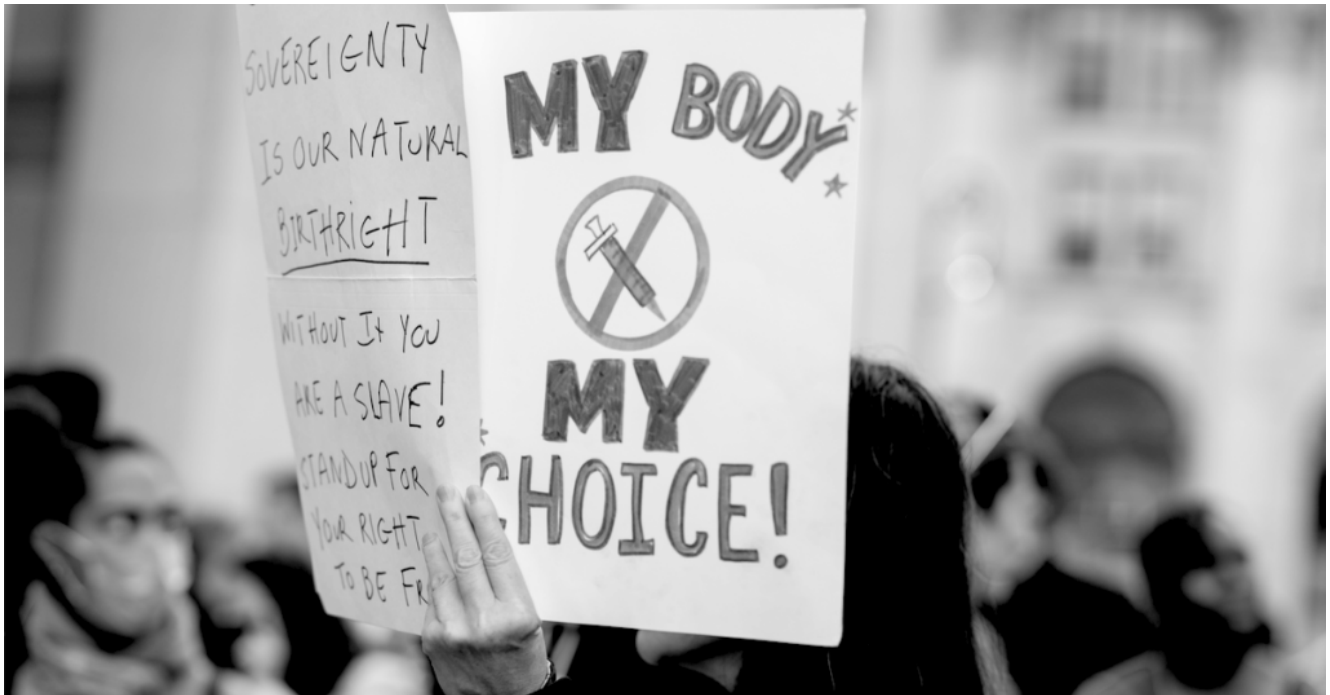


20 Research Studies Challenge Bad Science Used to Justify COVID Vaccine Mandates



The following research papers and studies raise doubts that COVID vaccine mandates are backed by science and good public health practice. Anyone seeking to challenge these mandates should consult these carefully. They demonstrate that these mandates provide no overall health benefit to the community and can even be harmful. Instead, the decision to accept the vaccine should be made by individuals according to their own assessment of risks in consultation with informed medical professionals.

The model of [Marek's disease](#) ('leaky' non-sterilizing, non-neutralizing vaccines that reduce symptoms but do not stop infection or transmission) and the concept of the [original antigenic sin](#) (the initial priming of the immune system prejudices the immune response to the pathogen or similar pathogen life-long) may explain what we are potentially facing now with these mass mandates of COVID vaccines (immune escape,

increased transmission, faster transmission, and potentially more 'hotter' variants).

In addition, such mandates result in the forced separation and segregation of society. They create hazards for people in their professional lives. For example, why would governments impose punitive career-altering vaccine mandates on an unvaccinated nurse who is most likely already immune due to natural exposure? Mandates also represent an encroachment on freedom and liberties and call into question the motives behind these mandates when the science shows no public benefit compared with the costs.

Below you can see the scientific evidence that call into question COVID-19 vaccine mandates.

<p>1) <u>No Significant Difference in Viral Load Between Vaccinated and Unvaccinated, Asymptomatic and Symptomatic Groups When Infected with SARS-CoV-2 Delta Variant</u>, Acharya, 2021</p>	<p>“Found no significant difference in cycle threshold values between vaccinated and unvaccinated, asymptomatic and symptomatic groups infected with SARS-CoV-2 Delta.”</p>
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2) [Vaccinated and unvaccinated individuals have similar viral loads in communities with a high prevalence of the SARS-CoV-2 delta variant,](#)
Riemersma, 2021
[Shedding of Infectious SARS-CoV-2 Despite Vaccination when the Delta Variant is Prevalent – Wisconsin, July 2021](#)

“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...if vaccinated individuals become infected with the delta variant, they may be sources of SARS-CoV-2 transmission to others...data substantiate the idea that vaccinated individuals who become infected with the Delta variant may have the potential to transmit SARS-CoV-2 to others.”

3) [Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections](#), Gazit, 2021

“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... SARS-CoV-2-naïve vaccines had a 13.06-fold (95% CI, 8.08 to 21.11) increased risk for breakthrough infection with the Delta variant compared to those previously infected.”...para 27 fold increased risk of symptomatic COVID and 8 fold increased risk of hospitalization (vaccinated over unvaccinated).

4) [Effectiveness of Covid-19 Vaccination Against Risk of Symptomatic Infection, Hospitalization, and Death Up to 9 Months: A Swedish Total-Population Cohort Study, Nordström, 2021](#)

“Report on their study which shows that (cohort comprised 842,974 pairs (N=1,684,958), including individuals vaccinated with 2 doses of ChAdOx1 nCoV-19, mRNA-1273, or BNT162b2, and matched unvaccinated individuals) “vaccine effectiveness of BNT162b2 against infection waned progressively from 92% (95% CI, 92-93, P<0.001) at day 15-30 to 47% (95% CI, 39-55, P<0.001) at day 121-180, and from day 211 and onwards no effectiveness could be detected (23%; 95% CI, -2-41, P=0.07)” ...while the vaccine provides temporary protection against infection, the efficacy declines below zero and then to negative efficacy territory at approximately 7 months, underscoring that the vaccinated are highly susceptible to infection and eventually become highly infected (more so than the unvaccinated).

<p>5) Waning of BNT162b2 vaccine protection against SARS-CoV-2 infection in Qatar, Chemaitelly, 2021</p>	<p>“Qatar study which showed that the vaccine efficacy (Pfizer) declined to near zero by 5 to 6-months and even immediate protection after one to two months were largely exaggerated... BNT162b2-induced protection against infection appears to wane rapidly after its peak right after the second dose.”</p>
<p>6) Transmission of SARS-CoV-2 Delta Variant Among Vaccinated Healthcare Workers, Vietnam, Chao, 2021</p>	<p>Looks at transmission of SARS-CoV-2 Delta variant among vaccinated healthcare workers in Vietnam. 69 healthcare workers were tested positive for SARS-CoV-2. 62 participated in the clinical study. Researchers reported “23 complete-genome sequences were obtained. They all belonged to the Delta variant, and were phylogenetically distinct from the contemporary Delta variant sequences obtained from community transmission cases, suggestive of ongoing transmission between the workers. Viral loads of breakthrough Delta variant infection cases were 251 times higher than those of cases infected with old strains detected between March-April 2020.”</p>

<p>7) Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings – Barnstable County, Massachusetts, July 2021, Brown, 2021</p>	<p>Barnstable, Massachusetts, July 2021 CDC MMWR study found that in 469 cases of COVID-19, there were 74% that occurred in fully vaccinated persons. “The vaccinated had on average more virus in their nose than the unvaccinated who were infected.”</p>
<p>8) An outbreak caused by the SARS-CoV-2 Delta variant (B.1.617.2) in a secondary care hospital in Finland, May 2021, Hetemäki, 2021</p>	<p>“In conclusion, this outbreak demonstrated that, despite full vaccination and universal masking of HCW, breakthrough infections by the Delta variant via symptomatic and asymptomatic HCW occurred, causing nosocomial infections...secondary transmission occurred from those with symptomatic infections despite use of personal protective equipment (PPE).”</p>

9) [Nosocomial outbreak caused by the SARS-CoV-2 Delta variant in a highly vaccinated population, Israel, July 2021, Shitrit, 2021](#)

“The PPE and masks were essentially ineffective in the healthcare setting. The index cases were usually fully vaccinated and most (if not all transmission) tended to occur between patients and staff who were masked and fully vaccinated, underscoring the high transmission of the Delta variant among vaccinated and masked persons...this nosocomial outbreak exemplifies the high transmissibility of the SARS-CoV-2 Delta variant among twice vaccinated and masked individuals.”

<p>10) COVID-19 vaccine surveillance report Week 42, PHE, 2021 Report # 44: PHE</p>	<p>Information on page 23 raises serious concerns when it reported that “waning of the N antibody response over time and (iii) recent observations from UK Health Security Agency (UKHSA) surveillance data that N antibody levels appear to be lower in individuals who acquire infection following 2 doses of vaccination.” Also shows a pronounced and very troubling trend, which is that the “double vaccinated persons are showing greater infection (per 100,000) than the unvaccinated, and especially in the older age groups e.g. 30 years and above.”</p>
<p>11) Waning Immune Humoral Response to BNT162b2 Covid-19 Vaccine over 6 Months, Levin, 2021</p>	<p>“Six months after receipt of the second dose of the BNT162b2 vaccine, humoral response was substantially decreased, especially among men, among persons 65 years of age or older, and among persons with immunosuppression.”</p>
<p>12) Increases in COVID-19 are unrelated to levels of vaccination across 68 countries and 2947 counties in the United States, Subramanian, 2021</p>	<p>“Increases in COVID-19 are unrelated to levels of vaccination across 68 countries and 2947 counties in the United States.”</p>

<p>13) Durability of immune responses to the BNT162b2 mRNA vaccine, Suthar, 2021</p>	<p>“Examined the durability of immune responses to the BNT162b2 mRNA vaccine. They “analyzed antibody responses to the homologous Wu strain as well as several variants of concern, including the emerging Mu (B.1.621) variant, and T cell responses in a subset of these volunteers at six months (day 210 post-primary vaccination) after the second dose ...“data demonstrate a substantial waning of antibody responses and T cell immunity to SARS-CoV-2 and its variants, at 6 months following the second immunization with the BNT162b2 vaccine.”</p>
<p>14) Infection-enhancing anti-SARS-CoV-2 antibodies recognize both the original Wuhan/D614G strain and Delta variants. A potential risk for mass vaccination?, Yahi, 2021</p>	<p>Reported that “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).”</p>

<p>15) Hospitalisation among vaccine breakthrough COVID-19 infections, Juthani, 2021</p>	<p>Identified 969 patients who were admitted to a Yale New Haven Health System hospital with a confirmed positive PCR test for SARS-CoV-2... “Observed a higher number of patients with severe or critical illness in those who received the BNT162b2 vaccine than in those who received mRNA-1273 or Ad.26.COV2.S.”</p>
<p>16) The impact of SARS-CoV-2 vaccination on Alpha & Delta variant transmission, Eyre, 2021</p>	<p>“Examined the impact of SARS-CoV-2 vaccination on Alpha & Delta variant transmission. They reported that “while vaccination still lowers the risk of infection, similar viral loads in vaccinated and unvaccinated individuals infected with Delta question how much vaccination prevents onward transmission... transmission reductions declined over time since second vaccination, for Delta reaching similar levels to unvaccinated individuals by 12 weeks for ChAd0x1 and attenuating substantially for BNT162b2. Protection from vaccination in contacts also declined in the 3 months after second vaccination...vaccination reduces transmission of Delta, but by less than the Alpha variant.”</p>

17) [SARS-CoV-2 Infection after Vaccination in Health Care Workers in California](#),
Keehner, 2021

“Reported on the resurgence of SARS-CoV-2 infection in a highly vaccinated health system workforce. Vaccination with mRNA vaccines began in mid-December 2020; by March, 76% of the workforce had been fully vaccinated, and by July, the percentage had risen to 87%. Infections had decreased dramatically by early February 2021... “coincident with the end of California’s mask mandate on June 15 and the rapid dominance of the B.1.617.2 (delta) variant that first emerged in mid-April and accounted for over 95% of UCSDH isolates by the end of July, infections increased rapidly, including cases among fully vaccinated persons...researchers reported that the “dramatic change in vaccine effectiveness from June to July is likely to be due to both the emergence of the delta variant and waning immunity over time.”

<p>18) <u>Community transmission and viral load kinetics of the SARS-CoV-2 delta (B.1.617.2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study,</u> Singanayagam, 2021</p>	<p>“Examined the transmission and viral load kinetics in vaccinated and unvaccinated individuals with mild delta variant infection in the community. They found that (in 602 community contacts (identified via the UK contract-tracing system) of 471 UK COVID-19 index cases were recruited to the Assessment of Transmission and Contagiousness of COVID-19 in Contacts cohort study and contributed 8145 upper respiratory tract samples from daily sampling for up to 20 days) “vaccination reduces the risk of delta variant infection and accelerates viral clearance. Nonetheless, fully vaccinated individuals with breakthrough infections have peak viral load similar to unvaccinated cases and can efficiently transmit infection in household settings, including to fully vaccinated contacts.”</p>
<p>19) <u>Waning Immunity after the BNT162b2 Vaccine in Israel,</u> Goldberg, 2021</p>	<p>“Immunity against the delta variant of SARS-CoV-2 waned in all age groups a few months after receipt of the second dose of vaccine.”</p>

20) [Viral loads of Delta-variant SARS-CoV-2 breakthrough infections after vaccination and booster with BNT162b2](#), [Levine-Tiefenbrun](#), 2021

The viral load reduction effectiveness declines with time after vaccination, “significantly decreasing at 3 months after vaccination and effectively vanishing after about 6 months.”