The Fallacy of Covid Vaccines And Transmission

Various faulty assumptions are driving Australia's public policy on vaccines. The latest data suggests that we should reconsider our course.

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The wheels are falling off the "vaccines are our our ticket to freedom" argument. It is becoming clear that the Covid vaccines are "leaky". They do not stop the vaccinated from acquiring the virus, particularly the now dominant Delta variant, and they do not prevent them from transmitting the virus. Moreover, the protection they do provide is likely short-lived, perhaps just six months.

Based on the faulty assumption that these vaccines stop transmissions, the media and politicians have oversimplified a rather complex science. Our vaccine policy should not be built on something we want it to do but what the data tells us it can do. The new mRNA injections, which were 95% effective in initial clinical trials at reducing symptoms in Alpha strain, are decreasingly effective against the Delta strain. This is seen by record cases and deaths in Israel, the world's most inoculated country.

The questions we need to ask about the vaccines include:

- Do they reduce transmission of Covid?
- Will they lead to herd immunity?
- Are they safe?

Do the Vaccines Reduce Transmission of Covid?

To cast further doubt on solely relying on vaccination to control Covid, in the three most vaccinated countries in the world – Israel (80%), Seychelles (70%), and Iceland (77%) – there are increasing numbers of Covid cases among the fully vaccinated. The waning efficacy of vaccines can be seen in Israel: by 30th August, Israel reached both record cases and deaths from Covid. This was exemplified in a locality in Jerusalem, where only 42.9% of the population has been fully vaccinated, but 85-90% of all hospitalised patients were fully vaccinated. Dr Vladimir Zelenko explains the situation well here.

In Iceland, Chief Epidemiologist Þórólfur Guðnason says vaccination has not led to the herd immunity for which experts had been hoping. In recent weeks, as the Delta variant outstripped all others in Iceland, it became clear that vaccinated people can easily contract it as well as spread it to others. In a briefing on 3rd August, he said that "the Covid-19 pandemic is not close to being over and will not be over until it's over everywhere".

Following this, on 8th August, he conceded the goal could not be to eradicate the virus from the community. Instead, he now believes it is necessary to try to achieve herd immunity by allowing the virus to spread throughout the community and prevent serious illness by protecting vulnerable groups. Looking at Iceland (77% vaccinated) and Australia (27.9% vaccinated), why would we think vaccination is our golden key out of the Covid nightmare?

We know that mRNA vaccines work by helping stop the replication of infections in the lungs but not in the mucosal linings of the mouth and nose. They do not prevent transmission and were not designed to do. In fact, in a preprint paper by the prestigious Oxford University Clinical Research Group, published

on the 10th August in *The Lancet*, recent studies showed that vaccinated individuals carry 251 times the load of the virus in their nostrils compared to the unvaccinated.

While moderating the symptoms of infection, injected individuals carry unusually high viral loads without becoming ill at first, potentially transforming them into presymptomatic spreaders. As previously discussed, this phenomenon may be the source of the post-vaccination surges in heavily vaccinated populations globally. As quoted by CDC director Rochelle Walensky, "these vaccinations have no ability to prevent infection by or transmission of the delta variant". This partial, non-sterilising immunity from the three novel COVID-19 vaccines will only get worse with re-vaccinations.

Will the Vaccines Lead to Herd Immunity?

Further proof of increased transmission in the vaccinated was confirmed on 30th July. The US Centers for Disease Control and Prevention announced that the Delta variant showed similarly high viral loads among unvaccinated and vaccinated cases. The CDC suggested an increased risk of transmission and raised concerns that, unlike with other variants, vaccinated people infected with Delta can transmit the virus.

Public Health England reached a similar conclusion on 6th August: virus levels in those who become infected with Delta having already been vaccinated may be similar to levels found in unvaccinated people. This may have implications for people's infectiousness, whether they have been vaccinated or not, meaning that vaccines will not suppress the virus spread as much as hoped.

In the UK, the Delta variant accounts for 99% of all Covid hospitalisations. Of these, 34.9% were fully vaccinated, and 55.1% had received at least one dose. Public Health England's Technical Briefing 20 in early August showed that while vaccination does reduce mortality in the over-50s by more than threefold, for those under 50, the fatality rate among the vaccinated is slightly higher than in the unvaccinated: 0.05 versus 0.03% (likely the result of several confounding variables).

On 10th August, a panel of experts, including most notably the head of the Oxford vaccine team, called for an end to mass testing in Britain because the Delta variant has destroyed any chance of herd immunity through vaccination. The scientists believe it is time to accept that there's no way of stopping the virus from spreading through the entire population, and monitoring people with mild symptoms is no longer helpful.

A pandemic can only be terminated for good if the population develops robust protective immunity against the virus. This naturally occurs through herd immunity and becomes stronger as a combined result of natural *disease-mediated immune selection* and *active immunisation* (i.e., as far as its adaptive, pathogen-specific component is concerned). The more robust the herd immunity becomes, the more effectively and durably the population controls the virus, the less frequently outbreaks will occur, and the less impressive those will be.

To quote Professor Robert Clancy, one of the most senior clinical immunologists in Australia and the most specialised when it comes to Covid:

> *The biology of Covid-19 infection dictates that while the parenteral genetic vaccines available to us will be necessary for short-term Covid control, they will have little impact on infection, will be limited in duration, and that antigen drift will create variants that will severely compromise efficacy. They will settle along influenza vaccine lines. Moreover, genetic vaccines by stimulating uncontrolled Spike protein synthesis will cause highly concerning adverse events of*

> *a short and long term nature that we can only surmise at this stage. All these outcomes have come about.*
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> *My point was, and is, that Ivermectin and like drugs are immediately needed, not to compete with vaccines, but to complement them: to reduce community spread; to treat early disease; to reduce progression to severe illness requiring admission to hospital and death, and to reduce the growing community repository of 'long Covid'. Making Ivermectin available across the Covid community now will be synergistic with the vaccine programme facilitating movement through the planned stages and greatly facilitate our reconnect with the world outside the bubble.*

In summary, the current vaccines will help reduce hospitalisation morbidity and death in the elderly and vulnerable but do little in preventing infection or reducing community spread. Indeed, they may achieve the opposite.

Are the Vaccines Safe?

To further interrogate the case for vaccinating the fit and healthy, there are increasing safety concerns about this. Statistics from the US Centers for Disease Control and Prevention (CDC) show 360 Covid deaths in children. All of them had serious comorbidities, yet for healthy children under the age of 18, 99.998% recovered with no treatment. Essentially, Influenza is more serious in healthy under 18-year-olds.

Furthermore, according to the CDC, myocarditis/pericarditis rates occur in approximately 12.6 cases per million doses of second-dose mRNA vaccine among individuals 12 to 39 years of age. However, if you're under the age of 40 and healthy, your risk of dying from COVID-19 is just 0.01%; you have a 99.99% chance of surviving the infection. For further safety concerns, see here, here and here.

So how do we justify vaccinating healthy under 18-year-olds from Covid who have a 99.998% chance of survival (according to the CDC) when vaccination increases transmission in those infected with Covid and potentially contributes to the production of variants? This isn't to mention the 50% decrease in efficacy after six months or the early triple therapy, which helps to reduce morbidity, long Covid and mortality. We could say the same for healthy people under 40 years old, who have a survival rate from Covid of 99.99%. Even healthy 50-59-year-olds have a 99.73% survival rate from Covid. So why risk mRNA injections when there is evidence for Ivermectin and triple therapy? How is this being ignored by APHRA, AMA, the TGA and other government authorities?

Instead, our governments have chosen to ignore history and have convinced themselves that these vaccines are safe. The problem is that they have done so at the expense of citizens who continue to trust the government and its health experts.

The Way Out of This

The government's starting point should be the lifting of lockdown restrictions as soon as possible. They can expedite this by using Ivermectin, Doxycycline and Zinc in triple therapy in early treatment protocols against Covid to reduce infection, hospital admissions, morbidity, long covid and mortality.

As per one of Australia's wisest academics, Professor Ramesh Thakur (former Assistant General of The United Nations), to escape the lockdowns and other measures which are causing enormous harms, we

should enact the following:

1. Set a hard target date for vaccines (non-mandatory) to be offered to all adults.
2. Proclaim in advance the end of all restrictions throughout Australia on that date. Those fully vaccinated are better protected against infections and, if infected, against the severity of illness. Those who have declined vaccination are solely responsible for their decision and its consequences for their health, but no more likely than the vaccinated to spread the virus.
3. Announce that domestic vaccination certificates are pointless and will not be required for any purpose based on everything we now know about transmissibility and breakthrough infections.
4. Terminate testing and contact tracing for asymptomatic people. It sustains a state of fear without serving any useful medical purpose.
5. Issue clear and coherent guidelines on voluntary best practice personal hygiene and social interactions to reduce spread, including rapid testing with the onset of symptoms and isolation following clinical diagnosis.
6. Loosen international travel but require rigorous protocols, including inexpensive and quick-results testing.
7. Invest in high-quality assessments of the efficacy of newly developed and repurposed early treatment drugs.
8. Invest in a substantial upgrade of the health, hospital and ICU infrastructure at the national level, with clear protocols for moving patients as required from infection hotspots to places with spare capacity. Thus we can guarantee open state borders.

The time for us to act is now. We are moving into dangerous territory. Together, we can help reduce the immense fear, suffering, health deterioration, and lockdowns in our nation by providing sane, safe, and practical solutions. It's time to lead with hope, not fear.