Contra

Brief Summary of Arguments Against Using *Only* Mass Vaccination Mid Coronavirus Pandemic.

Poor Efficacy

Delta Variant Key to Breakthrough Infections in Vaccinated Israelis

"Original antigenic sin": A potential threat beyond the development of booster vaccination against novel SARS-CoV-2 variants

"Regarding the novel variants, the accumulation of multiple mutations in the spike protein, which is the target for neutralizing antibodies, has challenged the efficacy of these vaccines. Several previous laboratory-based studies have reported that the neutralizing activity of sera obtained from individuals who were vaccinated is lower against novel SARS-CoV-2 variants, 2–5 highlighting the need for developing a booster vaccination containing new mutations of the virus.

A phenomenon called "original antigenic sin" (OAS) was firstly proposed by Francis 6 in 1960. This phenomenon occurs in the second exposure of the immune system to a similar pathogen to which it has previously been exposed. In this situation, the immune system progresses to the memory response, generating cross-reactive antibodies that may not be effective against the new pathogen. 7 In addition, it has been speculated that overproduction of memory B cells could compromise the activation of naïve B cells capable of producing efficient and novel antibodies. 8 In this way, OAS can trigger immune evasion of the emerging variants in those who had been affected by or vaccinated against former versions of the pathogen. In the context of coronaviruses, cross-neutralization is a rare event, but cross-reactivity in antibody binding to spike protein is common in SARS-CoV-2 and SARS-CoV."

SAGE 93 minutes: Coronavirus (COVID-19) response, 7 July 2021

"9. There are four major risks associated with high numbers of infections. These are an increase in hospitalisations and deaths, more 'Long-COVID'; workforce absences (including in the NHS); and the increased risk of new variants emerging. The combination of high prevalence and high levels of vaccination creates the conditions in which an immune escape variant is most likely to emerge. The likelihood of this happening is unknown, but such a variant would present a significant risk both in the UK and internationally."

The Lambda variant of SARS-CoV-2 has a better chance than the Delta variant to escape vaccines

"The newly emerging variants of SARS-CoV-2 from India (Delta variant) and South America (Lambda variant) have led to a higher infection rate of either vaccinated or unvaccinated people. We found that sera from Pfizer-BioNTech vaccine remain high reactivity toward the receptor-binding domain (RBD) of Delta variant while it drops dramatically toward that of Lambda variant. Interestingly, the overall titer of antibodies of Pfizer-BioNTech vaccinated individuals drops 3-fold after 6 months, which could be one of major reasons for breakthrough infections, emphasizing the importance of potential third boost shot. While a therapeutic antibody, Bamlanivimab, decreases binding affinity to Delta variant by ~20 fold, it fully lost binding to Lambda variant. Structural modeling of complexes of RBD with human receptor, Angiotensin Converting Enzyme 2 (ACE2), and Bamlanivimab suggest the potential basis of the change of binding. The data suggest possible danger and a potential surge of Lambda variant in near future."

Natural Immunity Superior

Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections

Conclusions:

This study demonstrated that natural immunity confers longer lasting and stronger protection against infection, symptomatic disease and hospitalization caused by the Delta variant of SARS-CoV-2, compared to the BNT162b2 two-dose vaccine-induced immunity. Individuals who were both previously infected with SARS-CoV-2 and given a single dose of the vaccine gained additional protection against the Delta Variant.

Necessity of COVID-19 vaccination in previously infected individuals

Conclusions: Individuals who have had SARS-CoV-2 infection are unlikely to benefit from COVID-19 vaccination, and vaccines can be safely prioritized to those who have not been infected before.

Risk of ADE

Vaccine Animal Trials for Sars 1, Mers and RSV. All of which are coronaviruses and exhibit a spike protein. This is where the Corona (Crown) virus gets its name. Coronaviruses have proved a unique obstacle to safe and effective vaccine production. Sars 1 shares 80% of the genetic code as Sars 2 (our current problem). As these problems are shared across the coronavirus family; adverse events/leakiness seems to

be shared by all the vaccines, including the Chinese (traditional: Inactive) Sinovac. I would argue that the burden of proof on their safety and efficacy for rollout of mass vaccination, mid pandemic, has a high bar and must be proven beyond a doubt. I believe that bar has already not been met. We have failed and should never have been attempted due to the unique risk of ADE with coronaviruses. These papers argue the same and base their conclusions in animal studies for previous coronaviruses. Focused protection, including education for the public and prioritizing early treatment, monoclonal antibodies and vaccines for the extremely vulnerable would have avoided this and provided a vastly better risk benefit ratio even with a leaky, definitionally unsafe vaccine.

Immunization with SARS coronavirus vaccines leads to pulmonary immunopathology on challenge with the SARS virus.

Conclusions: These SARS-CoV vaccines all induced antibody protection against infection with SARS-CoV. However, challenge of mice given any of the vaccines led to occurrence of Th2-type immunopathology suggesting hypersensitivity to SARS-CoV components was induced. Caution in proceeding to application of a SARS-CoV vaccine in humans is indicated.

Infection-enhancing anti-SARS-CoV-2 antibodies recognize both the original Wuhan/D614G strain and Delta variants. A potential risk for mass vaccination?

Antibody dependent enhancement (ADE) of infection is a safety concern for vaccine strategies. In a recent publication, Li et al. (Cell 184 :4203-4219, 2021) have reported that infection-enhancing antibodies directed against the N-terminal domain (NTD) of the SARS-CoV-2 spike protein facilitate virus infection in vitro, but not in vivo. However, this study was performed with the original Wuhan/D614G strain. Since the Covid-19 pandemic is now dominated with Delta variants, we analyzed the interaction of facilitating antibodies with the NTD of these variants. Using molecular modeling approaches, we show that enhancing antibodies have a higher affinity for Delta variants than for Wuhan/D614G NTDs. We show that enhancing antibodies reinforce the binding of the spike trimer to the host cell membrane by clamping the NTD to lipid raft microdomains. This stabilizing mechanism may facilitate the conformational change that induces the demasking of the receptor binding domain. As the NTD is also targeted by neutralizing antibodies, our data suggest that the balance between neutralizing and facilitating antibodies in vaccinated individuals is in favor of neutralization for the original Wuhan/D614G strain. However, in the case of the Delta variant, neutralizing antibodies have a decreased affinity for the spike protein, whereas facilitating antibodies display a strikingly increased affinity. Thus, ADE may be a concern for people receiving vaccines based on the original Wuhan strain spike sequence (either mRNA or viral vectors). Under these circumstances, second generation vaccines with spike protein formulations lacking structurally-conserved ADE-related epitopes should be considered.

Two Different Antibody-Dependent Enhancement (ADE) Risks for SARS-CoV-2 Antibodies

COVID-19 (SARS-CoV-2) disease severity and stages varies from asymptomatic, mild flu-like symptoms, moderate, severe, critical, and chronic disease. COVID-19 disease progression include lymphopenia, elevated proinflammatory cytokines and chemokines, accumulation of macrophages and neutrophils in lungs, immune dysregulation, cytokine storms, acute respiratory distress syndrome (ARDS), etc. Development of vaccines to severe acute respiratory syndrome (SARS), Middle East Respiratory Syndrome coronavirus (MERS-CoV), and other coronavirus has been difficult to create due to vaccine induced enhanced disease responses in animal models. Multiple betacoronaviruses including SARS-CoV-2 and SARS-CoV-1 expand cellular tropism by infecting some phagocytic cells (immature macrophages and dendritic cells) via antibody bound Fc receptor uptake of virus. Antibody-dependent enhancement (ADE) may be involved in the clinical observation of increased severity of symptoms associated with early high levels of SARS-CoV-2 antibodies in patients. Infants with multisystem inflammatory syndrome in children (MIS-C) associated with COVID-19 may also have ADE caused by maternally acquired SARS-CoV-2 antibodies bound to mast cells. ADE risks associated with SARS-CoV-2 has implications for COVID-19 and MIS-C treatments, B-cell vaccines, SARS-CoV-2 antibody therapy, and convalescent plasma therapy for patients. SARS-CoV-2 antibodies bound to mast cells may be involved in MIS-C and multisystem inflammatory syndrome in adults (MIS-A) following initial COVID-19 infection. SARS-CoV-2 antibodies bound to Fc receptors on macrophages and mast cells may represent two different mechanisms for ADE in patients. These two different ADE risks have possible implications for SARS-CoV-2 B-cell vaccines for subsets of populations based on age, cross-reactive antibodies, variabilities in antibody levels over time, and pregnancy. These models place increased emphasis on the importance of developing safe SARS-CoV-2 T cell vaccines that are not dependent upon antibodies.

COVID-19 Vaccines: Should We Fear ADE?

"Live virus challenge of animals given SARS or MERS vaccines resulted in vaccine hypersensitivity reactions (VAH), similar to those in humans given inactivated measles or respiratory syncytial virus vaccines. Safe and effective COVID-19 vaccines must avoid VAH."

A drug candidate for treating adverse reactions caused by pathogenic antibodies inducible by COVID-19 virus and vaccines

In a recent study, we reported that certain anti-spike antibodies of COVID-19 and SARS-CoV viruses can have a pathogenic effect through binding to sick lung epithelium cells and misleading immune responses to attack self-cells. We termed this new pathogenic mechanism "Antibody Dependent Auto-Attack" (ADAA). This study explores a drug candidate for prevention and treatment of such ADAA-based diseases. The drug candidate is a formulation comprising N-acetylneuraminic acid methyl ester (NANA-Me), an analog of N-acetylneuraminic acid. NANA-Me acts through a unique mechanism of action (MOA) which is repairment of the missing sialic acid on sick lung epithelium cells. This MOA can block the antibodies' binding to sick cells, which are vulnerable to

pathogenic antibodies. Our in vivo data showed that the formulation significantly reduced the sickness and deaths caused by pathogenic anti-spike antibodies. Therefore, the formulation has the potential to prevent and treat the serious conditions caused by pathogenic antibodies during a COVID-19 infection. In addition, the formulation has potential to prevent and treat the adverse reactions of COVID-19 vaccines because the vaccines can induce similar antibodies, including pathogenic antibodies. The formulation will be helpful in increasing the safety of the vaccines without reducing the vaccine's efficacy. Compared to existing antiviral drugs, the formulation has a unique MOA of targeting receptors, broad spectrum of indications, excellent safety profile, resistance to mutations, and can be easily produced.

Implications of antibody-dependent enhancement of infection for SARS-CoV-2 countermeasures

ADE has been observed with dengue virus2, Zika virus3, Ebola virus4 and, importantly in the context of COVID-19, coronaviruses (CoVs)5,6,7,8,9. Although no well-defined set of viral properties has been definitely established as causally linked to ADE, viruses with severe clinical manifestations of ADE show an ability to either replicate in macrophages or other immune cells or otherwise manipulate these cells' immunological state10,11. We believe that it is important to consider ADE in the context of efforts to develop countermeasures against the severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2). Indeed, data from previous CoV research strongly suggest that ADE may play a role in the virus's pathology. If this is the case with SARS-CoV-2, then careful design and testing of vaccines or alternative approaches to prophylaxis will be needed to prevent ADE.

Adverse Events

Most Information on Adverse Events is limited to "voluntary" databases, vaccine injury social media groups (Telegram etc) and articles, as it seems little to no peer-reviewed publication will publish information that could call the vaccine safety into question. You are, of course, free to discount these sources. However, I would caution against killing proverbial canaries when in a pandemic coal mine.

THE NOVEL CORONAVIRUS' SPIKE PROTEIN PLAYS ADDITIONAL KEY ROLE IN ILLNESS

"LA JOLLA—Scientists have known for a while that SARS-CoV-2's distinctive "spike" proteins help the virus infect its host by latching on to healthy cells. 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."

USA Vaccine Adverse Event Reporting System (VAERS)

VAERs Data Summary

Covid19 vaccinations through 5/31/2021 vs. Flu vaccinations 7/1/2019 – 5/31/2020 (last complete flu season)

Vaccine Type	# of Vaccinations	# of Deaths	Risk of Death	Percentage
Flu	167,447,642[1]	91	1 in 1,840,083	0.000054%
COVID19	167,733,972[2]	10,617	1 in 15,798	0.006330%

Risk of dying from COVID vaccine is 116.5 times greater than Flu Vaccine

Vaccine Type	# of Vaccinations	# of Adverse Reactions	Risk of Adverse Reaction	Percentage
Flu	167,447,642	10,448	1 in 16,027	0.006231%
COVID19	167,733,972	529,413	1 in 317	0.3156 %

Open VAERS

1,438,005 REPORTS OF VACCINE ADVERSE EVENTS IN VAERS

13,627 Post-COVID Vaccine Reported Deaths / 22,501 Total VAERS Reported Deaths

55,821 Post-COVID Vaccine Reported Hospitalizations/133,592 Total VAERS Reported Hospitalizations

623,341 COVID Vaccine Adverse Event Reports

United Kingdom (Yellow Card)

COVID-19 AstraZeneca Vaccine Analysis Print

TOTAL REACTIONS FOR DRUG 816393 1056

TOTAL REPORTS 229134

TOTAL FATAL OUTCOME REPORTS 1056

COVID-19 Moderna Vaccine Analysis Print

TOTAL REACTIONS FOR DRUG 43949

TOTAL REPORTS 14019

TOTAL FATAL OUTCOME REPORTS 17

COVID-19 mRNA Pfizer- BioNTech 9accine Analysis Print

TOTAL REACTIONS FOR DRUG 302146 508

TOTAL REPORTS 107215

TOTAL FATAL OUTCOME REPORTS 508

COVID-19 unspecified brand Vaccine Analysis Print

TOTAL REACTIONS FOR DRUG 3148 28

TOTAL REPORTS 1036

TOTAL FATAL OUTCOME REPORTS 28

European Union (Eudravigilance)

The EudraVigilance database reports that through July 31, 2021 there are **20,595 deaths and 1,960,607 injuries** reported following injections of COVID-19 vaccines:

- **COVID-19 MRNA VACCINE MODERNA (CX-024414)**
- **COVID-19 MRNA VACCINE PFIZER-BIONTECH**
- **COVID-19 VACCINE ASTRAZENECA (CHADOX1 NCOV-19)**
- **COVID-19 VACCINE JANSSEN (AD26.COV2.S**)

To find fatalities in Eudravigilance, enter a specific vaccine database, using the top menu slide, choose "Number of Individual Cases for a selected Reaction", choose any specific adverse event and in the bottom right will be listed the fatalities for the specific vaccine on that specific adverse reaction.

Circulating Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) Vaccine Antigen Detected in the Plasma of mRNA-1273 Vaccine Recipients.

Preliminary Findings of mRNA Covid-19 Vaccine Safety in Pregnant Persons

- Figure 4. Pregnancy Loss and Neonatal Outcomes in Published Studies and V-safe Pregnancy Registry Participants.

  "In Table 4, the authors report a rate of spontaneous abortion (Sab) in early pregnancy (<20 weeks) of 12.6% (104 Sabs/827 completed pregnancies). This number is misleading, however, as this subset represents only 20.9% of women enrolled in the registry, and 84.6% (n=700) of women received their first vaccine dose in the third trimester. For all other pregnancy outcomes, the authors calculated event proportions by dividing the number of events by the number of participants eligible for that event. However, for Sab they divide the number of events by the entire cohort of completed pregnancies, rendering the statistic meaningless.

  Moreover, although authors fail to report the median follow-up at the time of the analysis, they do state that limited follow-up calls were placed every 10 to 12 weeks, and pregnancies were ongoing in the vast majority of women who were vaccinated in their first and second trimesters. Therefore, the effect of the vaccines on early pregnancy losses (<20 weeks) is concerning and remains to be determined. Presumably, the Sab rate will be higher than 12.6% when more of the data on women vaccinated in early pregnancy is fully disclosed. Additionally, the authors indicate that the rate of Sabs in the published literature is between 10% and 26%.2-4 However, this range includes clinically-unrecognized pregnancies2,5,6 so the upper limit should be closer to 10% because the study relied on self-reporting that would only detect clinically recognized pregnancies.2,5,7 Reporting a Sab rate of 12.6% in Table 4 may lead some to conclude that there is no increased vaccine-associated risk of Sab in early pregnancy by comparing it to the background rate of 10% to 26%, whereas in reality the analysis cannot address this question in a meaningful fashion."

  - Dr. Peter McCullough

Menstrual experiences with COVID-19 vaccines

"When we were going through ethics approval, Katie and I had a discussion about how many people we anticipated would participate and the number we put in was 500 and that was being optimistic," said Kate Clancy, PhD, Director of Graduate Studies, Associate Professor of Anthropology, University of Illinois. "We hit 500 I think in the first couple of hours and in fact, were in the thousands within 24 hours."

Their research survey launched a few weeks ago and has nearly 130,000 replies from women sharing their menstrual experiences after vaccination. Clancy and Lee will use the data collected, "to better understand possible relationships between bleeding patterns and COVID-19 vaccine administration."

Quote Source.

Reports of Injuries, Deaths After COVID Vaccines Climb Steadily, as FDA, CDC Sign Off on Third Shot for Immunocompromised

"VAERS data released Friday by the CDC showed a total of 571,831 reports of adverse events from all age groups following COVID vaccines, including 12,791 deaths and 77,490 serious injuries between Dec. 14, 2020 and Aug. 6, 2021."

Mother weeps as she tells senator how Pfizer shot left her daughter wheelchair-bound.
"Why is she not back to normal? She was totally fine before this," said Stephanie de Garay, Maddie's mother. Maddie had volunteered for the Pfizer vaccine trial "to help everyone else and they're not helping here. Before Maddie got her final dose of the vaccine, she was healthy, got straight As, had lots of friends and had a life."

Some doctors attempted to attribute her neurological condition to anxiety and tried to send Maddie to a mental hospital. This caused her parents to seek aid from other sources. They met others suffering from similar adverse vaccine reactions who connected them with competent medical professionals."

The Covid vaccines may affect periods. Are we allowed to talk about this?

"I will spare the details but suffice to say that after I had my first jab of Pfizer in late May, my cycle was flung off course. I did consider reporting it to the MHRA's Yellow Card scheme, through which people can voluntarily report any suspected side effect from the jabs, but confess I felt silly to worry. It wasn't exactly a blood clot or a heart murmur. When I had my second dose, the man in the booth asked whether I had experienced any side effects. I mentioned the changes to my period. He logged it on my file, said it would be flagged to the MHRA scheme and a minute later a doctor rushed in to reassure me there was 'no reason to be concerned that the Covid jab would affect my fertility'. I hadn't asked if there was."

Did Pfizer Fail to Perform industry Standard Animal Testing Prior to Initiation of mRNA Clinical Trials?

The FOIA documents reveal animal study results demonstrating that the Pfizer mRNA-based vaccine does not remain at the injection site, but rather appears to spread widely after injection. According to the documents, pre-clinical studies show that the active part of the vaccine (mRNA-lipid nanoparticles), which produce the spike protein, spreads throughout the body and is then concentrated in various organs, including the ovaries and spleen. The FOIA-produced data sets are incomplete, so the full meaning of these data cannot be determined at this time. TrialSite has also learned via regulatory documents that apparently (at least in their European Medicines Agency submission), Pfizer did not follow industry-standard quality management practices during preclinical toxicology studies during vaccines, as key studies did not meet good laboratory practice (GLP). The full panel of industry-standard reproductive toxicity and genotoxicity studies were apparently also not performed.

SARS-CoV-2 mRNA Vaccine (BNT162, PF-07302048) PHARMACOKINETICS

See page 7 for concentrations of Lipid NanoParticle (Packaging for Spike Protein) in the body post vaccination.

Bioethics of Experimental COVID Vaccine Deployment under EUA: It's time we stop and look at what's going down

"What was most alarming to me was that my clinical primary practice physician colleague told me that each of these cases were reported as per the proper channels in Canada, and each was summarily determined to not be vaccine related by the authorities without significant investigation."

Effective Treatments & Effective Drugs

Early Treatment & Drug Combinations

Pathophysiological Basis and Rationale for Early Outpatient Treatment of SARS-CoV-2 (COVID-19) Infection.

Approximately 9 months of the severe acute respiratory syndrome coronavius-2 (SARS-CoV-2 [COVID-19]) spreading across the globe has led to widespread COVID-19 acute hospitalizations and death. The rapidity and highly communicable nature of the SARS-CoV-2 outbreak has hampered the design and execution of definitive randomized, controlled trials of therapy outside of the clinic or hospital. In the absence of clinical trial results, physicians must use what has been learned about the pathophysiology of SARS-CoV-2 infection in determining early outpatient treatment of the illness with the aim of preventing hospitalization or death. This article outlines key pathophysiological principles that relate to the patient with early infection treated at home. Therapeutic approaches based on these principles include 1) reduction of reinoculation, 2) combination antiviral therapy, 3) immunomodulation, 4) antiplatelet/antithrombotic therapy, and 5) administration of oxygen, monitoring, and telemedicine. Future randomized trials testing the principles and agents

discussed will undoubtedly refine and clarify their individual roles; however, we emphasize the immediate need for management guidance in the setting of widespread hospital resource consumption, morbidity, and mortality.

Ivermectin

[Review of the Emerging Evidence Demonstrating the Efficacy of Ivermectin in the Prophylaxis and Treatment of COVID-19]

In March 2020, the Front Line COVID-19 Critical Care Alliance (FLCCC) was created and led by Professor Paul E. Marik to continuously review the rapidly emerging basic science, translational, and clinical data to develop a treatment protocol for COVID-19. The FLCCC then recently discovered that ivermectin, an anti-parasitic medicine, has highly potent anti-viral and anti-inflammatory properties against COVID-19. They then identified repeated, consistent, large magnitude improvements in clinical outcomes in multiple, large, randomized and observational controlled trials in both prophylaxis and treatment of COVID-19. Further, data showing impacts on population wide health outcomes have

Review of the Emerging Evidence Supporting the Efficacy of Ivermectin in the Prophylaxis and Treatment of COVID-19 [FLCCC Alliance; updated Jan 16, 2021] 2 / 30 www.flccc.net resulted from multiple, large "natural experiments" that occurred when various city mayors and regional health ministries within South American countries initiated "ivermectin distribution" campaigns to their citizen populations in the hopes the drug would prove effective. The tight, reproducible, temporally associated decreases in case counts and case fatality rates in each of those regions compared to nearby regions without such campaigns, suggest that ivermectin may prove to be a global solution to the pandemic. This was further evidenced by the recent incorporation of ivermectin as a prophylaxis and treatment agent for COVID-19 in the national treatment guidelines of Belize, Macedonia, and the state of Uttar Pradesh in Northern India, populated by 210 million people. To our knowledge, the current review is the earliest to compile sufficient clinical data to demonstrate the strong signal of therapeutic efficacy as it is based on numerous clinical trials in multiple disease phases. One limitation is that half the controlled trials have been published in peer-reviewed publications, with the remainder taken from manuscripts uploaded to medicine pre-print servers. Although it is now standard practice for trials data from pre-print servers to immediately influence therapeutic practices during the pandemic, given the controversial therapeutics adopted as a result of this practice, the FLCCC argues that it is imperative that our major national and international health care agencies devote the necessary resources to more quickly validate these studies and confirm the major, positive epidemiological impacts that have been recorded when ivermectin is widely distributed among populations with a high incidence of COVID-19 infections.

[The FDA-approved drug ivermectin inhibits the replication of SARS-CoV-2 in vitro.]

Highlights

- Ivermectin is an inhibitor of the COVID-19 causative virus (SARS-CoV-2) in vitro.•
- A single treatment is able to effect ~5000-fold reduction in virus at 48 h in cell culture.
- Ivermectin is FDA-approved for parasitic infections, and therefore has a potential for repurposing.
- Ivermectin is widely available, due to its inclusion on the WHO model list of essential medicines.

FLCCC (Front Line COVID Critical Care Alliance)

EPIDEMIOLOGIC ANALYSES ON IVERMECTIN IN COVID-19

The Latest Results of Ivermectin's Success in Treating Outbreaks of COVID-19

Ivermectin in COVID-19

These pages contain the scientific rationale that justifies the use of ivermectin in COVID-19.

Treatment & Prophylaxis Protocols

MATH+ Hospital Treatment Protocol for COVID-19

I-RECOVER Management Protocol for Long Haul COVID-19 Syndrome (LHCS)

I-MASK+ Prevention & Early Outpatient Treatment Protocol for COVID-19

In October 2020, the FLCCC Alliance developed a preventive and early outpatient combination treatment protocol for COVID-19 called I-MASK+. It's centered around ivermectin, a well-known, FDA-approved anti-parasite drug that has been used successfully for more than four decades to treat onchocerciasis "river blindness" and other parasitic diseases. It is one of the safest drugs known. It is on the WHO's list of essential medicines, has been given 3.7 billion times around the globe, and has won the Nobel prize for its global and historic impacts in eradicating endemic parasitic infections in many parts of the world. Our medical discovery of a rapidly growing published medical evidence base, demonstrating ivermectin's unique and highly potent ability to inhibit SARS-CoV-2 replication and to suppress inflammation, prompted our team to use ivermectin for prevention and treatment in all stages of COVID-19. Ivermectin is not yet FDA-approved for the treatment of COVID-19, but on Jan 14, 2021, the NIH changed

their recommendation for the use of ivermectin in COVID-19 from “against” to “neutral”. (see our press release).

Our life-saving MATH+ Hospital Treatment Protocol for COVID-19 (available in several languages), created in March 2020, is intended for hospitalized patients. The recently developed I-MASK+ Prevention & Early Outpatient Treatment Protocol for COVID-19 (this page) is designed for use as a prevention and in early outpatient treatment, for those who test positive for COVID-19. The protocols complement each other, and both are physiologic-based combination treatment regimens developed by leaders in critical care medicine. All the component medicines are FDA-approved (except ivermectin), inexpensive, readily available and have been used for decades with well-established safety profiles.

Please download and share our I-MASK+ Prevention & Early Outpatient Treatment Protocol for COVID-19. (It is currently being translated into several languages).

Below are a list of links to our one-page summary of the latest evidence for the protocol, plus videos of FLCCC Alliance doctors discussing the emerging evidence for the use of ivermectin in the prevention and treatment of COVID-19, and a short list of up-to-date studies and clinical trials on this topic.

White paper on Ivermectin as a potential therapy for COVID-19

A group of senior doctors with vast clinical experience met on 19th July'20 under the aegis of Academy of Advanced Medical Education. The panel looked at Ivermectin, one of the old molecule and evaluated it's use in COVID 19 (Novel Coronavirus Disease 2019) management. After critical panel discussion, all the attending doctors came to a conclusion that Ivermectin can be a potential molecule for prophylaxis and treatment of people infected with Coronavirus, owing to its anti-viral properties coupled with effective cost, availability and good tolerability and safety.

Safety of Ivermectin

MEDICAL SAFETY OF IVERMECTIN

“Ivermectin was first approved as a human medicine in 1987. In addition to 40 years of extensive use as a veterinary medicine, it has been prescribed to hundreds of millions of human beings worldwide to prevent or treat a variety of parasitic diseases. Recently, the anti-SARS-cov-2 activity of ivermectin became the focus of numerous experimental studies and clinical trials, the results and interpretation of which generated a vigorous and still ongoing debate to establish how effective ivermectin is or could be against COVID-19. Drug approvals by regulatory authorities rely on a risk-benefit analysis. Benefit is assessed from clinical trials conducted in full compliance with guidelines. Severe adverse reactions are often too rare to enable clinical trials to generate accurate quantitative incidence data. Pharmacovigilance (or post-marketing drug surveillance) is another essential source of information on drug safety. The aim of this expert review

report is to propose an independent and fair assessment of ivermectin medical safety profile based on an extensive analysis of the publicly available information (over 500 articles and web sources) taking into account known limitations and uncertainties at the time of writing… The often-reiterated claim, even today, that ivermectin can be lethal in treated patients only rests on a one-page correspondence to the Lancet published in 1997. This claim is deemed to be unfounded as it has never been further substantiated until today and instead, subsequent publications repeatedly showed this claim was either incorrect or methodologically inaccurate."

Meta Analysis

[Meta-analysis of randomized trials of ivermectin to treat SARS-CoV-2 infection]

Ivermectin is an antiparasitic drug being investigated for repurposing against SARS-CoV-2. Ivermectin showed in-vitro activity against SARS-COV-2 at high concentrations. This metaanalysis investigated ivermectin in 24 randomized clinical trials (3328 patients) identified through systematic searches of PUBMED, EMBASE, MedRxiv and trial registries. Ivermectin was associated with reduced inflammatory markers (C-Reactive Protein, d-dimer and ferritin) and faster viral clearance by PCR. Viral clearance was treatment dose- and duration dependent. In 11 randomized trials of moderate/severe infection, there was a 56% reduction in mortality (Relative Risk 0.44 [95%CI 0.25-0.77]; p=0.004; 35/1064 (3%) deaths on ivermectin; 93/1063 (9%) deaths in controls) with favorable clinical recovery and reduced hospitalization. Many studies included were not peer reviewed and a wide range of doses were evaluated. Currently, WHO recommends the use of ivermectin only inside clinical trials. A network of large clinical trials is in progress to validate the results seen to date.

[Ivermectin for Prevention and Treatment of COVID-19 Infection: A Systematic Review, Meta-analysis, and Trial Sequential Analysis to Inform Clinical Guidelines]

Background: *Repurposed medicines may have a role against the SARS-CoV-2 virus. The antiparasitic ivermectin, with antiviral and anti-inflammatory properties, has now been tested in numerous clinical trials.*

Areas of uncertainty: *We assessed the efficacy of ivermectin treatment in reducing mortality, in secondary outcomes, and in chemoprophylaxis, among people with, or at high risk of, COVID-19 infection. Data sources: We searched bibliographic databases up to April 25, 2021. Two review authors sifted for studies, extracted data, and assessed risk of bias. Meta-analyses were conducted and certainty of the evidence was assessed using the GRADE approach and additionally in trial sequential analyses for mortality. Twenty-four randomized controlled trials involving 3406 participants met review inclusion.*

Quercetin

[A role for quercetin in coronavirus disease 2019 (COVID-19)]

“The WHO announced this new disease was to be known as "COVID-19." When looking for new antiviral compounds, knowledge of the main viral proteins is fundamental. The major druggable targets of SARS-CoV-2 include 3-chymotrypsin-like protease (3CLpro), papain-like protease (PLpro), RNA-dependent RNA polymerase, and spike (S) protein. Quercetin inhibits 3CLpro and PLpro with a docking binding energy corresponding to -6.25 and -4.62 kcal/mol, respectively. Quercetin has a theoretical, but significant, capability to interfere with SARS-CoV-2 replication, with the results showing this to be the fifth best compound out of 18 candidates. On the basis of the clinical COVID-19 manifestations, the multifaceted aspect of quercetin as both antiinflammatory and thrombin-inhibitory actions, should be taken into consideration.”

FLCCC Medical Evidence for Treatment

This page contains the medical evidence in support of the individual medical therapies that make up our MATH+ Hospital Treatment Protocol for COVID-19 as well as the I-MASK+ and I-MASS Preventive and Early Outpatient Treatment Protocols and the medicines included in our more recent I-RECOVER protocol for long-haul COVID syndrome. In October 2020, we added ivermectin to our COVID-19 protocols, which we regard as a core medication in the prevention and treatment of COVID-19.

Evidence of Poor Public Policy

The Noble Lies of COVID-19

Leading Contrarian Scientist & Doctors

Geert Vanden Bossche (DVM, PhD)

“Geert Vanden Bossche received his DVM from the University of Ghent, Belgium, and his PhD degree in Virology from the University of Hohenheim, Germany. He held adjunct faculty appointments at universities in Belgium and Germany. After his career in Academia, Geert joined several vaccine companies (GSK Biologicals, Novartis Vaccines, Solvay Biologicals) to serve various roles in vaccine R&D as well as in late vaccine development. Geert then moved on to join the Bill & Melinda Gates Foundation’s Global Health Discovery team in Seattle (USA) as Senior Program Officer; he then worked with the Global Alliance for Vaccines and Immunization (GAVI) in Geneva as Senior Ebola Program Manager. At GAVI he tracked efforts to develop an Ebola vaccine. He also represented GAVI in fora with other partners, including WHO, to review progress on the fight against Ebola and to build plans for global pandemic preparedness. Back in 2015, Geert scrutinized and questioned the safety of the Ebola vaccine that was used in ring

vaccination trials conducted by WHO in Guinea. His critical scientific analysis and report on the data published by WHO in the Lancet in 2015 was sent to all international health and regulatory authorities involved in the Ebola vaccination program. After working for GAVI, Geert joined the German Center for Infection Research in Cologne as Head of the Vaccine Development Office. He is at present primarily serving as a Biotech/ Vaccine consultant while also conducting his own research on Natural Killer cell-based vaccines."

Dr. Robert Malone (MD etc.,)

"Dr. Malone is the discoverer of in-vitro and in-vivo RNA transfection and the inventor of mRNA vaccines, while he was at the Salk Institute in 1988. His research was continued at Vical in 1989, where the first in-vivo mammalian experiments were designed by him. The mRNA, constructs, reagents were developed at the Salk institute and Vical by Dr. Malone. The initial patent disclosures were written by Dr. Malone in 1988-1989. Dr. Malone was also an inventor of DNA vaccines in 1988 and 1989. This work results in over 10 patents and numerous publications, yielding about 7000 citations for this work. Dr. Malone was also an inventor of DNA vaccines in 1988 and 1989."

Dr. Bret Weinstein (PhD)

Bret Weinstein is an evolutionary biologist and former professor at The Evergreen State College. He has become a successful online thought-leader and commentator.

Dr. Peter McCullough (MD etc.,)

"Dr. Peter McCullough is an internist, cardiologist, epidemiologist, in academic medical practice in Dallas, Texas, USA. He maintains ABIM certification in internal medicine and cardiovascular diseases. He practices both internal medicines including the management of common infectious diseases as well as the cardiovascular complications of both the viral infection and the injuries developing after the COVID-19 vaccine.

Since the outset of the pandemic, Dr. McCullough has been a leader in the medical response to the COVID-19 disaster and has published "Pathophysiological Basis and Rationale for Early Outpatient Treatment of SARS-CoV-2 (COVID-19) Infection" the first synthesis of sequenced multidrug treatment of ambulatory patients infected with SARS-CoV-2 in the American Journal of Medicine and subsequently updated in Reviews in Cardiovascular Medicine.

He has 46 peer-reviewed publications on the infection and has commented extensively on the medical response to the COVID-19 crisis in TheHill and on FOX NEWS Channel.

On November 19, 2020, Dr. McCullough testified in the US Senate Committee on Homeland Security and Governmental Affairs and throughout 2021 in the Texas Senate Committee on Health and Human Services, Colorado General Assembly, and New Hampshire Senate concerning many aspects of the pandemic response. Dr. McCullough

has had one full year of dedicated academic and clinical efforts in combating the SARS-CoV-2 virus and in doing so, has reviewed thousands of reports, participated in scientific congresses, group discussions, press releases, and has been considered among the world's experts on COVID-19."

Video & Podcasts - Medical Doctors, Evolutionary Biologists and Immunologists, Toxicologists et al.,

DarkHorse Podcast - PhDs Bret Weinstein & Hething Heying.

PhDs in Evolutionary Biology.

DarkHorse Podcast with Tess Lawrie & Bret Weinstein

COVID, Ivermectin, and the Crime of the Century - DarkHorse Podcast with Pierre Kory & Bret Weinstein

How to Save the World, in Three Easy Steps.

Peak Prosperity - Chris Martenson PhD

PhD and a postdoctoral program at Duke University. Specialized in neurotoxicology.

The Vaccines: Awesome Ingenuity or a Huge Mistake (Full Interview with Dr. Geert Vanden Bossche)

General Data

https://www.worldometers.info/coronavirus/worldwide-graphs/

Cases & Deaths Worldwide

COVID-19 Cases World Wide: 219,000,000 circa

COVID-19 Deaths World Wide: 4,500,000 circa

Case Fatality Rate (CFI): ~0.021%

Infection Model Estimates

https://ourworldindata.org/covid-models

Cases: 200,000,000 circa

Mean Infection Estimate: 700,000,000

Infection Fatality Rate (IFR) ~0.0058%

Estimated Infections (Mild, No Test, Unaware)