DR. HERMAN J. EDELING

NEUROSURGEON / MEDICO-LEGAL PRACTITIONER / MEDIATOR

M.B.,B.Ch.(Wits) : F.C.S.(S.A.)(Neuro) : HPCSA Reg No: MP 180408 : PR 2401002

Consulting Rooms
85 St Patrick Road
Houghton
Johannesburg.

Postal Address
PO Box 1158
Houghton
2041

Gauteng - Republic of South Africa

Telephone : 011-648-5101

Email : edeling@emlct.com

COVID-19 "VACCINE" MANDATES – MEDICAL ANALYSIS

With Reference to Criteria Specified in

Section 36 of the Bill of Rights of the Constitution of South Africa

INTRODUCTORY COMMENTS AND BACKGROUND

a) Evidence has been requested in relation to the factual and/or scientific justification for Covid-19 "vaccine" mandates. The following analysis is based on investigation of available evidence that is relevant to this question. The term SARS-CoV-2 refers to the virus that causes illness in humans, whereas the term Covid-19 refers to the illness produced by the SARS-CoV-2 virus.

b) There is a well-known official Covid-19 narrative, which includes claims, opinions and advice by politicians and medical/scientific experts. It is evident that many, if not all, of these experts hold appointments with the state, statutory organizations, universities, professional associations and/or the pharmaceutical industry. This narrative has been widely publicized in the mainstream media, and more recently also propagated by officials in business and education.

c) On 10 August 2021 concerns regarding the official Covid-19 narrative were communicated in an open letter to President Ramaphosa (Ref 1 - Letter to President) for the attention also of the Minister of Health and other relevant members of the national and provincial executives, as well as representatives of relevant institutions such as public health departments, universities, etc.

i) In the letter, which has been supported online by more than 4000 people (Ref 2 - Supporters' Comments) we pleaded with the President inter alia to track and publish daily statistics on the numbers (and proportions) of vaccinated individuals who (a) have any serious health issue; (b) have been admitted to hospital for any reason; and (c) who have died for any reason; as well as (d) the number (and proportion) of hospitalized individuals who have been vaccinated.

ii) On 7 September 2021, not having received any response from the President or the Minister of Health to the original submission or the subsequent submissions on 17 August 2021 and 26 August 2021, the letter was again submitted to the President and the Minister of health, and a further open letter was addressed to the Minister of Health (Ref 3 - Letter to Minister).

iii) Notwithstanding the importance of the pleas in these letters to the health of South Africans, and notwithstanding the fact that they were based on multiple referenced sources of relevant factual information, no response has been received to date from the President, the Minister of Health or any official acting on either of their behalf.

d) On 21 September 2021, in an attempt to properly understand the rationale and basis of various decisions that had been taken by the State in relation to Covid-19, a request for information in terms of the PAIA Act was submitted to the Minister of Health on behalf of the ACDP (African Christian Democratic Party).

i) The requester expressed the wish inter alia to be reasonably informed of all important scientific and factual information to either responsibly support or responsibly oppose “vaccination” on an individual and on a collective basis; and in order to take an informed decision on whether to submit to “vaccination” or not, and to responsibly inform others of the risks and benefits.

ii) Requested information included inter alia evidential material upon which the State had concluded that the Covid-19 “vaccines” that had been approved for emergency use authorisation:

(1) are efficacious or sufficiently efficacious to prevent contraction of SARS-CoV-2 virus, prevent transmission of the virus to others, lessen the burden of disease of those who do contract Covid-19, or to prevent or lessen the risk of death;

(2) are safe or sufficiently safe in the short, medium, and long-term.

iii) To date the requester has not been provided with the requested information.

e) On 8 October 2021 FTCSTN (Free the Children Save the Nation) NPC lodged an Appeal with SAHPRA (South African Health Products Regulatory Authority) in terms of Section 24A(1) of the Medicines and Related Substances Act, against authorisations granted by SAHPRA for the use of Covid 19 “vaccines” in children.

i) In the notice of appeal FTCSTN cited grounds of appeal which, in addition to the best interests and rights of children, provided reasons for their conclusion that there was no scientific, reasonable or rational reason for children to be “vaccinated” against the SARS-CoV-2 virus.

ii) On 25 October 2021, in preparation for a meeting with SAHPRA, FTCSTN wrote to SAHPRA requesting copies of the full and detailed approvals for the use of the “vaccines”, as well as supporting documentation.

iii) On 26 October 2021 FTCSTN met with SAHPRA in an attempt to resolve the appeal. SAHPRA failed to provide any factual, medical or scientific basis for the approvals against which FTCSTN head appealed, and the meeting failed to resolve the appeal.

iv) In subsequent correspondence SAHPRA refused to provide the requested information.

v) On 19 November 2021 FTCSTN wrote to the Minister of Health in terms of Section 24A (3) of the Medicines and Related Substances Act, formally requesting the Minister to establish an appeal committee to hear the appeal.

vi) To date the appeal committee has not been convened and the requested information has not been provided by SAHPRA.

f) Had the President or the Minister of Health or SAHPRA, or any officials acting on their behalf, responded to these pleas and provided the information that was requested, we would all have been in a good position to understand the benefits and risks of Covid-19 “vaccination” in South Africa, in which case litigation about Covid-19 “vaccine” mandates would probably be superfluous. In the absence of available South African statistics it has been necessary to rely on international statistics to understand these benefits and risks.

g) For clarity and coherence in this report, sections 1 to 5 include summaries of key elements of the official Covid-19 narrative, followed by researched facts, followed in turn by reasoned conclusions based on the facts. Active hyperlinks to references are provided.

h) In relation to Covid-19, the words “vaccine/s” and “vaccination” are deliberately referred to in quotation marks. The reason for this, as explained in our letter to the President, is that the Covid-19 “vaccines” that are in use in South Africa are in fact experimental genetic interventions. They are injections of synthetic viral genetic material, which are intended to program human cells to produce SARS-CoV-2 spike protein, i.e. a form of gene therapy. Furthermore, these Covid-19 “vaccines” do not comply with the traditional definition of vaccines. This being said, however, the analysis below applies irrespective of the naming convention.

i) The Covid-19 “vaccines” in current use in South Africa include the Pfizer, Moderna, Astra Zeneca and Johnson & Johnson products. The active substance of the Pfizer and Moderna “vaccines” is SARS-CoV-2 spike protein mRNA, which is protected in and carried into human cells by lipid nanoparticles. The active substance of the Astra Zeneca and Johnson & Johnson “vaccines” is SARS-CoV-2 spike protein DNA, which is attached to and carried into human cells by an inactive viral vector.

j) The mRNA or DNA in these Covid-19 “vaccines” exert their effect by programming human cells to produce SARS-CoV-2 spike protein. The intended purpose of producing SARS-CoV-2 spike protein is to stimulate the person’s immune system to produce antibodies to the SARS-CoV-2 spike protein, and thereby to protect against Covid 19 infection.

1. HOW IMPORTANT ARE COVID-19 "VACCINES" FOR THE HEALTH OF INDIVIDUALS AND THE HEALTH OF THE COMMUNITY?

1.1. **Official narrative:** *We are all at high risk of contracting Covid-19, which puts us at high risk of becoming ill, of being hospitalised, of being ventilated in ICU and of death. Covid-19 vaccination is therefore very important for the health of individuals and the health of the community.*

1.2. The evidence, however, finds:

1.2.1. The case numbers, as well as the hospitalization, ICU admission, ventilation and death numbers, on which these allegedly high risks are based, are artificially inflated.

1.2.1.1. The PCR tests, on which the published case-, hospitalisation-, ICU admission-, ventilation- and death numbers are based, yield false positive results, which are increased at higher test cycle rates. For example, individuals who are ill with influenza or other respiratory virus infections can be falsely diagnosed as "Covid-19 cases".

1.2.1.2. For these reasons the CDC has issued a "Lab Alert" stating that laboratories should discontinue the use of the existing PCR test and transition to another FDA-authorised Covid-19 test that is able to detect and differentiate between SARS-CoV-2 and influenza viruses (Ref 4 - CDC Lab Alert PCR) - (Ref 5 - Media Report - CDC Lab Alert PCR).

1.2.1.3. In the published Covid-19 statistics, even individuals who are not ill, but who have been exposed to, or who have recovered from, SARS-CoV-2, influenza or other respiratory viruses, are falsely diagnosed as "Covid-19 cases". According to medical terminology these individuals are not "cases" of anything as they are not ill.

1.2.1.3.1. By way of example, a "case" of influenza A or influenza B is diagnosed on the basis of clinical-, epidemiological- and laboratory criteria. A possible "influenza case" is classified as any person meeting the clinical criteria for an influenza-like illness; a probable "influenza case" is classified as any person meeting the clinical criteria and with an epidemiological link; and a confirmed "influenza case" is classified as any person meeting the clinical- and at least one of 4 laboratory criteria (Ref 6 - Case Definition Influenza). Note that the clinical criteria, i.e. illness, are required in each of the possible-, probable- and confirmed classification categories.

1.2.1.3.2. For the first time human beings are being classified as "cases" on the basis of a single laboratory criterion, without regard to any clinical criteria.

1.2.1.4. Doctors have expressed outrage at finding that deaths due to unrelated causes have been falsely certified as Covid-19 deaths, and that they themselves are pressurised to certify Covid-19 deaths where they know that the cause of death was not Covid-19.

1.2.2. Published infection fatality rates (IFRs) are very low in children and young adults. IFRs, which increase in the elderly, can be greatly reduced by safe and effective medical measures of prevention and treatment (see sections 4 and 5 below).

1.2.2.1. IFRs are estimated at 0.002% at age 10; 0.01% at age 25; 0.4% at age 55; 1.4% at age 65; 4.6% at age 75; and 15% at age 85 (Ref 7 - C-19 Fatality Age Specific Rates).

1.2.2.2. IFRs can be reduced by up to 75% with the use of appropriate early ambulatory multidrug therapy (e.g. from 1.4% to 0.35%) (Ref 8 - Early Ambulatory Multidrug Therapy).

1.2.3. The majority of South Africans are probably already immune to Covid-19.

1.2.3.1. As with all other infectious diseases, everybody who has survived Covid-19 has natural immunity to Covid-19.

1.2.3.2. On 1 July 2021, prior to the 3rd wave of Covid-19, the South African National Blood Service found antibodies to SARS-CoV-2 in 47% of blood donors (Ref 9 - SABTS Antibodies).

1.2.3.3. By December 2021 this proportion will of necessity be higher by virtue of all who contracted and survived Covid-19 in the 3rd wave and the commencement of the 4th wave.

1.2.3.4. In October 2021 it was reported that the chief actuary of Discovery had estimated that as many as 80% of South Africans may have had Covid-19 (Ref 10 - Discovery SA 80% C-19).

1.2.4. Natural immunity to Covid-19 is robust and long lasting.

1.2.4.1. Natural immunity includes the development of antibodies, B lymphocytes and T lymphocytes that recognise and react to all proteins of the virus, as opposed to the Covid-19 "vaccine" antibodies that only recognise and react to the spike protein of the virus (Ref 11 - SARS-CoV-2 T Cell Responses) - (Ref 12 - C-19 Natural v Vaccine Immunity) - (Ref 13 - C-19 Pre-Existing Immunity).

1.2.4.2. For the above reasons natural immunity is more effective than Covid-19 "vaccine" antibodies against mutated viruses, such as the Delta variant and Omicron variant.

1.2.4.3. In addition, by a process referred to as “cross-reactivity”, previously acquired immunity against other coronaviruses can provide immunity against the SARS-CoV-2 virus (Ref 14 - Cross Reactive CD4 T cells).

1.2.4.4. Whereas it is natural and necessary for antibody levels to decline after recovery from infection, natural immune responses include robust formation of immunological memory cells, which result in rapid and effective responses against subsequent encounters with the same antigen (Ref 15 - Immunological Memory Cells) - (Ref 16 - Natural Immunity Stronger & Longer Lasting).

1.2.4.5. Immunological memory cells provide long-lasting immunity (Ref 17 - Natural Immunity - Memory B & T Cells). Considering the role and function of immunological memory cells, and the duration of immunity to other known infectious diseases, natural immunity to Covid-19 may well be lifelong.

1.3. **Conclusion:** The risks associated with Covid-19 are considerably less than claimed. Development of effective and safe “vaccination” is considerably less important than claimed for the health of individuals and the health of the community.

2. ARE COVID-19 “VACCINES” EFFECTIVE? (HOW LIKELY IS IT THAT THEY WILL ACHIEVE THEIR PURPOSE?)

2.1. **Official narrative**. *The Covid-19 vaccines are effective at protecting individuals, and the community, from (a) transmitting the SARS-CoV-2 virus, (b) developing symptomatic Covid-19, (c) developing severe Covid-19 illness requiring hospitalisation, and (d) death from Covid-19.*

2.2. The evidence, however, finds:

2.2.1. Covid-19 “vaccination” causes transient immune suppression, that results in an increased susceptibility to infection and death, which persists for a number of weeks before the commencement of any benefit.

2.2.1.1. Statistics from 90 countries across the world, as found on Our World in Data Coronavirus Pandemic (Ref 18 - https://ourworldindata.org/coronavirus) (Ref 19 - Vaccination Covid Waves & Deaths) (Ref 20 - Vaccination Covid Surges Correlation) find that mass vaccination has been followed by surges of Covid-19 cases, as well as Covid-19 deaths.

2.2.1.2. “Vaccination” therefore results in a period of significantly increased risks for the individual and for the community, the results of which have been equivalent to “culling” of the elderly and most vulnerable members of the community.

2.2.1.3. For this reason, and long before the appearance of Covid-19, it has been known that it is irrational and contra-indicated to vaccinate during a pandemic.

2.2.2. Subsequent to the period of immune suppression, the Covid-19 "vaccines" fail to provide adequate protection from transmitting the SARS-CoV-2 virus or contracting Covid-19.

2.2.2.1. It is known that Covid-19 "vaccines" fail to provide immunity to Covid-19. Instructions provided by the WHO and other health authorities, that "vaccinated" persons should still employ nonpharmacological protective measures such as masking, social distancing etc., illustrate their belief that protection by "vaccination" against transmission is inadequate.

2.2.2.2. The WHO website (Ref 21 - https://www.who.int/) states inter alia: "*Getting vaccinated could save your life. COVID-19 vaccines provide strong protection against serious illness, hospitalization and death. There is also some evidence that being vaccinated will make it less likely that you will pass the virus on to others, which means your decision to get the vaccine also protects those around you. Even after getting vaccinated, keep taking precautions to protect yourself, family, friends and anyone else you may come into contact with. COVID-19 vaccines are highly effective, but some people will still get ill from COVID-19 after vaccination. There is also still a chance that you could also pass the virus on to others who are not vaccinated.*"

2.2.2.3. Considered in the light of real world statistics, it is evident that these statements of the WHO are unrealistically optimistic in favour of the effectiveness of Covid-19 "vaccines".

2.2.2.4. According to a study by among "vaccinated" healthcare workers in Vietnam, (Ref 22 - Transmission of Delta Variant - Vaccinated HCW) viral loads of SARS-CoV-2 Delta variant in fully "vaccinated" healthcare workers were 251 times higher than those of cases previously infected with older strains of SARS-CoV-2. The authors state inter alia:

2.2.2.4.1. "*We studied Oxford-AstraZeneca vaccine breakthrough infections associated with SARS-CoV-2 Delta variant among healthcare workers of a major hospital for infectious diseases in HCMC, Vietnam between 11th and 25th June 2021 (week 7 and 8 after the second dose).*"

2.2.2.4.2. "*Viral loads were 251 times higher than those in cases infected with old SARS-CoV-2 strains detected in Vietnam between March and April 2020.*"

2.2.2.4.3. "*Neutralizing antibody levels after vaccination and at diagnosis of the cases were lower than those in the matched uninfected controls. There was no correlation between vaccine-induced neutralizing antibody levels and viral loads or the development of symptoms.*"

2.2.2.4.4. "*Breakthrough Delta variant infections are associated with high viral loads, prolonged PCR positivity, and low levels of vaccine-induced neutralizing antibodies, explaining the transmission between the vaccinated people.*"

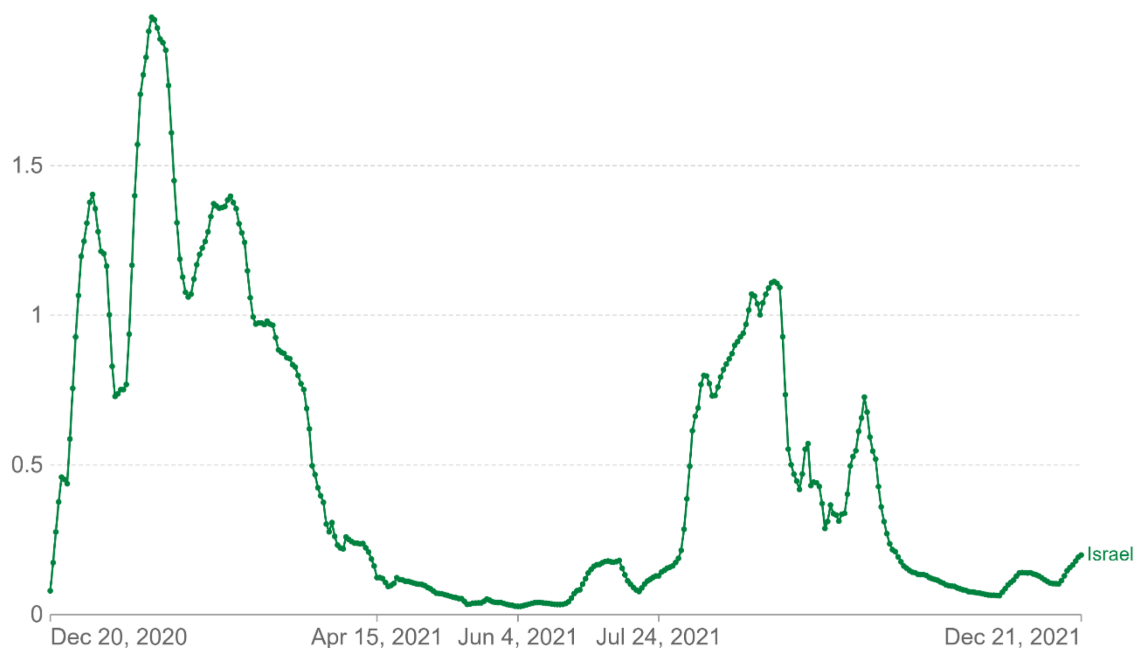
2.2.2.5. Commenting on this study in September 2021 (Ref 23 - Delta Transmission - Comment) Dr Peter McCullough stated inter alia: "*This is consistent with the observations in the U.S. from Farinholt and colleagues, and congruent with comments by the director of the Centres for Disease Control and Prevention conceding COVID-19 vaccines have failed to stop transmission of SARS-CoV-2*".

2.2.2.6. In September 2021 it was reported (Ref 24 - Israel Breakthrough Infections) that in Israel, which has effectively been a real world “laboratory” for Pfizer, Covid-19 infections had increased dramatically following “vaccination” of the majority of the population, that at that stage Israel had more Covid infections per capita than any country in the world.

2.2.2.7. According to Ref 25 - https://ourworldindata.org/covid-vaccinations, at which the following graph can be viewed and interrogated online, mass administration of vaccines in Israel commenced on 21 December 2020.

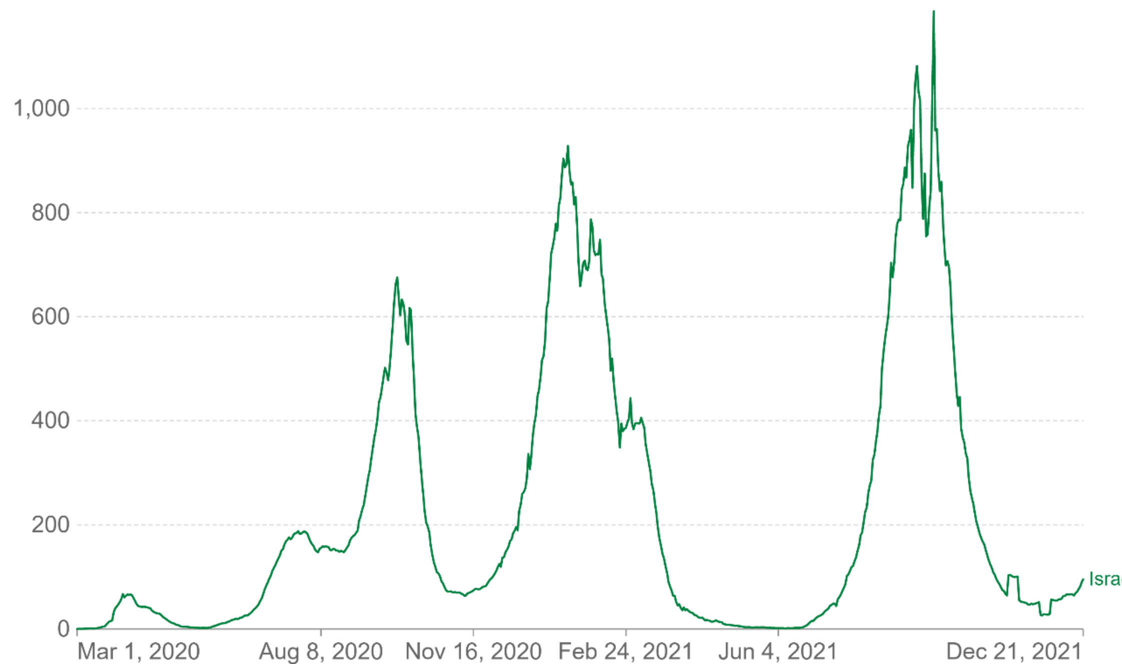
Daily COVID-19 vaccine doses administered per 100 people

Number of daily doses administered (rolling 7-day average), divided by the total population of the country. All doses, including boosters, are counted individually.



Source: Official data collated by Our World in Data – Last updated 22 December 2021, 08:10 (London time)
OurWorldInData.org/coronavirus • CC BY

2.2.2.8. According to Ref 26 - https://ourworldindata.org/covid-cases, at which the following graph can be viewed and interrogated online, the 1st wave of Covid-19 cases in Israel peaked on 27 September 2020 (prior to “vaccination”) with 675.49 cases per million people; the 2nd wave peaked on 17 January 2021 (weeks after the commencement of “vaccination”) with 928.24 cases per million people; and the 3rd wave peaked on 14 September 2021 (4 to 8 months after “vaccination”) with 1,186.82 cases per million people.



2.2.2.9. These successively increasing case numbers that followed Covid-19 “vaccination” are consistent with negative protection from transmission. Following “vaccination” of the majority of the population of Israel there was more community transmission of SARS-CoV-2 than before “vaccination”. According to these statistics a person who has been “vaccinated” has a greater capacity to transmit the SARS-CoV-2 virus to others than a person who has not been vaccinated.

2.2.2.10. These failures render any decision to mandate Covid-19 “vaccination” irrational, as the Covid-19 “vaccination” does not protect the community it is intended to protect.

2.2.3. At best Covid-19 “vaccination” protects the individual from (c) severe illness requiring hospitalization and (d) death, but this protection is limited in the following respects:

2.2.3.1. The onset of any Covid-19 “vaccine” protection is delayed until after the period of immune suppression (see above).

2.2.3.2. Covid-19 “vaccine” protection is limited to recognition of the spike protein of the SARS-CoV-2 virus, whereas natural immunity recognises all proteins of the virus (see above).

2.2.3.3. Covid-19 “vaccine” protection against mutated forms of the virus, such as the Delta variant, is poorer than protection against the original strain for which the “vaccines” have been programmed, whereas natural immunity against variants is robust and effective (see above).

2.2.3.4. The duration of Covid-19 “vaccine” protection wanes significantly by 6 months, as evidenced inter alia by the recommendations for “booster shots”, whereas natural immunity is long lasting (see above).

2.2.3.5. In summary, the claimed protection of Covid-19 “vaccination” against severe illness and death is limited in respect of (a) the time of onset of protection, (b) the duration of protection, (c) the elements of the SARS-CoV-2 virus against which the protection exists, and (d) strains of the SARS-CoV-2 virus against which the protection exists.

2.2.3.6. According to Public Health England SARS-CoV-2 Technical briefing 17, on 25 June 2021, (Ref 27 - PHE Technical Briefing 17 - Delta Variant) patients with SARS-CoV-2 Delta variant who had been “vaccinated” had a higher rate of death than patients who had not been “vaccinated”. Table 4 on pages 13 and 14 indicates the following:

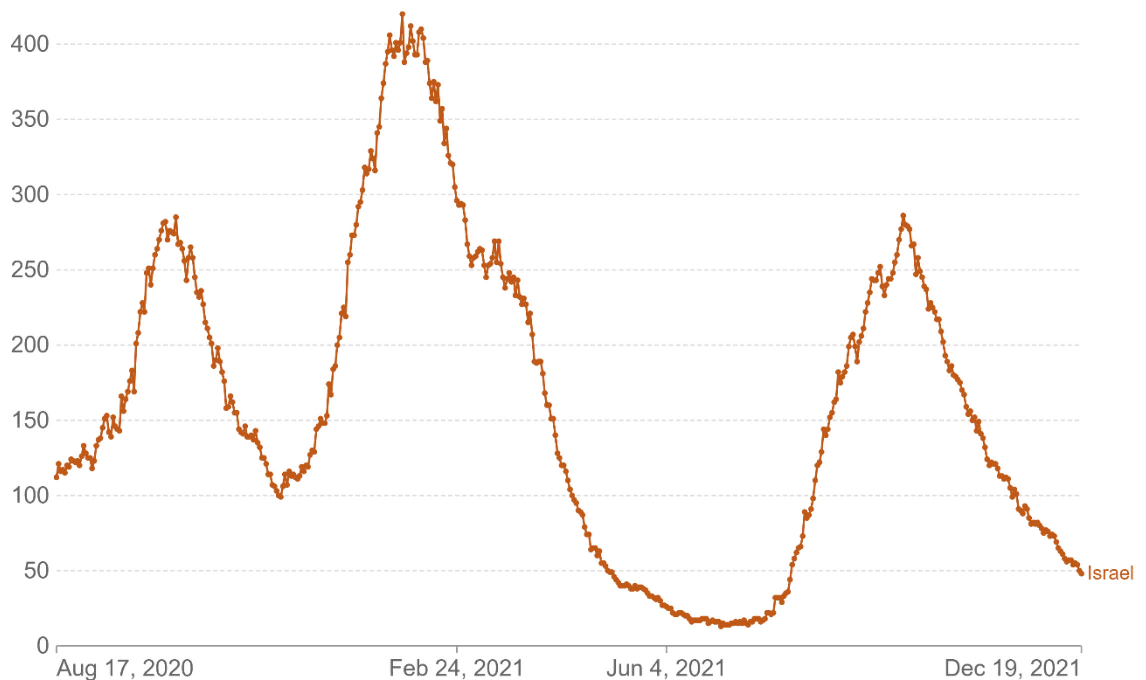
2.2.3.6.1. Of the cases of SARS-CoV-2 Delta variant identified between 1 February 2021 and 21 June 2021, 53,822 were “unvaccinated”, and 27,192 were “vaccinated” (6,242 less than 21 days after the first dose, 13,715 more than 21 days after the first dose and 7,235 who had received 2 doses).

2.2.3.6.2. Deaths within 28 days of a positive specimen date were 44 in the “unvaccinated” group. 44 Deaths out of 53,822 cases equals a death rate of 0.081751%.

2.2.3.6.3. Deaths within 28 days of a positive specimen date were 70 in the “vaccinated” group (1 less than 21 days after the first dose, 19 more than 21 days after the first dose and 50 who had received 2 doses). 70 Deaths out of 27,192 cases equals a death rate of 0.257429%, i.e. more than 3 times the death rate of the “unvaccinated” group.

2.2.3.7. In September 2021 it was reported (Ref 24 - Israel Breakthrough Infections) that in Israel Covid-19 hospitalizations and deaths had increased dramatically following “vaccination” of the majority of the population, and that at times hospitalizations for the “fully vaccinated” had reached upwards of 95 percent (Ref 28 - Israel 95% Hospitalised Patients Vaccinated).

2.2.3.8. According to [Ref 29 - https://ourworldindata.org/covid-hospitalizations](https://ourworldindata.org/covid-hospitalizations), at which the following graph can be viewed and interrogated online, the 1st wave of Covid-19 patients in ICU in Israel peaked on 13 October 2020 (prior to “vaccination”) with 285 patients in ICU; the 2nd wave peaked on 29 January 2021 (weeks after the commencement of “vaccination”) with 420 patients in ICU; and the 3rd wave peaked on 25 September 2021 (4 to 8 months after “vaccination”) with 286 patients in ICU.



2.2.3.9. Having regard to these peak numbers, as well as the troughs between waves, it is evident that the ICU admissions that followed Covid-19 “vaccination” are consistent with negative protection from severe illness for a number of weeks, followed by fair protection from severe illness, that commences about 4 months after “vaccination” and lasts for about 4 months, followed by loss of protection from severe illness.

2.2.3.10. According to Ref 30 - https://ourworldindata.org/covid-deaths, at which the following graph can be viewed and interrogated online, the 1st wave of Covid-19 deaths in Israel peaked on 14 October 2020 (prior to “vaccination”) with 4.17 deaths per million people; the 2nd wave peaked on 25 January 2021 (weeks after the commencement of “vaccination”) with 6.98 deaths per million people; and the 3rd wave peaked on 14 September 2021 (4 to 8 months after “vaccination”) with 3.58 deaths per million people.

2.2.3.11. Having regard to these peak numbers, as well as the troughs between waves, it is evident that the deaths that followed Covid-19 “vaccination” are consistent with a negative protection from death for a number of weeks, followed by fair protection from death, that commences 3 to 4 months after “vaccination” and lasts for about 4 months, followed by loss of protection from death from fair to modest levels.

2.2.3.12. The documented losses of protection from severe illness and death, that have occurred 4 to 8 months after Covid-19 “vaccination”, may be due to one or both of the following reasons:-

2.2.3.12.1. The phenomenon of “ADE” (antibody dependent enhancement), which has been explained by experts such as Dr Robert Malone. By this phenomenon Covid-19 “vaccination” induced antibodies become maladaptive, especially during the period of waning levels after a number of months, when they enhance entry of viruses into cells and promote infection rather than protect against infection.

2.2.3.12.2. The 3rd wave of Covid-19 was dominated by the mutated Delta variant. As stated above, Covid-19 “vaccine” protection against mutated forms of the virus, such as the Delta variant, is poorer than protection against the original strain for which the “vaccines” have been programmed.

2.3. **Conclusion:** In the short- and medium term Covid-19 “vaccines” are not effective at protecting individuals, or the community, from (a) transmitting the SARS-CoV-2 virus or (b) developing symptomatic Covid-19, while the protection from (c) severe illness and (d) death is limited and modest at best. Whereas it is too early to know what the long term holds, the available short- and medium term evidence predicts a poor long term prognosis. One has found no evidence to support the notion that “unvaccinated” persons pose any greater risk to the community than “vaccinated” persons.

3. HOW SAFE ARE THE COVID-19 “VACCINES”?

3.1. **Official narrative**. *The Covid-19 vaccines are safe.*

3.2. The evidence, however, finds:

3.2.1. Following Covid-19 “vaccines” early adverse events, which include serious illness, disability and death, are far more frequent than adverse events following traditional vaccines and follow predictable pathological patterns.

3.2.1.1. The SARS-CoV-2 spike protein, which is produced in human cells in response to “vaccination” with mRNA or DNA Covid-19 “vaccines”, is a pathogen. Prior to the mass administration of these “vaccines” it was anticipated that these “vaccine” induced spike proteins may cause anaphylaxis, thrombotic- and autoimmune complications, general immune dysfunction and death inter alia.

3.2.1.2. According to (Ref 25 - https://ourworldindata.org/covid-vaccinations), administration of Covid-19 “vaccines” in the United States was commenced on 14 December 2020. On 22 October 2020 a presentation to a meeting of the VRBPAC (Vaccines and Related Biological Products Advisory Committee) was given by the CBER (Centre for Biologics Evaluation and Research) of the US FDA (Food and Drug Administration), setting out CBER plans for monitoring Covid-19 “vaccine” safety and effectiveness (Ref 31 - FDA - VRBPAC -CBER - 20201022). In relation to FDA Safety Surveillance of Covid-19 “Vaccines”, the presentation included the following draft working list of possible adverse event outcomes:

3.2.1.2.1. Guillain-Barré syndrome, Acute disseminated encephalomyelitis, Transverse myelitis, Encephalitis / myelitis / encephalomyelitis / meningoencephalitis / meningitis / encephalopathy, Convulsions / seizures, Stroke, Narcolepsy and cataplexy, Anaphylaxis, Acute myocardial infarction, Myocarditis / pericarditis, Autoimmune disease, Deaths, Pregnancy and birth outcomes, Other acute demyelinating diseases, Non-anaphylactic allergic reactions, Thrombocytopenia, Disseminated intravascular coagulation, Venous thromboembolism, Arthritis and arthralgia / joint pain, Kawasaki disease, Multisystem Inflammatory Syndrome in Children, and Vaccine enhanced disease.

3.2.1.3. In July 2021 an analysis of CDC VAERS data (see page 11 of Ref 32 - CDC VAERS Analysis - July 2021) found that the reported death rate per 100,000 “vaccine” doses administered in 2021 was 24 times higher than the previous annual average. It is known that on the CDC VAERS system those who die within 2 weeks of Covid-19 “vaccination”, are not listed as “vaccine” deaths. This results in under recording of Covid-19 “vaccine” deaths.

3.2.1.4. Adverse events that have been reported following Covid-19 “vaccines” (Ref 33 - SA VAERS) include deaths, first trimester miscarriages, thrombotic disorders such as cerebrovascular accidents (stroke), myocardial infarction (heart attack), deep vein thrombosis and pulmonary embolism; autoimmune and inflammatory disorders such as Guillain-Barré syndrome, Bell’s palsy and myocarditis; as well as blood disorders, cognitive impairment, fatigue, headaches, menstrual disorders, skin disorders, myalgia, arthralgia, gastrointestinal disorders and immune dysfunction that results in inability to counter other infections and cancer.

3.2.1.5. In the UK Health Security Agency (UKHSA) Covid-19 “vaccine” surveillance report for Week 42 on 21 October 2021 (Ref 34 - UK Vaccine Report - Week 42) it was reported “*that N antibody levels appear to be lower in individuals who acquire infection following 2 doses of vaccination*”.

3.2.1.5.1. The N antibody is part of the natural immune response of an infected person to the nucleoprotein of the SARS-CoV-2 virus, whereas the S antibody is part of the natural immune response of an infected person to the spike protein of the SARS-CoV-2 virus, and is also the immune response to the spike protein generated by the Covid-19 “vaccines”.

3.2.1.5.2. The relevance of this finding is that it indicates immunosuppression by Covid-19 “vaccines” of the immune response to another protein. This finding has serious implications in relation to immunity to mutations of SARS-CoV-2, other infections and cancers. This finding provides an explanation for the mechanism by which “vaccine” enhanced disease was anticipated by the FDA prior to the rollout of Covid-19 vaccines, and by which immune dysfunction that results in inability to counter other infections and cancer has been reported following Covid-19 “vaccines”.

3.2.2. Research and analyses have found that, taking into account all cause morbidity and mortality, the Covid-19 “vaccines” cause more harm than good.

3.2.2.1. A research article (Ref 35 - All Cause Severe Morbidity) has found that Covid-19 “vaccines” have been proven to cause more harm than good based on pivotal clinical trial data analyzed using the proper scientific endpoint, namely “All Cause Severe Morbidity”. The authors concluded “*Scientific principles dictate that the mass immunization with COVID-19 vaccines must be halted immediately because we face a looming vaccine induced public health catastrophe.*”

3.2.2.2. An analysis by Steve Kirsch is reported to have found that the Covid-19 “vaccines” kill more people than they save for all age groups (Ref 36 - Kirsch Elephant - C-19 "Vaccines" Kill) and (Ref 37 - Kirsch Analysis - Cost Benefit By Age).

3.2.3. Investigators have found unexpected morphological abnormalities, as well as undeclared and harmful or potentially harmful substances, in the blood of Covid-19 “vaccinated” individuals.

3.2.3.1. Reported morphological abnormalities following Covid-19 “vaccination” include severe rouleaux formation or stacking of red blood cells, fragmented red blood cells, disrupted white blood cells and anucleate white blood cells, aggregation of platelets and fibrin strands (Ref 38 - Blood Microscopy Findings - Zandre Botha).

3.2.3.2. Tightly stacked red blood cells are dysfunctional as they cannot enter capillary vessels to deliver oxygen to tissues; disrupted- and anucleate white blood cells are dysfunctional as they cannot fight infections; and aggregation of platelets with fibrin strands are features of intravascular thrombosis or blood clotting.

3.2.3.3. Reported undeclared and harmful or potentially harmful substances include unexpected crystals and artefacts (see above). These same undeclared substances have been found in the vials of 4 different brands of Covid-19 “vaccine”. Scientific analysis of these substances is reported to have found that they include graphene oxide, carbon, metals and parasites (Ref 39 - Graphene Oxide - Prof Madrid) - (Ref 40 - Analysis of "Vaccine" Contents - Young). Inclusion of these substances in Covid-19 “vaccines” has not been made known by the manufacturers and the effects of these substances are unknown at this stage.

3.3. **Conclusion:** The Covid-19 “vaccines” are far from safe. In the first weeks following “vaccination”, and again in the medium term after some months, the Covid-19 “vaccines” cause more harm than good. Considering the thrombotic and immunological mechanisms of early vaccine injury, the long-term can only be worse.

4. ARE OTHER EFFECTIVE BUT LESS INVASIVE MEASURES AVAILABLE TO ACHIEVE THE SAME PURPOSE?

4.1. **Official narrative:** *There are no medical measures, other than vaccination, to protect individuals or the community from Covid-19.*

4.2. **The evidence, however, finds:**

4.2.1. Significant reductions in the risk of contracting Covid-19 have been found with the use of immune boosting nutraceuticals, particularly Vitamin D3, Zinc, Vitamin C, Quercetin and/or Melatonin (Ref 41 - Good News - Covid Prevention & Treatment).

4.2.2. Further reductions in the risk of contracting Covid-19 have been found with the use of repurposed antiviral agents such as Ivermectin (as above).

4.2.3. The following recommendations are based on available evidence (Ref 42 - FLCCC Prevention & Early Treatment Protocols):-

4.2.3.1. For low risk members of the community, provision of Vitamin D3 (1000-3000 IU/day), Zinc (30-40 mg/day) and Vitamin C (500-1000 mg twice per day) would provide good protection.

4.2.3.2. For higher risk members of the community, provision as above of Vitamin D3, Zinc and Vitamin C, plus Quercetin (250 mg per day) and Melatonin (6 mg before bedtime), as well as Ivermectin (0.2 mg/kg per dose – one dose on first day, repeat after 48 hours, then one dose weekly) would provide good protection.

4.3. **Conclusion:** There are safe and effective medical measures, other than “vaccination”, to protect individuals and the community from Covid-19.

5. ARE THERE AVAILABLE EFFECTIVE MEDICAL MEASURES TO TREAT THOSE WHO CONTRACT COVID-19?

5.1. **Official narrative**. *There are no effective medical measures for treating Covid-19. Those who contract Covid-19 should isolate at home without treatment; and only in case of respiratory decompensation should be admitted to hospital for oxygen, injected medications and non-invasive respiratory support, and in some cases ICU management with ventilation.*

5.2. The evidence, however, finds:

5.2.1. During Covid-19 stage 1 (viral proliferation - first 5 to 8 days of symptoms), use of the following is highly effective at assisting natural immune responses in ridding the patient of pathogens and ensuring recovery from the illness:

5.2.1.1. Vitamin D3, Zinc, Vitamin C, Quercetin and Melatonin; plus Ivermectin or Hydroxychloroquine, together with Azithromycin, Doxycycline or Clindamycin.

5.2.2. For the minority who develop Covid-19 stage 2 (inflammo-thrombotic response), addition of the following is highly effective at controlling the cytokine storm and excessive thrombosis, and ensuring recovery from the illness in most cases:

5.2.2.1. Corticosteroids, Colchicine, Antihistamines, Antileukotrienes, Antiplatelet Agents and Antithrombotic Agents; as well home-based support such as Nebulization, CPAP and Oxygen.

5.2.3. Tried and tested effective protocols for such treatments are freely available from those who have pioneered the medical treatment of Covid-19 (Ref 42 - FLCCC Prevention & Early Treatment Protocols) - (Ref 43 - Early Ambulatory Multidrug Therapy - Risk Reduction) - (Ref 44 - 8th Day Therapy - Dr Chetty) - (Ref 45 - WCH Early Home-Based Treatment).

5.3. **Conclusion:** There are well-established medical measures for safe and effective home-based treatment of Covid-19, particularly when instituted early following the onset of symptoms. Under the supervision of suitably informed general practitioners, these treatments prevent the need for hospitalization in the vast majority of cases.

6. EXPERT AFFIDAVITS

6.1. Having completed this report one has had the opportunity of reviewing the expert affidavits of Dr Peter McCullough (USA) (Ref 46 - McCullough Affidavit) and Dr Claire Craig (UK) (Ref 47 - Craig Affidavit), annexed to the application of the ACDP and others against the Minister of Health, Acting Director of the National Department of Health and the South African Health Products Regulatory Authority.

6.2. Both Dr McCullough and Dr Craig are recognized and respected experts in the field of Covid-19. The evidence and opinions set out in the affidavits of these experts supplement the evidence referred to in this report, and are consistent with and supportive of the opinions expressed herein.

7. FINAL CONCLUSIONS

7.1. Covid-19 “vaccine” mandates cannot be justified on medical grounds. Emerging evidence finds that the existing Covid-19 “vaccines” cause more harm than good, both to the individual and to the community.

7.2. Risks to the health and life of “vaccinated” individuals, that have already resulted from Covid-19 “vaccination”, are far greater than for the vaccines that were approved and in widespread use prior to the onset of the Covid-19 pandemic.

7.3. On the basis of the existing evidence of harm to the individual, as well as harm to the community, any and all coercion or pressure to be “vaccinated” should be terminated. Forced Covid-19 “vaccination” of any individual, which may result in grievous bodily harm or death, would be tantamount to assault.

7.4. It is known that the risks of Covid-19, as well as the risks of Covid-19 “vaccination”, differ between individuals, particularly in accordance with their age and underlying health status. In this regard an important question arises, whether Covid-19 “vaccination” should be recommended to any person or any group of persons. In answer to this question one has heard many express the opinion that Covid-19 “vaccination” should be recommended to elderly and vulnerable individuals. One has not, however, heard them express factual or scientific reasons for these opinions, and nor has one found any risk-benefit analysis that supports such opinions. On the basis of the currently available evidence the risk-benefit ratio of Covid-19 “vaccination” is such that “vaccination” would not be recommended to anybody on medical grounds.

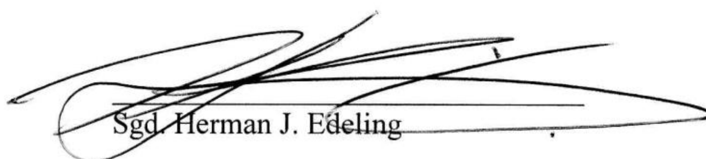
7.5. On the basis of particularly adverse risk-benefit ratios of certain groups of individuals, however, Covid-19 “vaccination” should be strenuously discouraged in children and in pregnant and breastfeeding women, as well as people with cancer, thrombotic conditions, chronic infections, autoimmune disease and AIDS.

7.6. Considering (a) the high incidence of natural immunity in the community, (b) the low infection fatality rates and (c) the superiority of natural immunity over the limited and transient protection offered by existing Covid-19 “vaccines”, as well as (d) the effectiveness of available medical measures for protection from and treatment of Covid-19; there is ample time for those who believe it to be necessary for proper development of safe and effective vaccines against Covid-19.

7.7. Having stated the above, it is important to emphasize that no doctor has the right to decide to administer or withhold any medical treatment without the informed consent of the patient. It is, however, the ethical duty of doctors to provide relevant and truthful information to patients, so that patients can be properly informed before making up their own minds and exercising their right to free choice.

7.8. To facilitate the provision of relevant and truthful information, it is proposed that this report and all the documents referenced herein, as well as all other reports and facts relevant to understanding of Covid-19, should be made freely available.

7.9. Considering the sorry state of medical confusion that has developed in relation to Covid-19 and its prevention and treatment, it is recommended that censorship of medical and scientific information and ad hominem attacks against those who hold opposing views should be stopped. Decision-makers should encourage open debate and sharing of information and ideas in all and any fora.



6 January 2022

FURTHER REFERENCES

Importance of Covid-19 “vaccines” for the health of individuals and the community

a) NN-Infection-fatality-rate-of-COVID-19-in-community-based-elderly-lower-than-earlier-estimates.
b) NN-Is the Virus Fictitious _ Laboratories in US Can’t Find COVID-19 in One of 1,500 Positive Tests.
c) NN-Why children should not receive the Covid shot.
d) NN-NE-NS-RX-N – Robert Kennedy – CHD to FDA VRBPAC 10.22.21
e) NN-NE-NS-Rx-N – An Australian Engineer Speaks Out – The Many Mysteries of Covid
f) NN-NE-NEW-Understanding Relative Risk Reduction (RRR) and Absolute Risk Reduction (ARR) in Vaccine Trials – PANDA

Effectiveness of Covid-19 “vaccines” at promoting the health of individuals and the community

g) NE NS RX-Vaccine death report 29 Sept 2021.
h) NE-NS-RX-COVID-19-VaccineSafetyElephant-Kirsch
i) NE NS-US COVID-19 Vaccines Proven to Cause More Harm than Good - Proper Scientific Endpoint, “All Cause Severe Morbidity”.
j) NE NS-PfizervaccineEffects-Herve-Seligmann-Eval38-H-signed.
k) NE-coronavirus-spreading-among-the-vaccinated-in-highly-vaccinated-countries-pdf.
l) NE-COVID-19 Deaths OverAge50-60%DoubleVaccinated.
m) NE-Large decline in vaccinated IgG antibodies.
n) NN NE-SARS-CoV-2 Natural Immunity vs Vaccine Immunity.
o) NE-Meeting of the COVID-19 Giants with Geert Vanden Bossche and Robert Malone MD - Robust Natural Immunity vs Limited Transient mRNA Immunity - mRNA Promotion of more infective variants.
p) NE-N-Immunosuppression after measles vaccination – PubMed

q) NE-N-whocdscsrisr991Measles
r) NE-NS-N-Should COVID-19 be a vaccine disease or a childhood disease - The BMJ
s) NE-N-‘Fully vaccinated’ were the majority of COVID deaths in Sweden, UK in September – LifeSite
t) NE-N-Public Health Scotland – 83% Deaths Vaccinated 21-10-20
u) NN-NE-NS-RX-N – Robert Kennedy – CHD to FDA VRBPAC 10.22.21
v) NE-N-Pfizer-FDA Briefing Document – 95% Claim
w) NE-N – Jansen – FDA Briefing Document
x) NE-NS-N – IFPMA – Vaccine Complex Journey – 2019
y) NE-NS-N- The 5 Stages of Vaccine Development – AIMST University
z) NE-NS-N – Phase 3 clinical trial of investigational vaccine for COVID-19 begins – National Institutes of Health (NIH)
aa) NN-NE-NS-Rx-N – An Australian Engineer Speaks Out – The Many Mysteries of Covid
bb) NN-NE-NEW-Understanding Relative Risk Reduction (RRR) and Absolute Risk Reduction (ARR) in Vaccine Trials – PANDA

Safety and risks of Covid-19 “vaccines”

cc) NE NS RX-Vaccine death report 29 Sept 2021.
dd) NS-20,595 DEAD 1.9 Million Injured (50% SERIOUS) European Union’s Database of Adverse Drug Reactions for COVID-19 Shots - Vaccine Impact.
ee) NS-SARS-CoV-2 mRNA Vaccination-Associated Myocarditis in Children.
ff) NS-VigiAccess-WHO-C-19 Vaccine 20211004.
gg) NS-COVID Vaccine Deaths in America.
hh) NS-Female_COVID19_vaccination_associates_with_lower_fertility10_1.
ii) NE-NS-N-Should COVID-19 be a vaccine disease or a childhood disease - The BMJ
jj) NS-N-SARS-CoV-2 mRNA Vaccination-Associated Myocarditis in Children Ages 12-17 – A Stratified National Database Analysis
kk) NN-NE-NS-RX-N – Robert Kennedy – CHD to FDA VRBPAC 10.22.21
ll) NE-NS-N – IFPMA – Vaccine Complex Journey – 2019

mm) NE-NS-N- The 5 Stages of Vaccine Development – AIMST University

nn) NE-NS-N – Phase 3 clinical trial of investigational vaccine for COVID-19 begins – National Institutes of Health (NIH)

oo) NN-NE-NS-Rx-N – An Australian Engineer Speaks Out – The Many Mysteries of Covid

pp) NS-N-Comprehensive investigations revealed consistent pathophysiological alterations after vaccination with COVID-19 vaccines

Other effective but less invasive available measures to prevent Covid-19, and effective early treatment of Covid-19

qq) RX-WCH_Covid-19-At-Home-Treatment-Guide-For-Healthy-Individuals_1

rr) RX-COVID-Rx-PatientTreatmentGuide-AAPS-Orient

ss) RX-20210728-CovidPatientTreatmentGuide-TFH-6-30-2021

tt) NE NS RX-Vaccine death report 29 Sept 2021

uu) NE-NS-RX-COVID-19-VaccineSafetyElephant-Kirsch

vv) NN-NE-NS-RX-N – Robert Kennedy – CHD to FDA VRBPAC 10.22.21

ww) NN-NE-NS-Rx-N – An Australian Engineer Speaks Out – The Many Mysteries of Covid

xx) N-Rx – Detox Protocol COVID Vaccines – Protection From Shedding