroxide 3%** throat gargle or nasal rinse (please dilute in 5 parts water or further to tolerability), or other antiseptic mouthwash as per I-MASK+.

For patients deemed at risk of serious illness (after consultation with us), you may have been supplied scripts for:

- **Azithromycin** 500 mg daily **five days**
- **Ivermectin** 0.4-0.6 mg/kg daily **five days**

b. Late symptom treatment

The late stage of covid can start anytime time from EIGHT days following the onset of the symptoms outlined in 2a.

Common late-stage symptoms include fatigue, muscle aches/pain, flu-like symptoms or shortness of breath.

Note that these later symptoms are almost always associated with a positive covid PCR test and a recent history of one or more of the early infection symptoms outlined above in 2a.

If you have tested positive for covid and have symptoms, please email

CovidConsultAus@gmail.com and include "**COVID POSITIVE PATIENT**" in the subject heading.

Vax unpacked

https://www.adelaide.edu.au/research/the-discovery-pod
the discovery pod: season 2, COVID-19, vaccine

Welcome to The Discovery Pod, where we talk to leading experts from the University of Adelaide about solutions to society's most pressing challenges.

Vaccinations are the global frontline in public health. So how do they protect us from disease? What are the different ways of making them? And why were COVID-19 vaccines able to be made so much faster than others?

Join our host, 2021 Young Australian of the Year Isobel Marshall, in conversation with microbiologist Professor James Paton, and vaccinologist Professor Helen Marshall.

Consultation Information & Guidelines

Consultation objectives

- To provide advice on prevention, preparedness and early home-based treatment for covid illness.
- To advise on evidence-based supplements.
- If deemed appropriate, prescription medications may be prescribed (ivermectin, azithromycin, prednisone etc.)

Consulting practitioners

- **Dr Georgina Hale** – General Medicine and Infectious Diseases Specialist (MBBS, FRACP, PhD).
- **Anthony Wollaston** – Nurse Practitioner. Anthony works directly with Dr Hale and as a Nurse Practitioner has prescription medication prescribing rights.
- In an effort to meet demand and assist as many people as possible, consultations will be with either Dr Hale or Anthony Wollaston. Patients are discussed between both practitioners.

Fees

- The fee for an initial consultation is $140 (20 mins).
- There are no Medicare rebates for these consultations and the consultation fee does not include the cost of any prescription medications.
- Payment will be taken at the commencement of the consultation via credit card (*please have your card details ready*). If you would prefer to pay via bank transfer, please advise when you return your intake form and details will be provided to enable cleared payment by the day of consultation.

Consultation scheduling

- Assistants to Dr Hale (Alison or Cath), will correspond with you regarding appointment bookings and other administrative matters.
- As per usual medical practice, consultations can only be for one individual per appointment time.
- We recommend that only ADULTS apply for consultations. NOTE: we may have to limit consultations to only HIGH-RISK adults in the future.
- *Consultations will be via phone.*
- If you would like to apply for an initial consultation, please read/complete **both** of the following documents and return both to **CovidConsultAus@gmail.com**:
    - **Patient Intake Application** – please complete and return as a typed *'Word'* document.
    - **Consent to Consultation** – please sign, then return as a PDF/image document.
- We currently have a 4-6 week wait for consultations for those who do not have covid. Receipt of your intake form will be acknowledged, and you will be contacted via email when we are able to offer a consultation.

Prescriptions

- If ivermectin or any other prescription medication needs to be prescribed, the prescription will be sent to a QLD pharmacy that will liaise with you regarding payment and mailing the order.

Recommended websites

- Front Line COVID-19 Critical Care Alliance – https://covid19criticalcare.com
- The McCullough Report by Dr Peter McCullough – https://podcasts.apple.com/au/podcast/the-mccullough-report/id1562849542
- C19 Early Treatment Studies – https://c19early.com/#fpall

I-MASK+

PREVENTION & EARLY OUTPATIENT TREATMENT PROTOCOL FOR COVID-19

PREVENTION PROTOCOL

Ivermectin[1]	**Chronic Prevention** 0.2 mg/kg per dose (take with or after a meal) — twice a week for as long as disease risk is elevated in your community **Post COVID-19 Exposure Prevention**[2] 0.4 mg/kg per dose (take with or after a meal) — one dose today, repeat after 48 hours
Vitamin D3	1,000–3,000 IU/day
Vitamin C	500–1,000 mg twice a day
Quercetin	250 mg/day
Zinc	30–40 mg/day (elemental zinc)
Melatonin	6 mg before bedtime (causes drowsiness)
Gargle mouthwash	2 x daily – gargle (do not swallow) antiseptic mouthwash with cetylpyridinium chloride (e.g. Scope™, Act™, Crest™), Listerine™ with essential oils, or povidone/iodine 1% solution as alternative.

EARLY OUTPATIENT PROTOCOL[3]

Ivermectin[1]	0.4–0.6 mg/kg per dose (take with or after a meal) — one dose daily, take for 5 days or until recovered Use upper dose range if: 1) in regions with aggressive variants (e.g. "Delta" variant); 2) treatment started on or after day 5 of symptoms or in pulmonary phase; or 3) multiple comorbidities/risk factors.
Fluvoxamine[4]	50 mg twice daily for 10–14 days Add to ivermectin if: 1) minimal response after 2 days of ivermectin; 2) in regions with more aggressive variants; 3) treatment started on or after day 5 of symptoms or in pulmonary phase; or 4) numerous comorbidities/risk factors. Avoid if patient is already on an SSRI.
Nasal/oral rinse	3 x daily – gargle (do not swallow) antiseptic mouthwash with cetylpyridinium chloride (e.g. Scope™, Act™, Crest™), Listerine™ with essential oils, or povidone/iodine 1% solution as alternative. Nasal rinse instructions below.[5]
Vitamin D3	4,000 IU/day
Vitamin C	500–1,000 mg twice a day
Quercetin	250 mg twice a day
Zinc	100 mg/day (elemental zinc)
Melatonin	10 mg before bedtime (causes drowsiness)
Aspirin	325 mg/day (unless contraindicated)
Pulse Oximeter	Monitoring of oxygen saturation is recommended (for instructions see page 2)

[1] The dosing may be updated as further scientific studies emerge. The safety of ivermectin in pregnancy has not been definitively established. Use in the 1st trimester should be discussed with your doctor.

[2] To use if a household member is COVID-19 positive, or you have prolonged exposure to a COVID-19 positive patient without wearing a mask

[3] For late phase — hospitalized patients — see the FLCCC's MATH+ Hospital Treatment Protocol for COVID-19 on www.flccc.net

[4] Some individuals who are prescribed fluvoxamine experience acute anxiety which needs to be carefully monitored for and treated by the prescribing clinician to prevent rare escalation to suicidal or violent behavior.

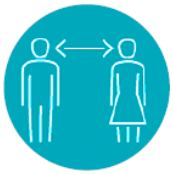
[5] Nasal rinse – 3 x daily. Use 10% povidone/iodine wound wash. Take 1 ml (1/4 tsp) mix with 9 ml saline solution (2 tsp). Use nasal irrigation bottle or syringe.

Please regard our **disclaimer** and further information on page 2 of this document.

Behavioral Prevention

WEAR MASKS

Wear a cloth, surgical, or N95 mask when in confined, poorly ventilated, crowded indoor spaces with non-household members.



KEEP DISTANCE

Until the end of the COVID-19 crisis, we recommend keeping a minimum distance of approx. 2 m / 6 feet in public from people who are not from your own household.

WASH HANDS

We recommend, after a stay during and after outings from home (shopping, subway etc.), a thorough hand cleaning (20–30 sec. with soap), or also to use a hand disinfectant in between.

I-MASK+
PREVENTION & EARLY OUTPATIENT TREATMENT PROTOCOL FOR COVID-19

IVERMECTIN

Summary of the Clinical Trials Evidence for Ivermectin in COVID-19

Ivermectin, an anti-parasitic medicine whose discovery won the Nobel Prize in 2015, has proven, highly potent, anti-viral and anti-inflammatory properties in laboratory studies. In the past 4 months, numerous, controlled clinical trials from multiple centers and countries worldwide are reporting consistent, large improvements in COVID-19 patient outcomes when treated with ivermectin.

Our comprehensive scientific review of these referenced trials on ivermectin can be found on www.flccc.net/flccc-ivermectin-in-the-prophylaxis-and-treatment-of-covid-19/

For a quick overview, a One-page Summary of our review on ivermectin can be found on www.flccc.net/flccc-ivermectin-summary

Body weight conversion (kg/lb) for ivermectin dose in prevention and treatment of COVID-19

Body weight Conversion (1 kg ≈ 2.2 lbs) (doses calculated per upper end of weight range)		**Dose** 0.2 mg/kg ≈ 0.09 mg/lb (Each tablet = 3 mg; doses rounded to nearest half tablet above)	
70–90 lb	32–40 kg	8 mg	(3 tablets = 9 mg)
91–110 lb	41–50 kg	10 mg	(3.5 tablets)
111–130 lb	51–59 kg	12 mg	(4 tablets)
131–150 lb	60–68 kg	13.5 mg	(4.5 tablets)
151–170 lb	69–77 kg	15 mg	(5 tablets)
171–190 lb	78–86 kg	16 mg	(5.5 tablets)
191–210 lb	87–95 kg	18 mg	(6 tablets)
211–230 lb	96–104 kg	20 mg	(7 tablets = 21 mg)
231–250 lb	105–113 kg	22 mg	(7.5 tablets=22.5 mg)
251–270 lb	114–122 kg	24 mg	(8 tablets)
271–290 lb	123–131 kg	26 mg	(9 tablets = 27 mg)
291–310 lb	132–140 kg	28 mg	(9.5 tablets=28.5 mg)

Pulse Oximeter (usage instructions)

In symptomatic patients, monitoring with home pulse oximetry is recommended (due to asymptomatic hypoxia). The limitations of home pulse oximeters should be recognized, and validated devices are preferred. Multiple readings should be taken over the course of the day, and a downward trend should be regarded as ominous. Baseline or ambulatory desaturation < 94% should prompt hospital admission. The following guidance is suggested:

- Use the index or middle finger; avoid the toes or ear lobe.
- Only accept values associated with a strong pulse signal.
- Observe readings for 30–60 seconds to identify the most common value.
- Remove nail polish from the finger on which measurements are made.
- Warm cold extremities prior to measurement.

For an overview of the developments in prevention and treatment of COVID-19, please visit flccc.net/covid-19-protocols

Please check our homepage regularly for updates of our COVID-19 Protocols. New medications may be added and/or dose changes to existing medications may be made as further scientific studies emerge!

We Can't Vaccinate This Pandemic Away

https://quadrant.org.au/opinion/public-health/2021/10/we-cant-vaccinate-this-pandemic-away/

31st October 2021

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Thirty frontline doctors in Australia recently treated over 600 patients with COVID-19. The treatment strategy was ivermectin (IVM) with doxycycline and zinc. Five patients required admission to hospital for progressive symptoms. There were no deaths. In a similar number of contemporary Australian patients not treated with IVM, 70 were hospitalised and six died.

This is consistent with world data bases: 31 randomised controlled trials show 62% benefit with IVM, and seven meta-analyses recorded a reduction in death of between 57% and 83%. Experienced clinicians have moved on to combine IVM with additional drugs, usually a broad-spectrum antibiotic such as doxycycline, and zinc, which has viricidal activity.

A logical conclusion would be that these results demand attention. With "freedom day" in NSW expected to be followed by increases in COVID-19 infections and hospital admissions, an IVM roll-out would be a logical outcome. That this has not happened may well prompt the question 'Why is that so?' The mainline press, which continues in its refusal to report and interrogate the evidence, also fails the public by presenting IVM as the antichrist of the medicine cabinet. A complex set of events has come together. These events and how they affect COVID-19 management and patient outcomes form the basis of this article.

FIRST, as patients were being treated with IVM in Sydney and Melbourne with the impressive results mentioned above, the Therapeutic Goods Administration (TGA – an Australian government agency) made an extraordinary move to shut down the prescribing of IVM by frontline doctors for the treatment and prevention of COVID-19. The TGA has form, as it made a similar ruling on hydroxychloroquine (HCQ), the other re-purposed off-patent drug shown to be effective in treating COVID-19. Importantly, the reasons given by the TGA to justify its decision were not correct.

The main TGA concern stated was that IVM would confuse the public and lead to hesitation to be vaccinated. That, too, is incorrect. Doctors overwhelmingly support vaccination against COVID-19. The combination of safe and effective IVM with a vaccination programme will enhance viral clearance, reduce disease severity, reduce hospital admissions and reduce deaths. However, groupthink quickly led

to professional bodies such as the AMA uncritically accepting the TGA policy. Even the Australian Academy of Science weighed in with political support for the TGA's decision, doing so without any evaluation of the science.

Then came the coup: the regulatory body responsible for registration of doctors, the Australian Health Practitioner Regulation Agency, warned that prescribing, dispensing, or even publicly discussing IVM, "compromised expected standards of practise", leaving open disciplinary measures which have since resulted in doctors having their licences revoked. A crescendo of intimidation has ensued, all based on a failure to interrogate the data and understand the clinical circumstance, with perhaps a touch of group hysteria thrown in.

The conclusion to be taken from these collective authoritarian decisions is that medical choice is no longer the prerogative of the doctor-patient relationship in Australia. Bureaucrats for any reason can decide and enforce medical issues without discussion with relevant medical experts. This is a problem throughout the Western world, but perhaps there is a light in the tunnel. Nebraska's attorney general recently ruled that the prescription of IVM for COVID-19 is a matter for the doctor and patient, not government.

THE SECOND development is a changing balance in evidence relevant to early treatment. Negative critique has been rebutted, and support has become stronger.

First, there has been a rebuttal of a misleading "Cochrane report". Traditionally, a Cochrane is considered the highest bar for drug efficacy, and the outcome of a Cochrane has profound influence on acceptance. The existing Cochrane report on IVM was ambivalent. This became the basis for rejection of IVM, and the cry for more studies. The National COVID-19 Health and Research Advisory Committee, established to counsel government on early treatment for COVID-19, took that flawed Cochrane report as gospel. From there a trickle-down effect informed opinion of both professional and government organisations, with vigorous support from an uncritical media. Recently, a group of respected non-aligned epidemiologists in the UK reviewed the Cochrane report and found it wanting. They showed defects in method, an exclusion of data points and studies, and a failure to include substantive regional and national experiences where IVM had been successfully adopted.

Not to be dismissed, IVM naysayers took a new tack: play the man (or the woman), not the ball. Their trick is to label IVM studies that do not fit their viewpoint as "fraudulent" while disparaging IVM's medical supporters as, among other insults, "New Age quacks". The value of the naysayers' critique, indeed their motivation, has been challenged in detail (see IVMMETA.com), failing on numerous counts that include an absence of evidence and misinformation. The conclusion was that these frivolous activities confined to a couple of uncertain studies (which are not included in quality meta-analyses) had no impact on the overwhelming data supporting the benefit for IVM use against COVID-19.

The mainline press welcomed claims supporting the anti-IVM narrative, with the BBC News plumbing new lows in journalism by combining false conclusions with bias that included misrepresentation of a highly regarded epidemiologist. A recent *Sydney Morning Herald* article was little better, distorting the science with ideology and bias. The reporter involved has not responded to a request to host a debate on the topic. They never do!

Second, and more positive, is the accumulation of evidence supporting the benefit from ***early*** treatment. Two recent and compelling studies further support the value of both IVM and HCQ, the latter having

been "cancelled" after being cited by Donald Trump as a potential treatment. All this came despite a meta-analysis of 32 early-treatment studies showing 64% protection.

The first of those is a WHO study in **Uttar Pradesh**, India's most populous state (230 million people). Medical teams visited 98,000 villages, providing kits (similar to those used in the Australian study) containing IVM for the treatment of those with COVID-19. Within five weeks, new cases had dropped by **97%**. Meanwhile in another Indian state, Kerala, with eight per cent the population of Uttar Pradesh, IVM was *not used* and as many as 31,000 COVID cases were recorded per day. Similar results are reported in areas of **Peru, Mexico and elsewhere.**

The second recent study treated 8,300 French patients with HCQ. There was a 93% reduction in mortality. A meta-analysis by the same authors included 32,000 patients from five countries and showed early HCQ treatment reduced mortality by 69%.

The inevitable and unavoidable conclusions to be drawn are that Cochrane negativity can no longer dominate an honest argument about IVM's use and, further, that the medication must be accepted in Australia as a safe and effective treatment capable of reducing the expected post-lockdown load on health systems.

THE THIRD development has been the frenetic response by media and government to an orchestrated campaign by pharmaceutical giant Merck promoting its re-purposed antiviral agent, Molnupiravir, before significant data assessment has been completed. Merck is now joined by Roche and Pfizer with their versions of re-positioned "wonder drugs". All have limited and conflicting data yet make extravagant claims. These antivirals are less effective than IVM and none have acceptable safety profiles. However, we see the Australian government making extraordinary claims and committing large sums to acquire these unproven oral therapies. Who can be advising government to allow such dubious claims and acquisitions at the expense of IVM and the Australian taxpayer?

The charge of hypocrisy and cynicism must first be directed at Merck, but also at "the experts", Dr.Tony Fauci, governments and, of course, the media. Merck stated IVM had no clinical value mere days before receiving a US$300 million grant to develop Molnupiravir. Available data suggests it provides eight-fold less protection than that found for IVM in the Australian study. Merck acquired Molnupiravir, originally developed by Emory University, after it failed against other RNA virus diseases. Questions about undisclosed data remain to be answered. The drug is a "son of Remdesavir", a RNA polymerase inhibitor with that failed randomised controlled trials (RCT). The Australian government has bought 300,000 courses of Remdesivir (the US government pays US$1,000 per course). This is beyond logic, certainly not based on science. As the TGA prevented doctors prescribing IVM because it would reduce vaccination rates, the question is simple: How will the TGA draw a distinction between Merck's Molnupiravir and IVM?

The elephant in the room for Molnupiravir is safety. The drug creates lethal mutants to terminate virus replication. Cell biologists express concern that some live mutants with resistance to vaccines are released into the environment. DNA mutations also occur, which could lead to disturbed growth and cross-generation transmission of genetic changes. The TGA will now have to wrestle with pressure from Big Pharma and government to register a drug with scant clinical data and untested safety concerns after denying the Australian a public cheap, safe and more effective treatment with IVM.

Any argument against IVM or HCQ use in treating COVID-19 is not based on science. Rather, it is politically driven, in tune with the pharmaceutical companies' profit motive. Who is pulling the strings?

THE FOURTH issue is the recognition that genetic vaccines have limited value. While doctors support the current vaccine roll-out, reported "danger signals" must be clarified. Both the DNA-vector vaccine (AstraZeneca) and mRNA vaccines (Pfizer and Moderna) behave as predicted by biology relevant to airways' protection (something not understood by the vast majority of "experts"): short duration of protection limited to control of systemic inflammation, with little impact on infection of the airways.

Israel was used as a laboratory for the Pfizer vaccine. Six months after vaccination, there was essentially no protection against infection or mild disease, although protection against severe disease remained at 85-to-90 per cent. Thereafter came a rapid and progressive loss of protection against more severe disease. Infected vaccinated and unvaccinated subjects have similar viral loads and transmission capacity. Immunity following natural infection is better and more durable than that induced by vaccination, so there is no sense in immunising those who have had COVID infection in the preceding six months.

In an Australian context, by New Year 2022, it is estimated about two million vaccinated Australians will have lost protection against infection and mild disease. Infections will increase as borders are opened and we re-enter the international community.

Our lockdown policy has limited the acquisition of natural immunity. Although we can expect high levels of infection with less severe disease, pressure on hospitals will increase. The experience of Israel and Iceland, each with high vaccination rates of 85% or more, provides a possible scenario for Australia. In Israel, with a population of less than 10 million, the "third wave" continues, with 1,500 new cases and 30 deaths a day (at the time of writing). More concerning are reports of high COVID mortality in older vaccinated subjects in some jurisdictions. Variants such as the further-mutated Delta variant in the UK will continue to appear, with unknown infectivity, response to current vaccines and pathogenicity. **Perhaps of greatest concern is the observation in the UK, and now in Sweden, that older vaccinated individuals have a higher incidence of COVID infection than those who are unvaccinated. At the same time others are describing a state of immune deficiency following vaccination with genetic vaccines.**

At this stage it is unclear as to whether this "deficiency" of the immune response is limited to the antibody response to COVID virus. This should not be a surprise to anyone who has done "Immunology 101", as enhancing antibody (*ie* antibody that promotes infection, rather than limits it) is well recognised in RNA virus infections, and "antigen excess causing a downregulation of immunity" is a basic tenet of immunology. Forgotten by most, is that genetic vaccines cause a large and unregulated amount of antigen (*ie* the spike protein) to be synthesised within the cells of the body, and the immune response will be a function of those unknown dynamics. These facts and the concerns they raise should be front and centre for regulators as they examine data to make decisions in regard to booster shots. The duration of protection following boosters is completely unknown, as is whether genetic vaccine boosters distort the immune system with net suppression. Are we setting ourselves up for monthly boosters, higher incidence of infections, more serious adverse events, or even more concerning immune outcomes. We just do not know! If ever there was a need for a safe, cheap effective oral therapy, now is it.

The concern for all genetic vaccines is the damage caused by uncontrolled release of toxic spike protein from cells throughout the body, and cell destruction due to T cells and antibody directed against spike

protein, expressed on cell surfaces. It is too early to know if there are long-term complications caused by injected mRNA due to displacement of physiological mRNA by synthetic "capped" mRNA in vaccines, or prion disease such as Parkinson's disease, due to "prion sequences" in the spike protein.

There are disturbing signals reporting severe adverse events and post-vaccination deaths across the globe. A high percent of these "signals" appear to have a causal relationship in subsequent analyses, reinforced by post-mortem reports showing specific tissue changes. Yet we are now seeing a push to vaccinate children under 12 who neither get severe disease nor significantly spread it. The cost/benefit of immunising children has been widely criticised, while misinformation continues to be delivered through the press. Similar concerns persist with respect to vaccination of pregnant women despite short term data from Pfizer suggesting safety. Incidence of miscarriages remains unclear. Follow-up of infants must be able to exclude complications due to placenta damage from spike protein and genetic changes due to injected mRNA.

TO CONCLUDE, we cannot vaccinate ourselves out of the pandemic. Most COVID deaths in England over the last seven months have been in vaccinated subjects, and studies across 68 countries confirm increases in COVID-19 infections are unrelated to levels of vaccination. Booster shots with current vaccines come with little support, and possible enhanced toxicity as reported to the FDA. There is very limited data showing prevention of serious disease, with the data presented to the FDA by Pfizer focussed on "infections", not serious disease. COVID deaths in older immunised subjects due to "enhancing antibody" need to be confirmed and investigated further. These concerns need to be resolved before booster shots are widely used.

Antigen-based vaccines such as NovaVax with its strong metrics on efficacy and safety, need to be considered. It is understood this vaccine will be available by year's end; indeed, on October 29 an application for provisional approval was filed with the TGA. Yet the Australian government continues to support genetic vaccines. Who can be advising the politicians on such a concerning course?

The management of COVID-19 in Australia requires re-shaping as we move into the next stage of the pandemic. It is easy to identify problems. It is more useful to recognise that the pandemic has opened cracks in the administration of medical practise. Transparency, communication, and flexibility, once strengths of our health system, are harder to find. Bureaucrats appear to make critical decisions for political reasons, while doctors are threatened with de-registration for supporting early drug treatment because it may affect vaccine roll-out. It is easy to conclude the system has been corrupted. The question is, who pulls the strings?

Part of the answer is that transnational organisations, such as WHO and mega pharmaceutical companies, have imprinted their political and commercial agendas all over the COVID-19 story. The genesis of their power play appears to reside in the terms of their confidential contracts with national governments. From the inadequate "investigation" of the Wuhan source of the virus to its refusal to admit IVM is the reason for successful COVID-19 control in Uttar Pradesh and its suppression of all cheap and readily available early treatments, the WHO cannot be trusted to lead the world out of the pandemic. Pharmaceutical companies subvert any evidence supporting cheap medications that threaten their profits. Conflict exist at every level with cross-appointments between pharmaceutical companies, government bodies with financial interests in pharmaceutical companies, and research grants from pharmaceutical companies. The US Food & Drug Administration has long been a nursery for highly paid lobbyists and careers within the pharmaceutical industry. If an example is needed to illustrate how distorted the system has become, go no further than Merck's promotion of Molnupiravir and the cynical support given by politicians,

academics and media only weeks after "cancelling" cheap, available, safer and more effective re-purposed drugs. Since the FDA in the US became funded through high application fees from the pharmaceutical companies, a shift in acceptance of expensive drugs offering little advantage over existing unpatented drugs has been noted.

What is difficult to understand is the groupthink acceptance of the mantra promoted by so-called experts, and by many professionals. In part this is due to the power vacuum in medical leadership that has occurred in recent years, but it may also reflect in part processes known to psychiatrists as cognitive dissonance and mass hysteria.

The medical profession in Australia was built on a proud tradition of excellence, with College systems and medical faculties led by the best of the best providing trickle-down leadership based on respect, knowledge and experience. This leadership was tightly connected to primary care doctors. That has changed, with Colleges now reduced to a gateway function geared to specialist accreditation and with "leadership" provided by bureaucrats. Medicine has been dissected by specialisation, losing its connections along the way. Academic medicine has lost the allure of earlier times in a post-truth world of political correctness, with fewer medical graduates entering PhD training programmes. Recruitment into research career paths is no longer an attractive option. Most specialists today would not know the name of their College presidents, once the most revered of positions. Instead the pandemic has enabled this information vacuum to be filled with a new breed of "experts" who either are not medically trained, and thus cannot grasp the clinical imperative, or have a past-distant medical degree but are a long way from real-life medicine. This has facilitated promotion of influence-peddling by pharmaceutical companies with the goal of impacting COVID-19 management. The current situation manipulated by Merck to "cancel" IVM and replace this treatment option with the less effective but patented Molnupiravir should be a wake-up call. Yet this expensive drug is lauded in the press and elsewhere as the "breakthrough we all needed".

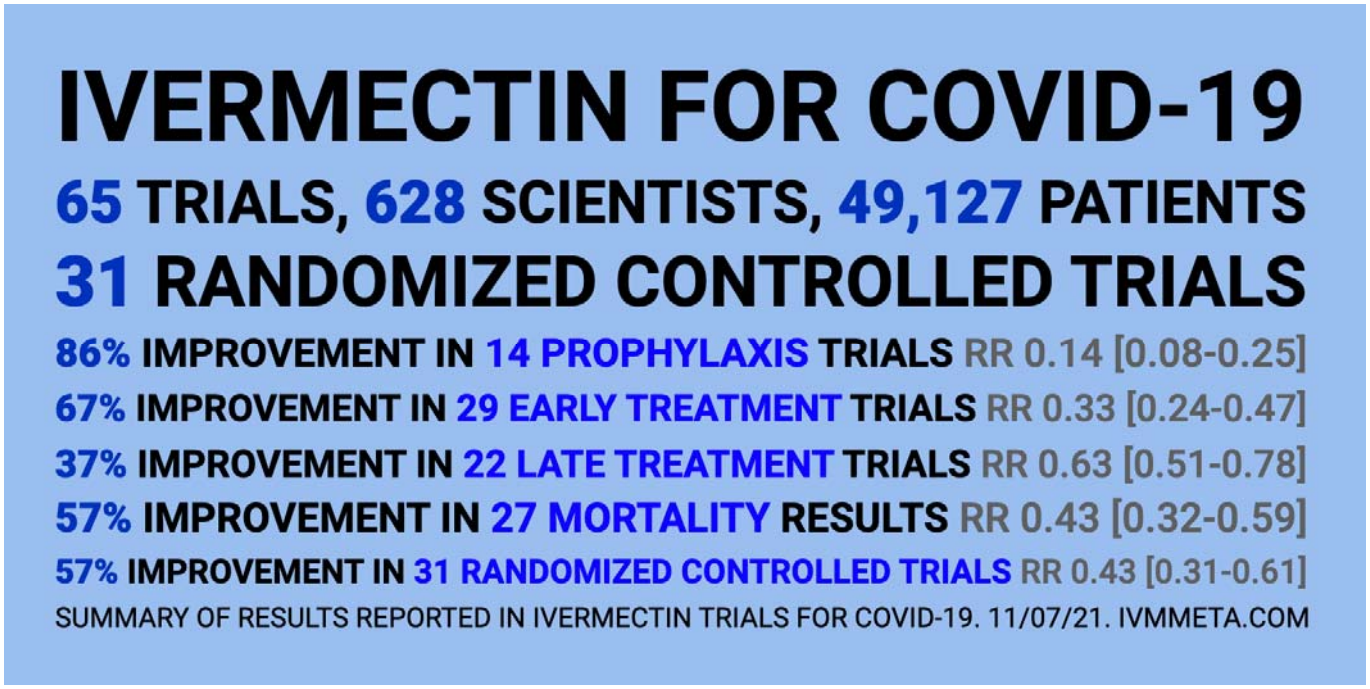
An example of pharmaceutical company "vigour" occurred with the launch of new anti-psychotic drugs in the 1990's. Companies manipulated a belief held by a few paediatricians and child psychiatrists that psychosis was common in young children, with funding, promotion and strong media support. It took several thousand deaths before sanity was restored to gullible doctors.

Uncritical acceptance of misinformation on IVM, driven by pharmaceutical companies to protect their vaccines and patented drugs, and strongly reinforced by academia, government and health authorities, leads to many unnecessary hospital admissions and deaths. The media has a concerning role in the propagation of misinformation, preferring to support an ideological narrative, rather than engage in responsible journalism. The appalling example by BBC News has been discussed.

This article is about a watershed moment in COVID-19 management. It is brought into focus by the TGA closing down the legal use of IVM for COVID-19, while Merck promotes an inadequately documented, potentially dangerous and less effective (but patented and very expensive) "lethal-mutant" anti-viral. Yet not a squeak of concern from the mainline press. The moment is brought squarely into relief as health services face the pressure of handling infections that will follow "escape" from lockdowns. The limits of vaccination to control this "third wave" across the globe demands drug support. New data on enhancing immunity and related immune deficiency, discussed above, calls for caution and a re-think about genetic vaccines.

How will the TGA and its advisers handle this crisis? How can a quality information trail be provided to politicians? The Nebraska ruling on IVM, noted and linked above, has gone viral around the world. The

question is, will legal sanity be sufficient to counter the pharmaceutical lobby and pressures they will bring on regulatory bodies? We all must live in hope!



https://covid19criticalcare.com/ https://ivmmeta.com/

How many mechanisms do you need? Ivermectin protects us from Covid in 20 ways

https://joannenova.com.au/2021/11/how-many-mechanisms-do-you-need-ivermectin-protects-us-from-covid-in-20-different-ways/

12 November 2021

Some claim that we don't know how ivermectin works, but oh boy we do

Not only do we know how ivermectin protects us, we know many pathways in detail. Ivermectin is useful at every stage of the disease. In the early stages, it reduces the odds of people getting infected, stops the virus multiplying, which reduces the viral load and the spread of the virus to your friends and strangers on the bus. It helps our cells warn neighbouring cells to get ready for a viral attack. It stops the virus getting through the outside wall of our cells, and also stops parts of the virus getting into the headquarters of our cells, the nucleus, where our DNA is.

Ivermectin is also a zinc ionophone which helps zinc cross into cells so zinc can do the good things zinc does…

As the virus tried to assemble itself inside our cells one of the processing tasks involves chopping long proteins into shorter parts. There are many enzymes involved but ivermectin binds to one key one called a Chymotrypsin-like-protease. Ivermectin also conveniently binds to two of the virus proteins as well (called Mpro and PLpro). Basically, ivermectin is the glue no assembly line wants.

In the late stages, ivermectin is an anti-inflammatory drug that reduces the cytokine storm in something like six different ways.

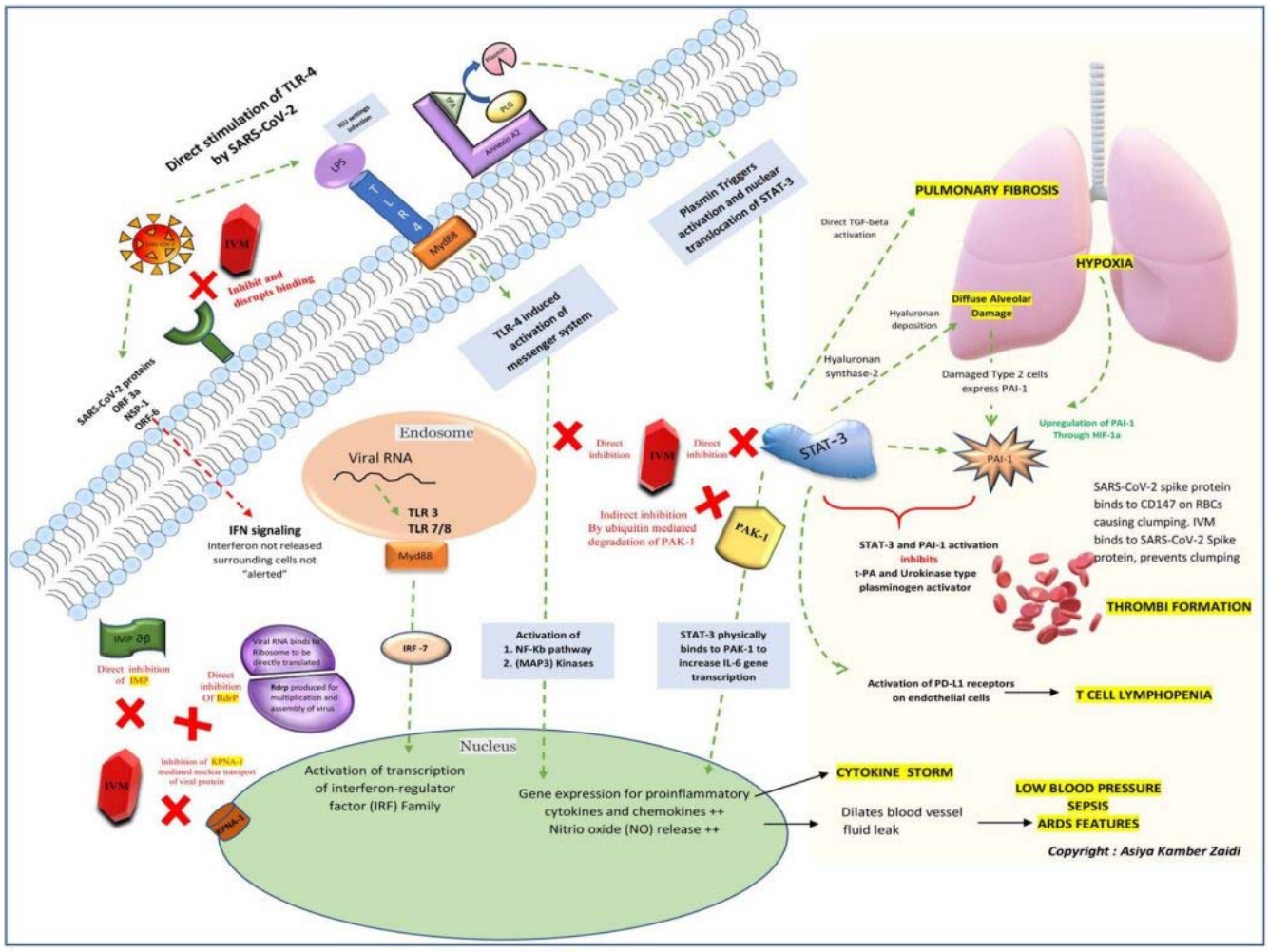
Ivermectin is not just "gum in the works" it's a kind of Swiss-knife-Velcro-tool — the most sticky, most useful, lock-and-key anti-viral.

With so many mechanisms of action, it's difficult for the virus to outsmart ivermectin and mutate around multiple blocks at once. We needed a three-drug-antiviral-cocktail to beat AIDS, but Ivermectin is an anti-viral cocktail all by itself.

Two researchers in Italy, Asiya Kamber Zaidi and Puya Dehgani-Mobaraki, published a paper detailing the 20 different levels of action. It's quite the marvel, a*nd it came out in May 2021*. (Don't our Chief Health Officers read these papers?)

Ivermectin is the new penicillin

Penicillin changed the world. Imagine if they had banned it?



Zaidi, Mechanisms of Action, Ivermectin, SARS-2, Covid-19 (See below for the caption with all the acronyms listed in detail.)

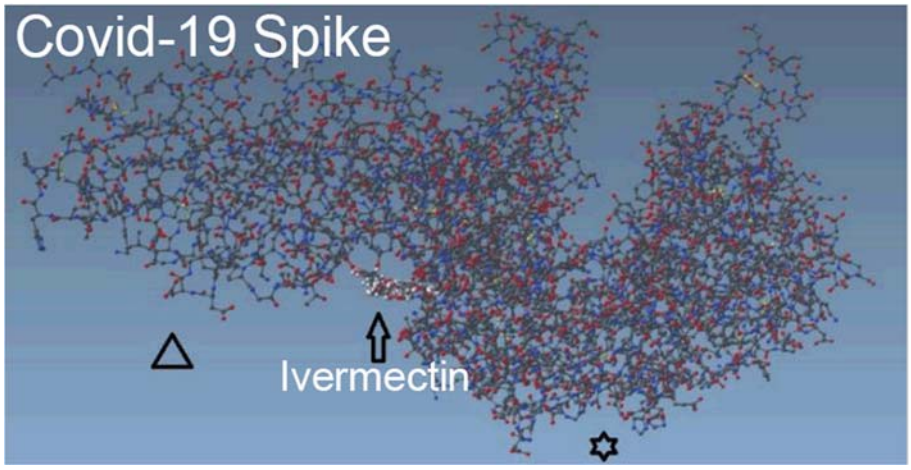
As the researchers say, "*The probability that an ineffective treatment generated results as positive for the 55 studies to date is estimated to be 1 in 23 trillion (p = 0.000000000000043)".*

Three ways to stop that virus getting in:

Ivermectin binds to the spike (at leucine 91), but it also binds to our ACE2 receptors as well (at histidine 378). It clogs up the lock-and-key from both ends, and when compared to Remdesivir and hydroxychloroquine, ivermectin bound more strongly to the spike than any of them.

"The free binding energy of the spike protein (open) was higher in Ivermectin (−398.536 kJ/mol) than remdesivir (−232.973 kJ/mol)." (Ewaes 2021)

In this case "higher" means more negative. The higher it is, the more strongly something binds. Negative binding energies mean that binding is spontaneous, and doesn't need an external energy source.



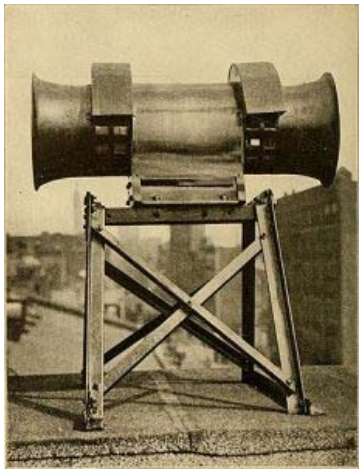
From Lehrer et al

Ivermectin also binds to TMPRSS2 — it's not a celebrity molecule like ACE2 — perhaps because someone didn't think through the PR campaign and call it "Empress2" or something pronounceable — but it is just as important apparently as ACE2. It seems SARS-2 can't get into cells which have ACE2 on the surface but *don't also have the TMPRSS2 enzym*e there as well (Parmar 2021). Think of TMPRSS2 as a pair of secateurs wandering around the cell surface that need to prune the Covid spike before it can use ACE2 to get into a cell. TMPRSS2 is the not so catchy name for *Transmembrane serine protease 2*.

Ivermectin also had the highest binding affinity for TMPRSS2. By binding so well to all three — the spike, the ACE2 receptor and the TMPRSS2 secateurs that prune or prime the spike, ivermectin makes it much harder for the virus to get inside a cell.

Protecting the cell nucleus

Once inside a cell, the virus gains access to most resources and tools it needs to produce "baby viruses", but there's much more strategy to this war than just a hijacking. Some viral proteins will be sent like trojan gifts to get inside the cell nucleus — which is effectively the command centre. To get through the locked "gates" into the nucleus, these proteins must get tagged by two labels called importin-α and importin-β — they mark "the cargo" as something headed for the nucleus. But ivermectin also binds to importin-α, competing with it for spots, and again foiling the virus, clogging up the system and making it hard for SARS2 to send these proteins through the gates.



This is especially important because the nucleus will send out warning signals to other cells — and the viral proteins aim to stop that alarm system being triggered.

Ivermectin helps cells sound the alarm

1919

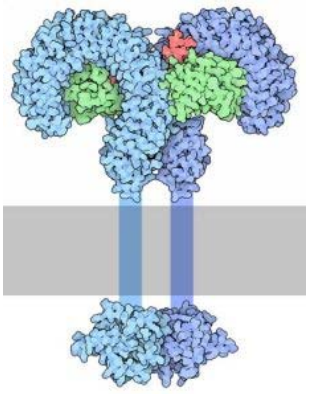
One of the first cytokines or messengers that a cell-under-siege sends out is called *interferon* (these names have a kind of Star Trek feeling, don't they?). Interferon works like an air raid siren. When it reaches other cells, it triggers an array of downstream effects. Cells ramp up their wartime defences, like for example, making particular enzymes and immune markers they'll need. But they also slow down the factories and machinery within them that make proteins. These are the same factories the virus wants to hijack and run at high speed to produce its own weapons and baby viruses. In

effect, cells are sabotaging their own infrastructure temporarily, to buy time. Some white blood cells called natural killer cells, also respond to interferon. It's a big deal.

This is such an important advantage for the virus there are at least three SARS proteins that antagonise or work against the interferon signalling system. If the virus can keep infected cells from releasing interferon, it can multiply unhindered for longer. This is all occurring during the early asymptomatic phase. Indeed, the interferon cascade will cause many of the symptoms that tell us we're coming down with something — like the fever, the aches, and the "flu-like malaise". Viruses that can slow this process can stop us feeling sick and keep us on our feet — unwittingly shedding baby viruses to infect the guys in the office or the kids at school.

The delay in interferon production not only helps the virus multiply and spread, but also increases the proinflammatory cytokines that cause so much trouble later.

Ivermectin is a multipronged anti-inflammatory

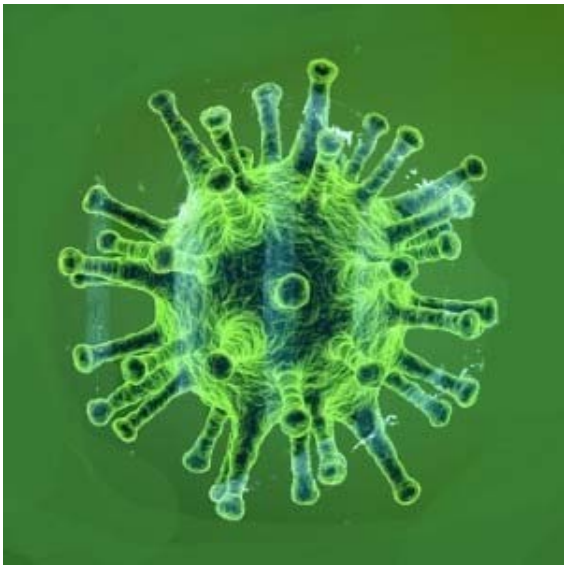


TLR4, Toll like receptor 4, by David Goodsell

The Covid virus isn't the only virus that attacks our interferon signally system, though it is a real hallmark of SARS-2, and ultimately the virus wreaks havoc with cytokines on many levels. Luckily ivermectin also works on several parts of the immune network and mostly the effect appears to be to slow down the key amplifiers that tend to run off the rails in bad Covid infection. Sorry, immunology is acroynm-hell, so bear with me, you'll get some idea of just how many pathways are affected. For starters, ivermectin slows down the Toll- like-Receptor-4 (TLR4) – these are ancient guards that have been around for a long time. They watch out for signs of spare parts of both bacteria and viruses and even just chemicals that are bad, and have a "pivotal role as an amplifier". We need our TLR4, we just don't want it to get "stuck on".

Strap yourself in, there is so much more. Ivermectin also blocks the NF-κB pathway (*Nuclear Factor-κB*). It suppresses the Akt/mTOR signalling, which inhibits PAK1 which reduces STAT3 and IL-6. STAT3 induces C-reactive protein (or CRP), so less STAT3 means less CRP. These are big names in the world of immunology. Your doctor measures your CRP as a sign of inflammation. People interested in living longer talk about the mTOR system — it's a is a kind of master controller for the whole cell cycle. Meanwhile IL-6, or interleukin 6 is another messenger that goes "inflammatory" in diseases like diabetes, depression, Alzheimers, and atherosclerosis. Obviously, it's better to face Covid without having "raised inflammatory markers" at the start.

Stopping at least one kind of coagulation



Because ivermectin binds to the virus spike at the right point it stops the virus sticking to the CD147 receptors of red blood cells. Each virus has about 100 spikes, so we can imagine how a swarm of viruses would work like a kind of malevolent velcro to agglomerate red blood cells into blobs that can't pass through blood vessels. There are lot of other ways blood can clot, but ivermectin smooths this form.

The safety tests have already been done

If ivermectin was a new drug discovery, and we read this paper, we might be spooked that ivermectin is so intimately and intricately involved with our core biochemistry. Wise researchers might warn that it may have significant unpredictable side effects and we should research it carefully — but most of those tests have already been done. Thanks to 30 years of mass human use with 3.8 billion doses we are aware there are only a few situations where ivermectin is dangerous, and doctors know all about that. People can still do damage through overdosing. Doses always matter. Ivermectin can bind to our GABA receptors if it can get across the blood brain barrier. In normal healthy people the blood-brain-barrier is intact and the drug is actively excluded. Doctors should be free to prescribe this "off label".

No leaky vaccine should be used without an antiviral back up.

Currently, infected people are generating nastier variants because the vaccines are leaky — vaccines reduce the severity (at least for some months) but they don't stop people shedding and transmitting the virus. We risk generating more deadly forms of Covid — just as we have unwittingly generated more deadly forms of Marek's disease in domestic chickens by giving them leaky vaccines for the last 50 years.

All of this could stop, and *all of this was known months ago.*

*Immunology is alphabet soup. If I have vastly oversimplified, I trust commenters will correct me.

The editors objections:

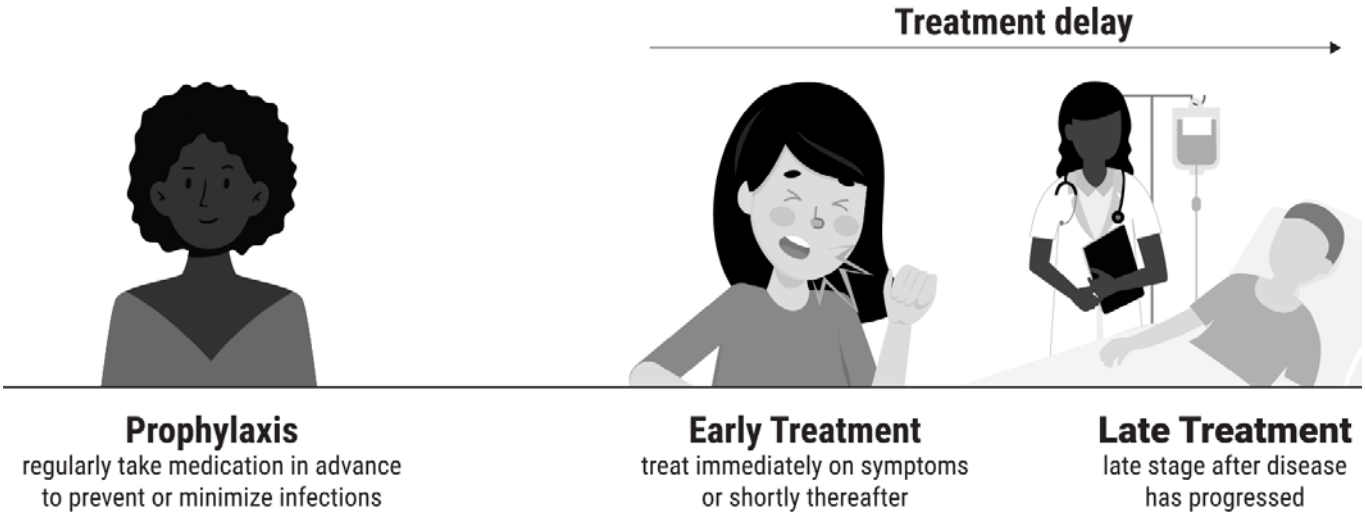
The Editor-in-Chief has retracted this article. Following publication, concerns were raised regarding the methodology and the conclusions of this review article. Postpublication review confirmed that ***while the review article appropriately describes the mechanism of action of ivermectin, the cited sources do not appear to show that there is clear clinical evidence of the effect of ivermectin for the treatment of SARS-CoV-2.*** *The Editor-in-Chief therefore no longer has confidence in the reliability of this review article. None of the authors agree to this retraction. The online version of this article contains the full text of the retracted article as Supplementary Information.*

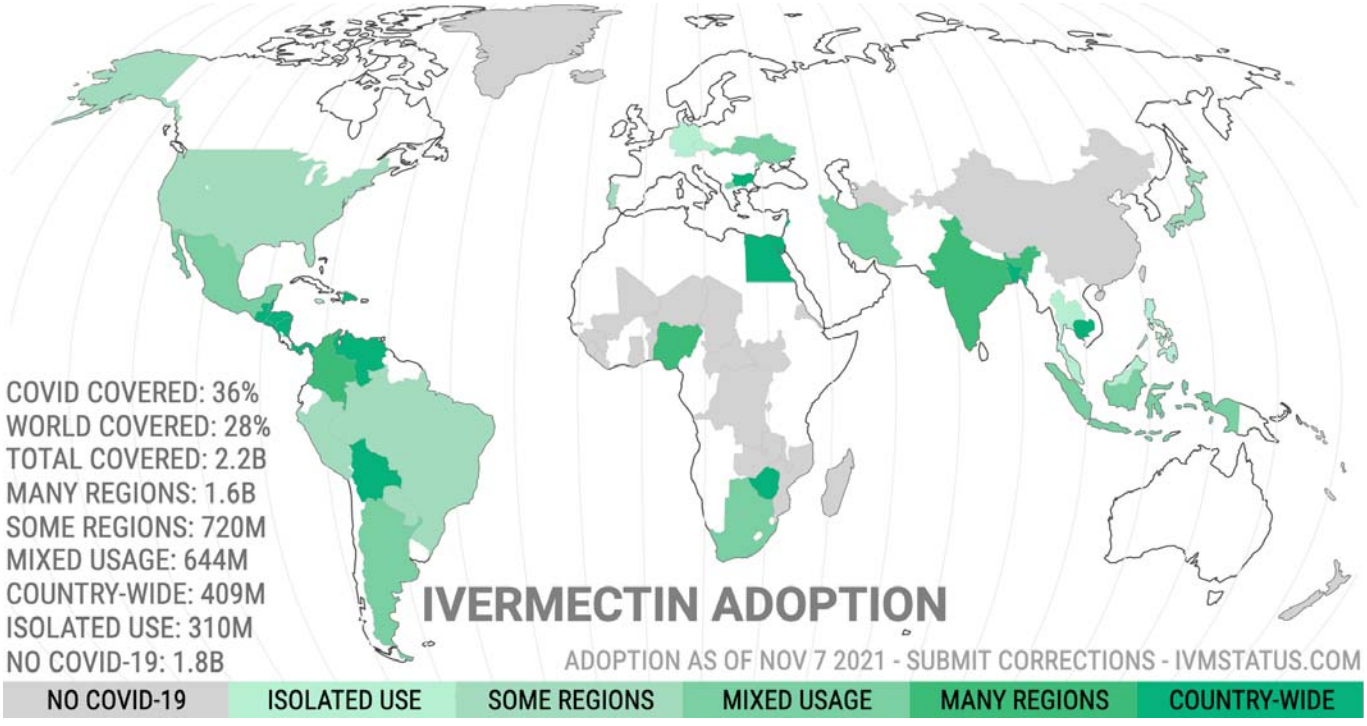
50 Studies are never enough. The article cites: real-time meta analysis of 52 studies listed at Ivmmeta.com. 2021 [on 2 May 2021]. Available from: https://ivmmeta.com/.

There are 65 studies there now.

Ivermectin for COVID-19: real-time meta-analysis of 65 studies

https://ivmmeta.com/

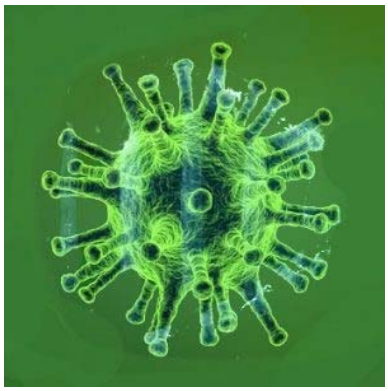




NOTE: Consult your professional health care providers and medical doctors.

UK Study finds Covid spreads just as easily from infected people who are Vaccinated

https://joannenova.com.au/2021/10/uk-study-finds-covid-spreads-just-as-easily-from-the-vaccinated/print/
Posted By *Jo Nova* on October 31, 2021 @ 12:38 pm In Health,Medicine,Microbiology



A new study shows vaccinated people are about 40% less likely to catch Covid, but *if or when they do catch it* they pose the same risk to the people close to them regardless of their vaccination status.

The study also confirmed that **vaccinated immunity was falling within three months of vaccination.** Presumably, if a vaccinated person is 40% less likely to catch Covid in the first place, then being vaccinated will reduce the odds of bringing the SARS virus home on any given day. But given that protection wanes so quickly and Covid has such a high exponential rate of spread, a temporary 40% reduction of the risk of catching the virus is not game-changing.

Relying on vaccination as the sole magic tool to suppress Covid is a fantasy that suits Big Pharma but not The People. And the Big Bad Risk of nastier variants coming from these super leaky vaccinees doesn't even get a mention. Read the post on the dark vaccine-induced evolution of Marek's disease in chickens. The arms race generated by 50 years of leaky-vaxxes turned a 1% killer into a 100% killer. We should not be mass vaccinating with a leaky vaccine unless we use an antiviral as well.

The Imperial College study shows that draconian rules isolating the unvaccinated from the vaccinated are not medically justified. Put another way, an unvaccinated person *infected* with Covid is no more likely to spread the virus than a vaccinated person.

The Imperial College study followed 621 people, and was unusually detailed in measuring the load curves of viral titres as they rise and fall. They found that when infected, both the vaxxed and unvaxxed reached similar peak levels of virus, which supports the idea that they are both just as infectious.

The Urgent need for Early Treatment

By measuring viral loads daily the Imperial College team confirmed that the initial rise of the virus is extraordinarily rapid for the first three days until it peaks. They also found that the early replication rate of the virus goes on to determine the trajectory of the whole infection. So action in the first few days is imperative. People who had the fastest rise and highest peaks also had the longest declines. It seems that whatever it is that slowed the infection in some people in the early days also helped to clear the virus faster. The authors don't expand on this, but many other studies show early treatment, and especially prophylactic treatment is the most useful.

It is madness to send people home without an early treatment kit, and madness not to give that kit to all the household contacts to use *before* they get infected. That was the extremely successful tactic used in Uttar Pradesh which largely eliminated the virus.

SPECTATOR | AUSTRALIA

Just the facts: coronavirus in Australia by the numbers – updated

Luke Massey 8 November 2021

https://spectator.com.au/2021/11/just-the-facts-coronavirus-in-australia-by-the-numbers-updated/

Notes: The data below is generally current as at 4 November 2021 however there may be some minor discrepancies due to jurisdictional reporting methods and timeframes etc. A key source of information for this article is the Australian Government Department of Health Coronavirus (COVID-19) case numbers and statistics website, which is updated daily and presents the statistics as a snapshot at a particular point in time. Information from this source used in this article was taken from 4 November 2021. For comparison purposes some reported and referenced raw data has been extrapolated to calculate averages and percentages.

Coronavirus in Australia – the official statistics as at 4 November 2021

Age group	Cases by age group	Combined total cases	% of overall case numbers	Deaths per age group	Total deaths	% of overall deaths by age group	CFR for age group	Overall CFR
0-9	23405	23405	13.45%	0	0	0%	0%	0%
10-19	25932	49337	14.9%	2	2	0.11%	0.007%	0.004%
20-29	35830	85167	20.59%	9	11	0.51%	0.03%	0.01%
30-39	30573	115740	17.57%	15	26	0.84%	0.05%	0.02%
40-49	21571	137311	12.4%	35	61	1.97%	0.16%	0.04%
50-59	16703	154014	9.6%	98	159	5.51%	0.59%	0.1%
60-69	10050	164064	5.78%	180	339	10.12%	1.79%	0.21%
70-79	5408	169472	3.11%	377	716	21.19%	6.97%	0.42%
80-89	3228	172700	1.86%	641	1357	36.03%	19.86%	0.79%
90+	1306	174006	0.75%	422	1779	23.72%	32.31%	1.02%
Aged care subset	3163			825			26.08%	
Total outside of aged care	170843			954			0.56%	

CFR – Case Fatality Rate **Coronavirus being Covid-19**

Setting the scene

- Australia has a population of approximately 25,780,000.
- The average life expectancy in Australia is 82.8.
- Covid-19 arrived in Australia in early 2020 and we have now had more than 18 months of first-hand insight into its health effects and impact on the hospital system.
- The vast majority of Covid-19 cases recover from the disease without clinical intervention.

Demographics and mortality risk of Covid-19 in Australia

The average age of death from Covid-19 in Australia (you would think an important statistic to identify which categories are at greater risk of mortality) is almost impossible to find and is not published by the Federal or State Governments as part of their routine reporting. However, it has previously been reported as approximately 85. The median age at death from Covid-19 in Australia is approximately 84.

The official Federal Government Covid-19 statistics current as at 4 November 2021 show:

- The overall case fatality rate (CFR) for Covid-19 in Australia is approximately 1.01% (1,781 deaths out of 175,813 cases). This is less than the CFR in other developed countries including the USA, UK, France and Spain.
- The vast majority (78.91%) of people diagnosed with Covid-19 in Australia are under 50 but they account for only 3.43% of all Covid-19 deaths. The CFR for Covid-19 in Australians aged under 50 is 0.04% (or 61 out of approximately 137,311).
- Out of the more than 23,000 cases in people aged under 10 there have been no deaths recorded.
- The under 20 age group accounts for more than a quarter (28.35%) of all cases. This age group has a CFR of 0.004%.
- The under 30 age group accounts for almost half (48.94%) of all cases but only 0.62% of all Covid-19 related deaths. This age group has a CFR of 0.01%.
- The under 40 age group accounts for 66.51% of all cases. This age group has a CFR of 0.02%.
- The under 50 age group accounts for more than three quarters (78.91%) of all cases. This age group has a CFR of 0.04%.
- The under 60 age group accounts for 88.51% of all cases. This age group has a CFR of 0.1%.
- The under 70 age group accounts for 94.29% of all cases. This age group has a CFR of 0.2%.
- The over 70 age group accounts for only 5.71% of all Covid-19 cases but 80.94% of all Covid-19 deaths.
- Aged Care cases account for only 1.82% of all Covid-19 cases but almost half (46.37%) of all Covid-19 deaths

The severity of disease and case fatality rate generally increases according to increasing age, e.g. the older you are the more seriously it is likely to affect you.

- The majority of deaths in Australia overall, like other developed countries, occur among older people. Sixty-six per cent of deaths registered in Australia in 2019 were among people aged 75 or over. The current statistics on Covid-19 in Australia reflect this same trend.

The official Federal Government Covid-19 statistics current as at 4 November 2021 reveal:

- Approximately 46% of all Covid-19 deaths recorded in Australia have occurred in aged care. An aged care home (sometimes known as a nursing home or residential aged care facility) is for older people who can no longer live at home and need ongoing help with everyday tasks or health care.
- Out of 1,306 cases of people aged over 90 who have tested positive to Covid-19, 884 have survived. This means that those aged over 90 have a statistical chance of over 65% of overcoming Covid-19.
- Outside of aged care the overall CFR for Covid-19 in Australia is 0.56%. If you are not an aged care resident you have a chance of approximately 99.44% of surviving a Covid-19 infection.
- In 2021 there have been 147,388 positive Covid-19 cases in Australia and 872 recorded deaths in Covid-19 positive patients. This equates to a CFR in Australia in 2021 of 0.59%.

- The current hospitalisation rate for Covid-19 cases in Australia as at 27 October is 4.66% (or 978 out of 20,975). The current ICU admission rate for Covid-19 in Australia is 0.86% (or 180 out of 20,975).

The "Delta wave" struck Australia from roughly 1 July 2021

- Since then, there have been 145,129 Covid-19 cases and 871 deaths. This equates to a CFR of 0.6%. This is significantly lower than the overall Covid-19 CFR of 2.97% prior to the "Delta wave" demonstrating that although it is more infectious it is far less deadly.
- Much has been reported on the "Delta wave" being a greater threat to younger people when compared to the original Covid-19 strain. Yet while the number of positive Covid-19 cases recorded in the under 20 age category has exploded since the arrival of the Delta variant (from 4,209 to 49,337) there have been only two deaths recorded as due to Covid-19 in this age group, although the actual cause of death in one of these cases has been disputed by the hospital, who stated that Covid was not the cause of death.
- The most recent Communicable Diseases Intelligence Report reveals that in 2021 the ICU admission rate for Covid-19 positive cases aged under 18 is 0.09%. This is significantly less than the overall ICU admission rates. This report also notes that cases may be hospitalised for reasons other than clinical COVID-19 related care.

Some comparisons with influenza

On a purely statistical level the impact of Covid-19 has been substantially offset by the sudden and almost total disappearance of influenza in Australia, which in the past 5 years has seen hundreds of thousands of cases, tens of thousands of hospitalisations and thousands of deaths. After more than 18 months of the pandemic in Australia it appears Covid-19 is filling that void.

- In Australia in 2017 there were over 200,000 cases of influenza, more than 10,000 hospitalisations and over 1,000 deaths.
- In Australia in 2019 there were over 300,000 cases of influenza, approximately 4000 hospitalisations and over 900 deaths.
- In both of these years, there were no restrictions or lockdowns.

The state of Queensland, Australia, specific information

- In Queensland since the beginning of the pandemic there have been 2,092 Covid-19 cases and 7 deaths.
- In Queensland there have been approximately 269,000 people subjected to Covid-19 related quarantine notices. Over 99% of people subjected to a Covid-19 related quarantine notices have been found to be negative for Covid-19.
- **In 2017** in Queensland there were 264 confirmed deaths from influenza, with 58,616 lab-confirmed cases of the disease officially recorded. This equates to a CFR of 0.47%. **The number of deaths attributed to influenza in Queensland in 2017 is 37 times the amount of deaths from Covid-19 in Queensland since the beginning of the pandemic. However, there were no restrictions or lockdowns.**
- **In 2019** in Queensland there were again 264 confirmed deaths from influenza, with 68,148 lab-confirmed cases of the disease officially recorded. This equates to a CFR of 0.38%. The number of deaths attributed to influenza in Queensland in **2019 is 37 times** the amount of deaths from Covid-19 in Queensland since the beginning of the pandemic. However, there were no restrictions or lockdowns.

- In Queensland in 2020 there were 6047 confirmed cases of influenza. 309 were admitted to hospital and 28 of these were admitted to ICU. There were 20 confirmed deaths due to influenza, more than 3 times the amount of Covid-19 related deaths (6).
- The overall annual averages for influenza in Queensland from 2017 to 2020 inclusive were:
- More than 30,000 cases
- More than 2,500 hospitalisations
- Approximately 150 deaths
- A CFR of 0.36%
- **In Queensland it is clear that Covid-19 has had much less of an impact on the health of Queenslanders than an average influenza "season" and significantly less burden on the Queensland hospital system, which is nevertheless reportedly under significant pressure despite virtually no Covid-19 or influenza cases (along with Western Australia and the Northern Territory).**

National statistics on deaths

- The Australian Bureau of Statistics records show there were 71,503 deaths that occurred between January and July 2021 and were registered by 31 August (including 6,257 deaths from respiratory disease). This is 4,199 deaths (6.2%) more than the 2015-19 average and 1,766 (2.5%) more than 2020. Yet only one of these deaths was due to Covid-19.
- In 2020 there were 141,116 deaths recorded in Australia. Only 0.64% (909) of these were Covid-19 related.
- In 2020 there was a decrease in mortality in Australia. Both males and females recorded the lowest standardised death rates (SDR) in the last decade. The 6% decrease in the SDR between 2019 and 2020 is the largest single-year change in the last 10 years.
- Tragically, 3,139 people died by suicide in 2020 (more than three times the number of Covid-19 deaths in the same period) making suicide the 15th leading cause of death. Covid-19 was the 38th leading cause of death.
- Covid-19 has had no negative impact on the overall average number of deaths in Australia and the average age at death.

Covid-19 vaccination information

- The Australian Federal Government has invested over $5 billion dollars of taxpayer money into 5 separate agreements to secure more than 195 million doses of Covid-19 vaccines. This is enough for every single Australian regardless of age to receive more than six doses.
- The World Health Organisation (WHO) states that most people diagnosed with Covid-19 have mild to moderate symptoms and recover without medical treatment. The WHO lists common symptoms of Covid-19 to include fever, dry cough, tiredness, aches and pains, sore throat and headaches.
- As at 31 October 2021 (the most current information from the Therapeutic Goods Administration (TGA)) there had been just over 76,000 reported adverse events following receipt of a Covid-19 vaccine. Very common side effects from the Covid-19 vaccines are similar to those experienced by symptomatic Covid-19 cases including tiredness, headache, muscle pain, fever and chills, joint pain and nausea. Similarly to Covid-19 positive cases, most people who have an adverse reaction to the Covid-19 vaccine recover without medical treatment.
- The TGA has however received 595 reports of deaths following Covid-19 vaccinations. The TGA acknowledges that as adverse event reports from consumers and health professionals are voluntary, there is under-reporting by these groups of adverse events related to therapeutic goods in Australia.

- As at 21 October 2021 there had been 383 reported deaths following receipt of the Astrazeneca vaccine. Eight of these people are confirmed to have died due to adverse reactions from the Astrazeneca Covid-19 vaccine.
- As at 31 October 2021 there had been 47 people treated in ICU for confirmed Thrombosis with Thrombocytopenia (TTS) following receipt of the Astrazeneca vaccine.
- There have been 158 confirmed and probable cases of (TTS) as a result of the Astrazeneca vaccine. There have been 141 reports of Guillain-Barre Syndrome following the Astrazeneca vaccine. To 31 October 2021, the TGA has received 87 reports of suspected Immune Thrombocytopenia (ITP) following vaccination with the Astrazeneca vaccine that could be linked to vaccination and no other obvious cause was identified.
- As at 21 October 2021 there had been 212 reported deaths following receipt of the Pfizer vaccine.
- To 31 October 2021, the TGA had received 446 reports of suspected myocarditis alone or in combination with pericarditis and 1124 reports of suspected pericarditis alone following the Pfizer and Moderna vaccine.

Data from NSW from the period between 16 June and 23 October provided the following information regarding the vaccination status of confirmed Covid-19 cases and what impact this had on the case outcomes:

- There were a total of 67,946 positive Covid-19 cases during this period and 501 deaths equating to an overall CFR of 0.74%. (For comparison there were 102,880 confirmed influenza cases and 653 influenza linked deaths in NSW in 2017, and a CFR of 0.63%).
- 56,919 (or approximately 84.09%) of the Covid-19 cases were in people who hadn't received a Covid-19 vaccine. This includes 12,544 cases in people younger than 12 years old who were ineligible to be vaccinated. Unvaccinated people accounted for 72.14% of all Covid-19 related deaths (or 360 out of 499) and had a CFR of 0.63% (360 deaths out of 56,919 cases).
- Approximately 15.91% of the Covid-19 cases (10,772) were in people who had received either one or two doses of a Covid-19 vaccine. In this cohort there were 128 deaths recorded equating to a CFR of 1.19%. This cohort of vaccinated, although only 15.91% of the overall case numbers, accounted for approximately 25.65% of all recorded Covid-19 related deaths in this period.
- The hospital admission rate of those who had received either one or two Covid-19 vaccine doses but still ended up contracting the virus was 12.87% (1,386 out of 10,772) as opposed to 15.33% (8,726 out of 56,919) in those who hadn't received a vaccine.
- There were 129 people who received either one or two Covid-19 vaccine doses but ended up contracting the virus anyway and who were subsequently admitted to ICU. The ICU admission rate of those who had received either one or two Covid-19 vaccine doses but ended up contracting the virus was 1.2% as opposed to 1.93% in those who hadn't received a vaccine.
- Since 16 June, most positive Covid-19 cases in healthcare workers associated with the current NSW outbreak have been infected in the community and outside of a healthcare setting (842 out of 1010 or 83%).
- Of the 1010 healthcare workers that have been diagnosed with Covid-19 in the current outbreak, 416 (41%) have been fully vaccinated and 109 (11%) have been partially vaccinated. That equates to 52% of Covid-19 cases in healthcare workers having received either one or two doses of a Covid-19 vaccine.
- Since 16 June 2021, there have been 311 cases reported in aged care workers. Of these, 63 people (20%) had received one vaccine dose, and 119 people (38%) were fully vaccinated. That equates to 58% of Covid-19 cases in aged care workers having received either one or two doses of a Covid-19 vaccine.

- Since 16 June 2021 there have been approximately 12,544 Covid-19 cases in children under 11 years old. None of these people were vaccinated and there were no deaths recorded in this age group.
- Since 16 June 2021, 19.53% of Covid-19 cases aged older than 11 years (e.g. eligible to be vaccinated) had received either one or two Covid-19 vaccine doses.
- Approximately 80% of all Covid-19 related deaths in NSW were in people aged over 60.
- The under 40 age group accounted for about 69% of all Covid-19 cases but only 3.41% of all Covid-19 related deaths.
- This data from NSW indicates that the vaccine reduces the likelihood of contracting Covid-19. Nevertheless, if you are vaccinated but later contract Covid-19 you are only slightly less likely to be hospitalised or admitted to ICU than those who aren't vaccinated. Interestingly **those who received either one or two Covid-19 vaccine doses but contracted Covid-19 anyway, had almost double the CFR (1.19%) of those who were unvaccinated (0.63%).**
- The under 30 age group in Australia is at virtually no risk of death from Covid-19 with the virus having a recorded CFR in this age group of only 0.01% out of approximately 85,000 confirmed cases. The CFR is even less in the under 20 age group which is the age group with the lowest vaccination rate.

Comment

A multitude of illnesses, diseases and injuries are prevalent in our community. These include many which are directly linked to activities which we are completely free to pursue such as drinking alcohol, smoking tobacco, consuming significant amounts of unhealthy foods, sunbaking, playing contact or extreme sports. These are personal decisions made with knowledge and acceptance of risk.

Covid-19 is not a death sentence. In Australia it has a case fatality rate of just over 1%, meaning that the vast majority of those who test positive will not die. Covid-19 is a virus that poses risks specifically to the elderly and those with existing comorbidities, and extremely negligible risk to those below 60. The vast majority of those who have died with Covid-19 in Australia are over 80 years old and have pre-existing illnesses.

Sensible precautions should be directed towards minimising the risks to those in the at-risk categories. If others outside of those at risk categories also wish to engage in the same precautions then they should be free to do so. Otherwise, Australians should be free to go about their lives without the significant burden of extreme wide-ranging restrictions. All Australians should be free to make an informed decision about how to manage the risks to their health and safety arising from Covid-19. We should especially be free to decide whether or not to receive a Covid-19 vaccination without coercion or the threat of being stripped of our jobs and ability to earn a livelihood for ourselves and our families.

New Feelings Way: learning how to live true to ourselves by living true to our feelings.

The Golden rule is: Never interfere with another's will.