COVID-19 Leaky Vaccine Hesitancy (v2.5)

Table of Contents

Introduction

The hysterical rhetoric has reached dehumanizing and genocidal “unvaccinated people are plague rats responsible for mass death and must be ostracized, denied health care and imprisoned in camps” levels.

So this is a fully sourced explanation of the hesitancy toward these vaccines. No conspiracies, just data and science. I’m not anti-vax, most of us aren’t. We just have concerns about these specific vaccines. Those hesitating will not vaccinate until these concerns are addressed instead of dismissed.

This document is written for the layman. Don’t feel intimidated to read it, you’ll be able to follow it.

Summarizing the hesitancy

The 3 core concerns summarized, the numbers in brackets lead to sourced details of each point:

1. Leaky mRNA vaccines *don’t prevent reinfection*.[1] This forces *escape variant* mutation.[2] Specific targeting of the spike protein (dangerous on its own) by mRNAs mean that *minor mutations can evade it*[3] and the mRNA antibodies cause *lifelong*[4] innate antibody *suppression against coronaviruses & variants* risking Antibody Dependent Enhancement (ADE).[5] Variants treated with leaky vaccines repeat this loop, mutating *more* escape variants, until an end scenario similar to bacterial Antibiotic Resistance occurs.[6]

2. Variants are mutating *longer immune response evasion*.[7] Infected, vaccinated, asymptomatic hosts returning to close social contact *will* unknowingly reinfect each other,[8] exponentially increasing *overall total mutation rates* and risk of *lethal strains* worldwide[9] as longer asymptomatic incubation leads to successful transmission *before* the host dies,[10] and builds h*igher viral loads* when the immune response *finally* kicks in, risking *cytokine storms*.[11]

3. Despite the hysteria, *the CDC & UK government’s* ***own data*** shows that healthy unvaccinated people under 50 years old who catch *either* COVID[12] *or* Delta[13] have almost *no* risk of hospitalization or death. A 100% reduction of a 0.01% risk of symptoms is not worth vaccine side-effects or ADE, especially for young healthy people who have excellent immune systems and their entire lives ahead of them where they may have to deal with the above consequences.

[1] Leaky vaccines

A vaccine that prevents or reduces *symptoms*, but doesn't prevent *reinfection* or *transmission*:

> *https://en.wikipedia.org/wiki/Marek%27s_disease*
>
> *"The Marek's disease vaccine is a **leaky vaccine,** which means that **only the symptoms of the disease are prevented. Infection of the host** and the **transmission of the virus** are **not inhibited** **by the vaccine.** This **contrasts with most other vaccines, where infection of the host is prevented.**"*
>
> *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4516275/*
>
> *"Immunity elicited by direct vaccination or by maternal vaccination **prolongs host survival but does not prevent infection, viral replication or transmission, thus extending the infectious periods of strains otherwise too lethal to persist.**"*

A common rebuttal is "but you're *less* likely to be reinfected or transmit it because your viral load is lower thanks to the vaccines". You may have a lower viral load of the exact strain of COVID-19 the vaccines were designed for, but *that* strain is no longer a concern since variants have taken over:

> *https://www.scientificamerican.com/article/why-do-variants-such-as-delta-become-dominant1/*
>
> *"**[Delta] has become the predominant strain of the virus**, accounting for more than 90 percent of new COVID cases in the U.S."*

The current vaccines are like installing outdated anti-virus software from 20 years ago, protecting you against an old version of a virus that is no longer the version you're likely to be infected with. That anti-virus software appears to have an expiration date as well:

> *https://www.haaretz.com/israel-news/coronavirus-delta-variant-is-50-percent-more-infectious-israeli-top-official-says-1.10068650*
>
> *"She added that **50 percent of the current infections are vaccinated individuals**. "Previously we thought that fully vaccinated individuals are protected, but we now see that **vaccine effectiveness is roughly 40 percent.**""*
>
> *https://www.cnbc.com/2021/08/25/covid-protection-for-the-fully-vaccinated-is-waning-uk-study-finds.html*
>
> *A U.K. study of over 400,000 people who had received both shots of the Pfizer-BioNTech vaccine found its **effectiveness fell to 74% five or six months after receiving both doses.***
>
> *An analysis of over 700,000 people who had received both doses of the Oxford-AstraZeneca vaccine showed its **effectiveness fell to 67% after four to five months.***

The CDC themselves openly admit that Delta viral loads are the same, whether vaccinated or not:

> *https://www.cdc.gov/media/releases/2021/s0730-mmwr-covid-19.html*
>
> *"demonstrating that **Delta infection resulted in similarly high SARS-CoV-2 viral loads in vaccinated and unvaccinated people.** High viral loads suggest an **increased risk of transmission** and raised concern that, unlike with other variants, **vaccinated people infected with Delta can transmit the virus.**"*
>
> *https://www.medrxiv.org/content/10.1101/2021.07.31.21261387v1*
>
> *"We find **no difference in viral loads** when comparing unvaccinated individuals to those who have vaccine "breakthrough" infections. Furthermore, individuals with vaccine breakthrough infections frequently test positive with **viral loads consistent with the ability to shed infectious viruses."***

These current mRNA vaccines are *by definition* leaky vaccines. The CDC reports **7,525** breakthrough cases (reinfection after full vaccination) in **164 million** vaccinations across the USA which works out to about a **0.004%** breakthrough rate:

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

And **2.39 billion** people worldwide have been partially **(1.15B)** or fully **(1.25B)** vaccinated:

> https://ourworldindata.org/covid-vaccinations?country=OWID_WRL

Since the USA's **0.004%** breakthrough rate is only counting *full* vaccinations we'll multiply the **1.25B** *fully* vaccinated people worldwide by that rate, resulting in potentially **50,000** *fully* vaccinated breakthrough cases worldwide.

Since two doses is supposed to offer more protection than one dose, then presumably the partially vaccinated number would have a higher breakthrough rate but let's err on the low side and say that the partially vaccinated only have the same **0.004%** breakthrough rate as the fully vaccinated. That still works out to **46,000** more breakthrough cases.

Add that **46M** to the **50M** for the fully vaccinated and the "extremely rare breakthrough cases" are potentially **96,000** cases worldwide. And we've got over **7.5B** people on Earth. If we're aiming for even double our current number, around half of the Earth's population, that could add *another **96,000*** vaccinated breakthrough cases all thanks to the vaccines being leaky.

So the CDC's own data suggests 192,000 "extremely rare breakthrough cases" worldwide.

The CDC has *stopped* monitoring non-hospitalized breakthrough cases, so the number is likely higher:

> *https://www.cdc.gov/mmwr/volumes/70/wr/mm7021e3.htm*
>
> *"Beginning May 1, 2021, CDC transitioned from monitoring **all** reported COVID-19 vaccine breakthrough infections to investigating **only those among patients who are hospitalized or die**"*

***Remember*:** The concern isn't *seriousness* of symptoms, but of *continued viral replication and spread* (even asymptomatic) in and between hosts. *Every* mutation is a dice roll risk of becoming more lethal, so the breakthrough cases that don't lead to a hospital visit are just as important as those that do.

We're told "No vaccine is 100% effective!" to justify using leaky vaccines...yet the CDC says:

> *https://www.cdc.gov/vaccines/vpd/polio/hcp/effectiveness-duration-protection.html*
>
> *"Two doses of inactivated **polio vaccine** (IPV) are 90% effective or more against polio; **three doses are 99% to 100% effective.**"*

And the World Health Organization (WHO) says:

> *https://www.who.int/news-room/fact-sheets/detail/hepatitis-b*
>
> *"A safe and effective vaccine that offers **98% to 100% protection against hepatitis B** is available. Preventing hepatitis B infection averts the development of complications including chronic disease and liver cancer."*
>
> *https://en.wikipedia.org/wiki/Measles*
>
> *The MMR vaccine is 95% effective for preventing measles after one dose if the vaccine is given to a child who is 12 months or older; if a second dose of the MMR vaccine is given, **it will provide immunity in 99% of children.***
>
> *https://www.ctvnews.ca/health/leaky-vaccines-may-strengthen-viruses-study-1.2492523*
>
> ***"When a vaccine works as intended -- such as for smallpox, polio and measles -- it protects those vaccinated and prevents the transmission of the virus."***

When you are mass vaccinating billions of people in the middle of a pandemic, there is a ***massive*** difference between a vaccine that's 95% or 80% or 60% effective and *doesn't* prevent reinfection or transmission, and a vaccine that's 99% or 100% effective and *does* prevent them.

[2] Leaky vaccines cause escape variants

This is a basic evolutionary function that has been known, accepted and non-controversial for years:

> *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4516275/*
>
> *"**Imperfect Vaccination** Can **Enhance the Transmission** of Highly Virulent Pathogens"*
>
> ***"Vaccines that keep hosts alive but still allow transmission** could thus allow very virulent strains to circulate in a population"*
>
> *"natural selection removes pathogen strains that are so "hot" that they kill their hosts and, therefore, themselves. **Vaccines that let the hosts survive but do not prevent the spread of the pathogen** relax this selection, allowing the evolution of hotter pathogens to occur. **This type of vaccine is often called a leaky vaccine."***
>
> *"When vaccines **prevent** transmission, **as is the case for nearly all vaccines used in humans**, this type of evolution towards increased virulence is **blocked**"*
>
> *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2663389/*
>
> *"show that **host immunity can exacerbate selection for virulence** and therefore that **vaccines that reduce pathogen replication** may select for **more virulent pathogens**, **eroding the benefits of vaccination** and putting the unvaccinated at greater risk."*

This process is "Stress-Induced Mutagenesis" (SIM), which increases mutation rates & risks. Even in an asymptomatic host, each mutation is a chance to *become* a symptomatic escape variant:

> *https://journals.plos.org/plosbiology/article?id=10.1371/journal.pbio.2002862*
>
> *"a large body of work demonstrates stress-induced mutagenesis (SIM)—a transient **increase in mutation rates under stresses such as antibiotic exposure** or starvation—via specific pathways that are typically suppressed under rapid growth"*
>
> *"The regular high-fidelity, methyl-directed mismatch repair pathway (MMR) is suppressed, and error-prone DNA repair machinery (involving DNA polymerase IV and V) is upregulated, **ultimately increasing the mutation rate**"*

In fact SIM is intentionally used during "Gain of Function" research by applying stress to force a faster rate of random mutations, allowing researchers to cherry-pick samples of mutations that lean toward a desired outcome. This "passaging" process is repeated until the desired outcome/function is achieved.

This is *NOT* a moral judgement of GOF or related to lab leak theories. GOF can be used for good.

I'm simply showing that "stressors that don't fully eliminate the virus *increase* the mutation rate *and thus* the chance of evolving mutations that better escape or evade those stressors" is ***not*** a conspiracy. It's a well-known, fully accepted evolutionary process, routinely used by researchers:

https://journals.asm.org/doi/pdf/10.1128/JVI.01248-18

"the low-fidelity RNA-dependent RNA polymerases of RNA viruses have frequently been exploited in this context to identify genetic mutations that support zoonotic transmission, e.g., influenza virus H5N1 (20, 21).

These approaches, which normally ***involve the application of a strong selection pressure through serial passaging of viruses*** *in vitro or in vivo, are broadly referred to as classical gain-of-function (GOF) experiments"*

In the Serial Passaging process our leakily vaccinated & reinfected human beings are the "medium containing cells and other stressors" and the non-neutralizing antibodies are the pressuring stressors:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4918420/

"a fraction of an initial viral stock is added to ***a medium containing cells and other stressors (e.g., drugs or antibodies).***

The virus can then infect the cells ***under an external pressure (the drugs or the antibodies)*** *and new viral particles are released, giving rise to a new stock. These steps constitute a single passage."*

"Under antibodies pressure, ***increasing the mutation rate increases the likelihood of acquiring mutations*** *that lower the binding free energy of the protein-antibodies interaction,* ***and then lead to escape."***

[3] Vaccines target the spike protein

The vaccines rely on targeting the exact spike protein from early COVID-19 that they were based on:

https://massivesci.com/articles/covid19-vaccines-variants-spike-protein-mutation-cdc-urges-caution/

"The most salient form of ***genetic mutation found in these variants*** *involves* ***changes to the spike protein (S protein)****, which is important because* ***S proteins are the main protein type used as a target*** *in COVID-19 vaccines currently being used****, regardless of underlying technology****, including vaccines based on mRNA (BioNTech/Pfizer, Moderna/NIAID), DNA and viral vectors (AstraZeneca/Oxford, Johnson & Johnson), or protein subunits (Novavax, others under development)."*

But the spike proteins themselves appear to be a dangerous part of the virus that does actual damage, even when attached to a harmless pseudo-virus:

https://www.salk.edu/news-release/the-novel-coronavirus-spike-protein-plays-additional-key-role-in-illness/

> *"In the new study, the researchers created a "pseudovirus" that was surrounded by SARS-CoV-2 classic crown of spike proteins,* ***but did not contain any actual virus.*** *Exposure to this pseudovirus resulted in* ***damage to the lungs and arteries*** *of an animal model—proving that* ***the spike protein alone was enough to cause disease****"*
>
> *"The team then replicated this process in the lab, exposing healthy endothelial cells (which line arteries) to the spike protein. They showed that* ***the spike protein damaged the cells*** *by binding ACE2."*
>
> *"this is the* ***first study*** *to show that the* ***damage occurs*** *when cells are exposed to the* ***spike protein on its own.****"*
>
> *"If you remove the* ***replicating capabilities*** *of the virus, it* ***still*** *has a* ***major damaging effect on the vascular cells****, simply by virtue of its ability to bind to this ACE2 receptor, the S protein receptor, now famous thanks to COVID"*

The statement "the virus spike proteins (which behave very differently than those safely encoded by vaccines)" was stealth-added to the article afterward, but with no explanation of exactly how they're different or how that makes this experiment's findings completely irrelevant.

> *"Now,* ***a major new study*** *shows that the virus spike proteins (which behave very differently than those safely encoded by vaccines) also play a key role in the disease itself."*
>
> *"****this is the first study to show*** *that the* ***damage occurs*** *when cells are exposed to the* ***spike protein on its own.****"*

This makes it sound like *until* April 30, 2021, *long* after the vaccines were developed and rolled out, no one knew the spike protein the mRNAs are designed to instruct your cells to produce are also the part of COVID-19 doing the damage. To a layman this sounds like they thought they put marshmallows in your body and just found out those marshmallows had razor blades inside.

Is this wrong? It's possible, I welcome thorough explanations. Because it sounds like the spike proteins the mRNA has you produce can do damage, which would explain the vaccine side effects being reported. It's reasonable to be hesitant when no one will thoroughly address this.

The mRNAs' specific targeting means all a variant needs is minor mutations to the spike protein:

> *https://ccforum.biomedcentral.com/articles/10.1186/s13054-021-03662-x*
>
> *"Currently,* ***all vaccines*** *are based on introducing* ***spike protein****"*
>
> *"efficiency may be compromised by the emergence of SARS-CoV-2 variants especially those possessing* ***spike proteins and RBD mutations*** *that increase affinity to ACE2 such as Alpha, and Iota variant, by potentially* ***escaping neutralizing antibodies*** *and competing with those agents for the same binding targets"*

[4] Original Antigenic Sin

Your *first immune response* is the response that dominates during reinfections, *even if* that response becomes *ineffective* (like a variant that has mutated its spike protein) or if that response has become *damaging* (like an auto-immune disorder), *preventing a possible better immune response:*

> *https://en.wikipedia.org/wiki/Original_antigenic_sin*
>
> *"refers to the propensity of the body's immune system to **preferentially utilize immunological memory based on a previous infection** when a **second slightly different version** of that foreign pathogen (e.g. a virus or bacterium) is encountered.*
>
> *This leaves the immune system "trapped" by the first response it has made to each antigen, and **unable to mount potentially more effective responses during subsequent infections**"*

Auto-immune disorders are your immune system mistakenly attacking healthy tissue, and because of OAS the best we can do is use drugs to weaken your immune system, hoping it'll kill you slower:

> *https://medlineplus.gov/ency/article/000816.htm*
>
> *"An autoimmune disorder occurs when the **body's immune system attacks and destroys healthy body tissue by mistake.**"*

Old people who survived the 1918 influenza pandemic can *still* produce antibodies *80 years* later:

> *https://www.cidrap.umn.edu/news-perspective/2008/08/researchers-find-long-lived-immunity-1918-pandemic-virus*
>
> *"A study of the blood of older people who survived the 1918 influenza pandemic reveals that **antibodies to the strain have lasted a lifetime**"*
>
> *"The group found that **100% of the subjects** had serum-neutralizing activity against the 1918 virus and 94% showed serologic reactivity to the 1918 hemagglutinin."*

[5] Innate antibodies VS mRNA antibodies

By definition an "escape variant" is a variant of the virus that has randomly mutated in some way that helped it "escape" your immune response (or else it would have been eliminated):

> *https://en.wikipedia.org/wiki/Antigenic_escape*
>
> *"in many cases these vaccines are not able to cover the wide variety of strains a pathogen may have. Instead they may only protect against one or two strains, **leading to the escape of strains not covered by the vaccine.***
>
> *This results in the pathogens being able to attack targets of the immune system **different than those intended to be targeted by the vaccination.**"*

https://en.wikipedia.org/wiki/Original_antigenic_sin

*"Between primary and secondary infections, **or following vaccination**, a virus may undergo **antigenic drift**, in which the viral **surface proteins** (the epitopes) are **altered through natural mutation**, allowing the virus to **escape the immune system.**"*

i.e. your immune response that handled the *original* virus strain is less effective for variants of it.

https://en.wikipedia.org/wiki/Original_antigenic_sin

*"When this happens, the altered virus preferentially reactivates previously activated high-affinity memory B cells and spurs antibody production. **However, the antibodies produced by these B cells generally ineffectively bind to the altered epitopes.**"*

The mRNAs are one specific set of instructions to produce one specific protein from the original strain of COVID-19 that existed when the mRNAs were developed. We can't predict random mutations so the current mRNAs can't possibly contain instructions for a variant that doesn't exist yet.

And because of Original Antigenic Sin the immune response that is less effective against an escape variant of the strain it was for also prevents a new, better immune response from developing:

https://en.wikipedia.org/wiki/Original_antigenic_sin

*"In addition, **these antibodies inhibit the activation of higher-affinity naive B cells that would be able to make more effective antibodies to the second virus.** This leads to a **less effective immune response** and recurrent infections may take longer to clear."*

In the end this means *more* mRNA vaccines *will* be needed for ***each*** *variant.* Pfizer is already applying for FDA Emergeny Use Authorization of a Delta mRNA booster shot:

https://www.cbsnews.com/news/covid-vaccine-pfizer-biontech-booster-shot-delta-variant-emergency-use-authorization/

*""Pfizer and BioNTech plan to share their **booster** data with the Food and Drug Administration in August and **file for emergency use authorization** shortly thereafter, a Pfizer spokesperson said.""*

*"**a third dose may be needed within six to 12 months after full vaccination**," Pfizer said. "While protection against severe disease remained high across the full six months, **a decline in efficacy against symptomatic disease over time and the continued emergence of variants are expected.***

*Based on the totality of the data they have to date, Pfizer and BioNTech believe that **a third dose** may be beneficial to maintain the highest levels of protection.""*

Logically, we cannot stay *ahead* of the variants since we can't predict what random mutations will happen. We can only *react* to the appearance of variants and then scramble to make another booster. Each booster shot designed for a variant *will* work against *that specific variant*. But what potential side-effect pile-ups or unintended domino effects happen to our immune systems when a human being has a *dozen* or more mRNA vaccines stacked in their system? *Who knows? It's never been tried before.*

And do we have a *better* way to notice when new variants appear (or when they go from Variants Of Interest to Variants Of Concern) *other* than seeing enough people dying from it that it stands out?

[6] Antibiotic resistance

While COVID-19 is viral, not bacterial, the concept is the same. Use your critical thinking skills:

1. Not taking your full dose of antibiotics only kills off the weakest bacteria that was easily killed off and leaves behind the strongest bacteria that needed more antibiotics to wipe out

2. That strong bacteria continues to replicate on top of now having less competition

3. Next round of antibiotics need to be stronger because the new infection is the stronger bacteria

4. Not taking that full dose repeats this loop until eventually the bacteria can't be treated, or the treatment would be too hazardous to the patient

With COVID-19, leaky vaccines are the equivalent of Step 1 (the vaccine only reduces symptoms but doesn't kill off the virus or prevent reinfection or transmission, especially of variants):

> *https://www.fda.gov/consumers/consumer-updates/combating-antibiotic-resistance*
>
> *"It's important to take the medication as prescribed by your doctor, even if you are feeling better.* ***If treatment stops too soon, and you become sick again, the remaining bacteria may become resistant to the antibiotic that you've taken.****"*

Booster shots that are leaky will repeat this loop, forcing new variants to evolve that we will be treating with more leaky vaccines. Each loop puts us closer to the equivalent of antibiotic resistance with a mutation that the repeatedly vaccinated create that *no one*, vaccinated or UNvaccinated, can survive.

You ***CANNOT*** safely use leaky vaccines in the middle of an on-going pandemic.

[7] Variants have longer incubation periods

The incubation period is from the moment of infection to the point where symptoms appear.

During this period the virus is replicating, increasing in viral load, which increases the number of mutations, which increases the random chance for deadly mutations. You can also unknowingly infect others during the incubation period, even if they're vaccinated (with the leaky vaccines).

Since these leaky vaccines just reduce your symptoms but don't stop reinfection or transmission, you're less likely to know when you should isolate yourself. A weekend of bar-hopping or a week of riding subways during the incubation period means your mutations have *plenty* of opportunity to spread to other hosts *before* your immune response kicks in and you realize you're infected.

Multiple Variants Of Concern are mutating longer incubation periods, finding different ways to avoid triggering an immune response, allowing longer asymptomatic spread & higher viral loads:

> *https://www.nature.com/articles/d41586-021-01540-8*
>
> *"within hours of infecting a person, Alpha **suppresses the rapid-response defence** that the body mounts against all invaders. By **blocking** this 'innate immune response', the virus buys itself **more opportunities to infect other people.**"*

Why is this bad? Imagine a worst-case scenario where a variant evolves that evades your immune system for a month, or 6 months, but kills you the instant your immune response is triggered. You would infect thousands of others before your immune response kicks in, and each person you infected would follow, as if everyone has a countdown timer above their heads until they self-destruct.

Longer asymptomatic incubation resulting in higher viral loads means a more severe immune response when it's finally triggered and your system has a massive viral load spread throughout it:

> *https://www.ucsf.edu/news/2021/06/420826/mutation-highly-infectious-alpha-variant-may-help-coronavirus-evade-immune*
>
> *"it **contains mutations** that make it better adapted to **foil the innate immune system**, at least for long enough to **allow the virus to replicate and potentially find new hosts**"*
>
> *"By halting the body's initial immune response, the virus **buys time to deepen the infection of its host** as well as increase its chances of **being transmitted to another person.**"*

Ideally you want to be symptomatic enough to know you're infected so you isolate yourself and avoid spreading it (and any mutations), but not have symptoms severe enough to be hospitalized or die.

[8] Vaccinated people will reinfect eachother

Since the prize of "a return to normal" was dangled in front of everyone to bribe them into getting these leaky vaccines, the vaccinated expect to be allowed to return to maskless close-contact in crowds.

This is the literal worst possible decision that could be made at this point in the pandemic.

The vaccinated, most of them not realizing they can even BE reinfected or transmit the virus (or its variants), let alone knowing *when* they're infected if they're asymptomatic, will be the "variant factories" that the unvaccinated were incorrectly (and potentially maliciously) labelled.

[9] Vaccinated people will increase mutations exponentially

Imagine you have two groups of people:

- 100 UNvaccinated people who have just been infected and have severe symptoms
- 100 vaccinated people who have just been reinfected but are asymptomatic

The unvaccinated people are likely to notice they have symptoms and stay home, isolating themselves. They're also likely to be excluded by society based on vaccine passports etc which means even if they wanted to be in crowded places they won't be allowed.

How many people are those unvaccinated hosts likely to spread their infection to? Let's say each spreads it to 10 close friends & family. That's 1,100 hosts with the virus replicating, increasing their viral load and each replication is a chance for a bad mutation.

The vaccinated people, being asymptomatic, have no idea they're infected and contagious, even to other vaccinated people who also don't know they're able to be reinfected. Because they believe they've earned a return to normal they no longer wear their masks or socially distance on subways, in grocery stores, parties, and the vaccine passports mean they're encouraged to gather in large groups again, often in small enclosed or cramped spaces like bars, concerts, theaters, etc.

How many people are those vaccinated hosts likely to spread their infection to? Possibly hundreds, maybe thousands each. Let's say they all go to a concert and each unknowingly infects 100 other people. That's 11,000 hosts incubating mutations of the virus. But after the concert, those 11,000 hosts ride the subway to go partying and in the morning they hit a restaurant for their hangover breakfast etc, all while carrying their vaccine passports and not wearing masks.

So each of those 11,000 infects another 100 people within 24hrs of being infected. Now we've got 1,100,000 asymptomatic hosts incubating mutations of the virus, while not social distancing, and each replication in each of them is a chance for a bad mutation.

***Remember*:** The concern isn't *seriousness* of symptoms, but of *continued viral replication and spread* (even asymptomatic) in and between hosts. *Every* mutation is a dice roll risk of becoming more lethal.

Regardless of the severity of each host's symptoms, the astronomical exponential increase in overall number and rate of worldwide mutations is like playing Russian Roulette with a Gatling gun. All it takes is for *just one* of those mutations to be more dangerous in some way.

Vaccinated people should be *fully informed* that they've been given leaky vaccines and that they are able to be reinfected and transmit the virus, with full viral loads, even if they're asymptomatic so they understand the risks to themselves, their family and friends, and they should continue to stay masked and isolated since they cannot tell when they're infected and a danger to others.

[10] "Viruses become more infectious but less deadly" does NOT apply

You may have heard that a virus evolves to be less deadly. This is normally true, and the explanation is logical: if a mutation is too deadly then it kills the host, which prevents it from spreading, leaving only the less deadly mutations to spread.

Unfortunately with COVID-19:

- The variants are mutating longer asymptomatic contagious incubation periods
- We are attempting a worldwide mass leaky vaccination in the middle of a pandemic
- Leakily vaccinated people are going to be allowed to mingle in crowds without masks

This combination means that a virus will be able to spread *effortlessly* before it kills the host, so there's no selection pressure that will select for *less* deadly mutations. All a mutation has to do is spread to another host before it kills its current host. And as shown earlier, the more mutations, the more risk of a deadly mutation.

[11] Risk of cytokine storms

The symptoms you feel when you're "sick" are your immune response attacking the virus. This happens after the incubation period when your body realizes you're infected and sends in the troops. The *higher* your viral load, the more *severe* your immune response.

But the variants are mutating longer incubation periods, which means higher viral load build-up. And if your viral load is *too* high, the immune response may be a ***cytokine storm***:

> *https://en.wikipedia.org/wiki/Cytokine_storm_syndrome*
>
> *"Normally, cytokines are part of the body's immune response to infection, but their **sudden release in large quantities** can cause **multisystem organ failure and death.**"*
>
> *"It is believed that **cytokine storms** were responsible for the disproportionate number of **healthy young adult deaths** during the 1918 influenza pandemic"*

[12] Manually calculating the ACTUAL risk using official data
We'll use the official CDC stats for America. Feel free to use any location, the end result is consistent.

> ***NOTE:*** *Age groups used below switch between 18-49yo, 18-39yo and <50yo at various points for easier-to-follow math because the CDC charts and UK data split age groups differently.*
>
> *I fully encourage you to follow the steps laid out below to verify the calculations for yourself.*

We'll use a male under 50yo with no comorbidities because the warning isn't "unhealthy old people should get the vaccine", it's "*EVERYONE* is at risk and *MUST* get the vaccine". But how true is that?

1. Go to https://covid.cdc.gov/covid-data-tracker/#demographics

2. Go to the middle left chart **"Cases by Age Group"**. We're going to compare that with the **"Deaths by Age Group"** chart to its right

3. Click on the little grid icons at the top-right (beside the Download buttons) of the two charts, to switch to the table views of the numbers which are easier to read

4. So going by these ***official numbers*** directly ***from the CDC***, in ***all recorded COVID-19 history*** across ***ALL OF AMERICA***, a population of ***328 MILLION*** people with ***29.8 MILLION cases of COVID-19 with age group data available***...

5. ...The 18-49yos range has **26,015 deaths** combined, divided by **16,137,119 cases**. Multiply that by 100 to get the percent and that's a **0.16%** rate of death, with most of them being over 40yo (i.e. not young adults) since 40-49yos are about *double* the <40yos *combined*.

HOWEVER, lets take that 0.16% and account for comorbidities, using the CDC's official data.

We'll assume that side effects from COVID-19 worth taking the vaccine to avoid would probably cause symptoms severe enough to show up in the official CDC hospitalization data:

1. Go to https://gis.cdc.gov/grasp/COVIDNet/COVID19_5.html#medicalConditionsColumnDiv and look at the "Selected Underlying Conditions" chart at the bottom.

2. Remove Pediatric and Pregnant so just Adult is selected

3. Now under "Selected Medical Condition" un-check them all except "No known condition" at the bottom (i.e. no known/obvious comorbidities)

4. Hover over the bar and as you can see, the percent of hospitalizations with ***no comorbidities*** for adults since the start of the pandemic across all of America is **8.1%** (at the time of this writing).

   Therefore 91.9% of documented cases resulting in hospitalization involve comorbidities.

5. Now scroll up to the top table on that page, "COVID-19-Associated Hospitalizations by Age"

6. Un-check everyone but 18-49yo and look under the chart at the "Cumulative case count by age group" section

7. At the time of writing this it says **54,156** total cases of hospitalizations between 18-49yo

8. Removing the 91.9% of cases with comorbidities (as shown in Step 4 above), that's **4,386 hospitalizations** for the ENTIRE 18-49yo age group across ALL OF AMERICA since DAY ONE of the pandemic if they have no comorbidities

9. And using that 91.9% comorbidity rate, if we take the very first chart's **26,015** total deaths and remove 91.9% of them, we get about **2,107 deaths** of 18-49yo's with no comorbidities

10. Then we divide that **2,107** deaths by the **16,137,119** total cases for 18-49yo's (from Step 5 in the first chart we looked at) and multiply it by 100 to get the percent:

    That's a 0.0131% risk of death for 18-49yo's with no comorbidities.

11. **However**, remember that the 40-49yo's are skewing that number because (as shown in the very first chart we looked at) they're about *double* the deaths of the rest of of the 18-39yo group *combined*. i.e. 18-39yo's are about 1/3rd of the total number

12. Since a large part of the debate is "should *young, healthy people* get the vaccine?" then for hospitalizations if we remove the 40-49yo group to focus on just the "young and healthy" 18-39yo's with no comorbidities for a moment, the **1/3rd** of **4,386** (from Step 8) that the 18-39yo's represent is around **1,462 hospitalizations** since the start of the pandemic, across all of America

13. And for deaths, if we remove that same 40-49yo group to just look at healthy young adults with no comorbidites, the 1/3rd of **0.0131%** (from Step 10) the 18-39yos represent comes out to only a **0.0044% risk of death**.

14. So even if the vaccines were 100% effective with no risks, that would only be a 0.004% benefit.

15. Now let's take that **1,462** and divide it by the 14 months the CDC's chart accounts for and that's about **104 hospitalized** 18-39yo's with no comorbidities **per month. Across ALL of America.**

16. And to put *that* number in perspective, if we divide that 104 hospitalizations by 50 states, we get about **2 hospitalized 18-39yo's** with no comorbidities, **per state, per month, across all of America, since the start of the pandemic**.

17. And if we reduce *that* down further by sex, COVID-19 hits women harder than men so if we remove, say, 60% of those 2 hospitalizations, we're talking around **basically ONE** 18-39yo male with **no comorbidities, per state, per month,** since the **start of COVID-19,** across **29.8 MILLION** age-data recorded cases of COVID-19 in a country with **328 MILLION** people

In summary the official CDC data shows:

- 91.9% of hospitalizations of 18-49yo's involve one or more comorbidities
- 18-39yo's with no comorbidities have a 0.0131% chance of death from COVID-19
- Males in that group are hospitalized at the equivalent of one per state, per month

Your first instinct may be "But this doesn't make sense! I heard all these stories of young healthy people in ICUs dying left and right! I was told someone young and healthy *just like me* died horribly and they're taking up the ICU beds that other people need! How could the *actual* rates be that low?"

But *this is the official CDC data* that has been available for anyone to calculate. And you presumably just followed along, calculating it for yourself so you saw the numbers first hand instead of a headline.

So if you disagree with these numbers then the only possible explanations are:

1. Either the CDC data is accurate and people fear mongering are exaggerating/lying/uninformed
2. Or the CDC is, for some reason, posting innacurate data that makes COVID-19 risks look minor
3. Or doctors & hospitals everywhere are forgetting or choosing not to send the CDC accurate data

Options 2 and 3 both require conspiracy theories. Option 1 is the most likely and mirrors a lot of the fear-mongering we've seen over the last few years in general from media and politicians.

But let's say that the CDC and doctors *aren't* putting out inaccurate data that for some reason *supports* vaccine hesitancy...do the numbers above *really* sound like they warrant the amount of bullying and harassment and hate that someone who's under 50yo, with no comorbidities, is facing for wanting to just wait a few months to see if alternative treatments or better vaccines are available?

The vaccinated are calling the unvaccinated plague rats who should be denied care and should die.

Would it be unreasonable for a woman to hesitate taking the first birth control pill ever made? Or for someone with depression to hesitate taking the first depression meds ever put on the market? Or for a gamer to wait for patches with bug fixes instead of installing Cyberpunk 2077 on launch day? And wouldn't it be unsettling if everyone forced people to do these things while censoring ***ALL*** questions?

[13] But the vaccines protect against variants right?

The UK government tracks Delta cases based on age & vaccination status, here's the latest update. Again, please follow the math for yourself if you're skeptical, all the steps to calculate are laid out here:

1. Go to pages 18 & 19 of https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005517/Technical_Briefing_19.pdf and let's look at the table titled *"Table 5. Attendance to emergency care and deaths by vaccination status among all sequenced and genotyped Delta cases in England from 1 February 2021 to 19 July 2021"*

2. This covers Feb 1st to July 19th of 2021. With the top-left box labeled "Variant" being column 1, the numbers in **columns 6, 7 and 8 combined are people with 1-2 doses of the vaccine**, and the numbers in **column 9 are *UNvaccinated* people**

3. **Make sure to use the rows labeled <50 since we are focusing on <50yo's**

4. Starting with the bottom set of rows (deaths from Delta in <50yo's):

Risk of death for <50yo's with Delta

	Unvaccinated	Total
Total cases	119,063	119,063
Deaths	34	34
Chance of dying	(34 / 119,063) * 100	**0.029%**

	<21 days post dose 1	≥ 21 days post dose 1	2 doses	Total
Total cases	20,930	27,714	15,346	63,990
Deaths	3	3	4	10
Chance of dying	(10 / 63,990) * 100			**0.016%**

So a <50yo UNvaccinated patient has about a 0.03% chance of death from Delta. If they were vaccinated they'd have a 0.016% chance of death from Delta. Not only is that risk next to nothing for *EITHER* of them, but if we take the UNvaccinated 0.03% chance and remove the 91.9% comorbidities for that age range from the CDC comorbidity data, we get **0.00243%**

So going by the official UK Delta numbers, an UNvaccinated <50yo with no comorbidities has around a 0.002% risk of death from the Delta variant.

5. What about Delta severe hospitalizations? Let's look at the second set of rows from the bottom:

Risk of severe hospitalization for <50yo's with Delta

	Unvaccinated	Total
Total cases	119,063	119,063
Hospitalization	1,712	1,712
Chance of hosp	(1,712 / 119,063) * 100	**1.44%**

	<21 days post dose 1	≥ 21 days post dose 1	2 doses	Total
Total cases	20,930	27,714	15,346	63,990
Hospitalization	185	239	140	564
Chance of hosp		(564 / 63,990) * 100		**0.88%**

So **a <50yo UNvaccinated person has about a 1.44% chance of severe hospitalization from Delta**, which is definitely not good, but **the same person vaccinated has a 0.88% chance of ending up in that same ICU bed.**

Even if we say "but for 100,000 people with Delta, 1.44% is 1,440 UNvaccinated patients hospitalized!"...that's also 880 vaccinated patients hospitalized (who were told they were going to be protected if they got the vaccine)

And if we remove 91.9% as having comorbidities based on the CDC comorbidity data for that age range, **an UNvaccinated Delta patient with no comorbidities has a 0.12% risk of hospitalization, and the same person vaccinated has a 0.07% risk**

6. So people <50yo in general (vaccinated or UNvaccinated), especially with no comorbidities, aren't at any real risk from the Delta variant...and even if the vaccine had *no* risks, at *best* the vaccinated patients have maybe half of that already pretty much non-existent risk

In summary the official UK Delta variant data shows:

Risk of death for <50yo's with Delta

Patient Status	Total	No Comorbidities
Unvaccinated	0.03%	0.02%
Vaccinated	0.016%	0.001%

Risk of severe hospitalization for <50yo's with Delta

Patient Status	Total	No Comorbidities
Unvaccinated	1.44%	0.12%
Vaccinated	0.88%	0.07%

Frequently Asked Questions

[A] "Aren't the unvaccinated causing the variants? They're variant factories!"

Think it through logically: what are the odds of the virus selecting for mutations that evade the vaccination in people who haven't had the vaccination? That's like bacteria becoming resistant to an antibiotic you haven't taken yet.

The unvaccinated *can* cause variants, because *every mutation risks being a variant*, but reinfected vaccinated people (even if asymptomatic) are mutating the same way...the difference being that their leaky vaccination provides selection pressure to promote mutations that resist or escape it.

As long as a virus can find new hosts, it doesn't *need* to mutate to survive. So the unvaccinated are actually *less* likely to create vaccine-escaping variants.

Alternatively if the vaccines were NOT leaky, they would prevent reinfection and transmission and the virus *wouldn't* be able to spread. Either of these are better than mass leaky vaccinations.

[B] "But the vaccines are effective against variants!"

You can find various numbers depending on where you look but the overall trend is exactly what you'd expect if you've read the rest of this document: the vaccines are less effective with each new variant. Which makes sense: the vaccine was designed for the original COVID-19 strain and the variants are by definition mutations that have mutated to escape the leaky vaccinations' antibodies:

> *https://www.medrxiv.org/content/10.1101/2021.05.20.21257461v1.full.pdf*
>
> *"summary estimates of the VE against any disease with infection for some of the variants of concern (VOC). The average VE for the VOC B.1.1.7, B.1.1.28 (P1) and B.1.351 are 86% (95% CI: 65 – 84%), 61% (95% CI: 43 - 73%) and 56% (95% CI: 29 - 73%), respectively"*
>
> *https://www.cdc.gov/mmwr/volumes/70/wr/mm7034e4.htm?s_cid=mm7034e4_w*
>
> *"The VE point estimates declined from **91%** before predominance of the SARS-CoV-2 Delta variant to **66%** since the SARS-CoV-2 Delta variant became predominant"*
>
> *https://www.biorxiv.org/content/10.1101/2021.07.28.454085v1*
>
> *"the Lambda S is highly infectious and resistant to the vaccine-induced humoral immunity, and the robust resistance of the Lambda S to the vaccine-induced neutralization is determined by a large deletion in the NTD"*

In less confusing chart form:

Vaccine Effectiveness against variants

Variant	Vaccine Effectiveness
B.1.1.7 (Alpha)	86%
B.1.1.28 (Gamma)	61%
B.1.351 (Beta)	56%
B.1.617.2 (Delta)	66%
C.37 (Lambda)	(not enough data, but appears nearly immune to the vaccines so far)

[C] "Well *any* risks from the vaccine are better than getting *actual* covid!"

If you're in your 80s with multiple comorbidities where COVID is genuinely dangerous, you could at least try to make an argument for that (if you could also address ADE, AOS, etc). But for young healthy people? And *especially* for anyone under 18yo who's physically active and has their peak immune system? And for *CHILDREN?*

As shown in the calculations using the official data, the benefit for anyone under 50yo with no comorbidities is about 0.01%. Now *is* the risk of myocardia, blood clots, stroke, etc from one or both of the vaccine shots or upcoming boosters *better?*

That choice is yours. But I recommend you calculate the official data for the 0-18 age range first, instead of going by headlines and anecdotes that apparently aren't being submitted to the CDC.

[D] "But the spike proteins in the vaccine are different than the virus!"

In what way? The Salk Institute appears to have only just reported that they're actually dangerous on April 30, 2021. Did we know that before then? Does the way they're different affect the damage they do or the amount that are created or how they spread or move? Is this NOT the first test for this? Do we have tests on whether the vaccine spike proteins do any damage at all?

If they don't, what's the explanation for side effects? If the vaccine "is completely harmless (ignore the side effects being reported)" and has spike proteins that "are totally different from the actual virus and won't harm you" and is somehow the first vaccine in the history of medicine that is actually risk-free, what exactly is the mechanism causing myocardia and blood clots etc?

Shouldn't we be able to explain what's happening *before* injecting billions of people?

[E] "The vaccines don't cause variants because Delta appeared before the vaccinations"

It's not that *only* leaky vaccines cause variants. Any mutation can. But the vaccines being leaky means that they put specific evolutionary pressure on the virus to escape them. A variant that would have been otherwise harmless, when handed a large population of people who've just been given a vaccine that makes them vulnerable to that mutation, can cause it to become the new dominant strain and further mutate into variants that escape it even more competently.

[F] "What if everyone had gotten vaccinated properly though?"

The problem is not only are we using leaky vaccines but there is no way to execute a worldwide mass vaccination in the middle of a pandemic in a non-leaky way *on top* of the vaccines also being leaky.

We would have had to somehow vaccinate everyone in the entire world on the exact same day at the exact same time with these leaky vaccines, then have everyone isolate perfectly until the second dose, and then repeat the worldwide simultaneous vaccination followed by more isolation. Even if we somehow managed to orchestrate all of that (which would involve stockpiling vaccines and having staff ready to handle this and getting everyone out of their homes lined up socially distanced to get vaccinated at the same time etc), we would still be dealing with innate immune system issues etc.

The plan was a Fool's Errand from the start. If the vaccines weren't leaky, or the pandemic was a small outbreak in an isolated community, or a dozen other "what if…?" scenarios were true, we might've been able to do it. But you ***CANNOT*** safely use leaky vaccines in the middle of an on-going pandemic.

[G] "Well what *could* we have done?"

In retrospect when we realized COVID-19 was mainly dangerous for old people and (as you can see from the official stats calculated earlier) was never a significant danger for young people, all we had to do was lockdown old people and let the young continue to run the economy and socialize as usual while encouraging the handling of comorbidities and keeping immune systems at peak via exercise, vitamins, healthy lifestyles etc

Young adults would all get sick but only a very small minority (again, going by the official statistics calculated earlier) would be in severe danger. No leaky vaccines would mean everyone's innate immune system is able to do its job and we would avoid variants. We would achieve herd immunity and then old people would be safe to rejoin society.

No economic ruin, no destruction of businesses, no year and a half of lockdowns, depression, children forced to isolate, etc

[H] “Ok then how do we turn this around?”

Imagine trying to turn the Titanic around. You have multiple crews on multiple decks that have to communicate and they all have to do their individual jobs in sync just to get the ship to start to change course. Now imagine most of those crew members refuse to believe there’s an iceberg ahead and some of them have political, financial, etc interests invested in NOT changing course.

[I] “So you think all these doctors and medical professionals are just LYING??”

Despite what you’ve seen on TV and in movies, doctors are simply human beings like yourself who’ve specialized in a field of study. It’s comforting to believe that every doctor knows everything about every medical field, but that’s simply not the case. In general, doctors go to med school and learn the basics of a ton of different areas of medicine and then they select a specific area of things to focus on.
A doctor who specializes in the brain won’t necessarily have a very deep knowledge of lung or skin conditions or colon cancer or the history of those fields and the latest happenings relating to them, relative to a specialist in those areas.

When you see your family doctor, they essentially know the basic common problems well, and then like a “jack of all trades master of none” they can diagnose you enough to know which specialist to send you to, who will have more expertise in an area.

As a result it’s possible for your doctor or experts chiming in to not know very much about the history of virology and experiments from the field, or know much about the vaccines aside from the generic briefing they’ve been given. And for the most part they are on the frontlines seeing dead bodies all day and probably aren’t following every little development and study that comes out. They know vaccines are good, get vaccines in people, and anyone hesitant is an ignorant stubborn anti-vax conspiracy theorist falling for Facebook memes and Fox News propaganda.

[J] “Ok so you think everyone *ELSE* is LYING??”

A lot of statistics are floating around and pushed in the media that say things like “the vaccine is 94% effective” and “X age range has 10x the risk as Y age range” and “unvaccinated people have worse symptoms than vaccinated people”, but these are misleading. Here’s an example from the CDC:

https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-age.html

They use 18-29yo as the reference group and 40-49yo’s have ***10x*** the rate of death! That’s horrifying! Except as we calculated earlier using the CDC’s own stats, 18-29yo’s without any comorbidities have a 0.004% rate of death or less...so that scary “10x the rate” is really only a 0.04% rate. Not as scary a number as you might have imagined seeing “10x”.

The important questions to ask when you see stats are:

- **“<u>94% effective relative to *WHAT?*</u>”** i.e. are they showing you the Relative Risk Ratio or the Absolute Risk Ratio? If you only have a 0.12% risk of hospitalization from Delta as a <50yo with no comorbidities, “94% effectiveness” isn’t really significant. But it’s harder to convince people to risk potential side-effects with “the vaccine will make you less than a percent safer”.

- “**<u>What are the age ranges?</u>**” i.e. a headline saying “Millions of Unvaccinated People Are Dying” sounds scary. But if they don’t show the data sorted by age groups then it’s likely that they’re talking about overall cases across all age ranges combined which leads you to believe your healthy 18yo son or your 25yo best friend with no comorbidities has the same risk of death as an 85yo with multiple comorbidities who has a 600x higher risk than them

- **“<u>Which strain of COVID?</u>”** i.e. “Vaccinated People Have Lower Rates of COVID Than Unvaccinated” is likely going by the original strain of COVID-19 the mRNAs are designed for. “Unvaccinated Man Dies of COVID” sounds bad, but how old was he, how many comorbidities did he have, and what strain of COVID did he get? Did they even test for which strain?

- **“<u>10x the risk as *WHAT?*</u>”** i.e. if your age range has 10x the risk of another age range, but *that* age range only has a 0.01% risk, “10x the risk” is really only 0.1%

- **“<u>Worse than *WHAT?*</u>”** i.e. 0.01% ***is*** technically “worse” than 0.005%, but both are pretty insignificant numbers. If you have 1 apple and I give you 1 apple, you now have twice the apples, a 100% increase! Wow! ...but it’s just a single apple

- **“<u>What were the time periods?</u>”** i.e. what constituted “unvaccinated”? People with no vaccine in them at all? People vaccinated within the last 14 days? Was the time period for side effects only counting for a few weeks after the vaccine? Is that enough time for everyone who has side effects to develop them, notice them, and be bothered enough by them to seek hospital care?

A CEO might say “My business is 1000x more successful than last year! And we’re producing 50% less pollution!” but if the business made $1 last year, that’s only a $1000 profit and if it was dumping 1000 barrels of nuclear waste into the ocean, that’s still 500 barrels.

No matter what headlines you see and what stats you see from whatever trusted news source you see them on, you can always follow the calculations in this document using the official CDC stats and see them for yourself.

And those numbers don’t in any way back up the political and media hysteria. And scary headlines and anecdotes don’t change what a leaky vaccine is or how they affect a virus etc

[K] “So are we going to see a fourth wave and fourth lockdown?”
Given the course of actions we’re taking, letting leakily vaccinated people who think they’re protected all go back to mingling face to face and classrooms with no masks or distancing, combined with an incoming winter cold & flu season, after ensuring no one’s immune system has encountered a single germ for almost 2 years with the amount of mask-wearing and isolating and hand-washing etc..?

...I can’t see any way there *couldn’t* be a fourth wave and a return to lockdowns. The vaccinated *should* isolate themselves immediately to prevent asymptomatically spreading infections to everyone, until we have vaccines that *aren’t* leaky, or ideally better alternative treatments than these leaky vaccines.

[L] “Ok well what vitamins should I take?”

You can look up more elaborate regimens but make sure you’re getting Vitamin D3, Zinc and pop a one-a-day multivitamin. Bare minimum take a multivitamin. Try to handle any comorbidities you have.

[M] “What if I or someone I know got the vaccine and the things in this doc are right?”

Understand that you are able to be reinfected and to transmit the infection to others, even if you’re asymptomatic. When you visit your grandparents, you may be carrying a variant without realizing it. This may mean you choose to continue following social distancing precautions around them, or it may mean you get a COVID test before visiting them, it’s up to you. But you should be aware of the risks.

In theory, a scenario we could end up seeing is that vaccinated people have to keep getting new boosters for new variants their leaky boosters keep creating, locking down every time a new variant appears to avoid catching it and triggering ADE until a new booster is made for that variant. If you’re over 80, this probably isn’t even that bad a scenario for you since you’re probably retired and mainly just want to be able to have your family and close friends visit. But if you’re under 50, or you have children, this would be an unfortunate lifestyle for you or them to have to live out.
Absolute worst case scenario, if we do enter an Antibody Dependent Enhancement scenario where the variants are deadly for the vaccinated, ADE is triggered upon reinfection. So you could theoretically isolate (or have an older family member you’re worried about isolate) and avoid getting reinfected until a solution comes along. Take your vitamins, work on any comorbidities you have, and just try to avoid getting reinfected where ADE could be triggered.

[N] “Debate me bro!”

I’d love to. Unfortunately the rabid hysteria everyone has embraced with frightening ease after two years of psychological lockdown torture combined with the dehumanization of anyone who questions these vaccines means it’s literally not safe to engage with anyone in public about this topic.

We are being called plague rats and blamed for the deaths of everyone’s loved ones by people who haven’t heard 99% of the basic terminology in this doc in their entire lives. I hope someday people will reflect on how quick they were to inject their children and turn on their neighbors over something they’ve put less time into researching than they spend deciding what to order from Uber Eats.

That said, if I see a good thorough rebuttal video to this doc by someone who’s actually done their research instead of using feels-based arguments, I might chance it and get in touch for a discussion.

[O] “This is all lies! Why should I believe anything here?! You know more than the experts?”

Everything in this document is sourced. I’m simply showing that vaccine hesitancy with regards to these particular leaky vaccines and the mRNA technology used in them is completely valid.

If you are able to thoroughly rebut the things in this document, then I welcome you to do so publicly. If you can make a convincing case then you may convince a significant number of vaccine hesitant people to get vaccinated. You will have to explain exactly why these vaccines aren’t leaky, why ADE isn’t a risk, why the spike proteins don’t cause damage, how the vaccines cause damage, why the CDC’s official data doesn’t show the risk the media and experts say there is, how the vaccines won’t suppress your innate immune system’s antibodies against future variants, how *exactly* “if everyone gets vaccinated we’ll all be able to return to normal” will work when these vaccines are leaky, etc, etc

Because emotional pleas, shaming language, threats, vague rebuttals like “that’s just not how it works okay??” and “it’s just different okay??” and “it’s just better okay??” and “that doesn’t even make sense, this is just all just crazy conspiracies” and talking down to us like we haven’t done more research on this topic than you or are all just crazy backwoods hillbilly anti-vaxxers who think every vaccine is bad and gives children autism etc isn’t going to work, especially not coming from people who are still saying nonsense like “the vaccines prevent infection” or “but you’ll have a lower viral load” or “the unvaccinated are causing variants” etc which just shows that you haven’t done even basic research.

Please debunk this document in full so that those of us waiting for actual discussion can get vaccinated.

Until then, we will continue to take care of our health, take our vitamins, and wait for alternatives that don’t involve using leaky mRNA vaccines that don’t prevent reinfection or transmission and suppress our innate immune system’s versatile antibodies over a 0.01% risk according to the CDC’s *own data*.

P.S. Please wear masks and stay 6 feet away, as you may be asymptomatically incubating new variants.