The Inanity of RNA Vaccines For COVID-19

Pierre Lescaudron
Sott.net
Wed, 27 Jan 2021 14:08 UTC

© Unknown
Quote from Denis Rancourt, IUHM
The present article is a follow-up of *Compelling Evidence That SARS-CoV-2 Was Man-Made* published in June 2020, which I encourage people to read first. In it, I concluded as follows:

It's probable that **by the end of 2020, like every year, a flu epidemic will emerge. This virus will, conveniently, be deemed a close relative to SARS-CoV-2, maybe with 'extra terrifying features'.**

But there will be no need to despair because, by this time, the authorities will have prepared a vaccine. That's one of the reasons why hydroxychloroquine was lambasted and banned. If a safe and effective treatment already exists, who is going to accept a rushed and unknown vaccine? A vaccine that will allegedly protect people against COVID-20, but will in reality be designed to 'cancel' the beneficial changes induced by the mutated strain of SARS-CoV-2. [...]

It's probable that the vaccination won't be mandatory. Remember that the authorities are now "kinder and gentler". Instead of brute force, the authorities are more likely to use moral blackmail - "Get vaccinated to protect others!" - combined with social blackmail - "No vaccine = no job, no shopping, no travel, no socializing!" Basically, you're free to choose between the vaccine passport or a life sentence in an isolated cell.

Here we are 7 months later. As suspected, new variants have appeared, manufactured COVID-19 deaths are 'piling up', the vaccine passport has already been adopted by several countries and vaccination campaigns have been launched around the world.

In theory, medicines, vaccines included, are approved and used because their benefits far exceed their risks. In this sense, the ideal medicine would display zero risks and total effectiveness against an uncured and deadly disease. We'll see in the present article that the COVID-19 vaccines, particularly the Pfizer vaccine, is pretty much the opposite of the ideal drug. It is dangerous, ineffective and targets a benign disease that already has known effective and safe treatments.

**Where's The Pandemic?**

**Case Fatality Rate**

According to the WHO, in October 2020 an estimated 750 million people - about 10% of the world's population - had been infected by SARS-CoV-2, and one million people had died of COVID-19. Those figures lead to a case fatality rate (CFR) of 0.13%, which is the typical CFR exhibited by the seasonal flu. When treated properly, like in Marseilles - where a hydroxychloroquine-based protocol and early clinical diagnosis is used - the CFR drops as low as 0.05%.

In Singapore, where the use of hydroxychloroquine is widespread and no national lockdown was ever imposed, the CFR of COVID-19 is the same as
Marseilles, a mere 0.05% (29 deaths out of 59,000 cases).

What kind of pandemic exhibits a case fatality rate equal to, or lower than, seasonal flu?

Real COVID deaths

The numbers above are based on the official data published by the WHO. Those numbers, particularly the total COVID deaths, are grossly inflated due to various deceptions:

1/ Comorbidity:
94% of the people who died of COVID-19 had comorbidity factors. A majority of them had not one but several comorbidity factors - in particular hypertension, obesity, chronic lung disease, diabetes and cardiovascular disease. For example a UK patient who had advanced cancer, kidney failure and diabetes, and had tested positive within 60 days prior to his death, will have his demise automatically attributed to COVID-19. In the UK, at the very least 30% of deaths attributed to COVID-19 are actually due to a comorbidity.

2/ False positives:
A lot of deaths were attributed to COVID-19 solely on the basis of a positive PCR test. In the words of its inventor Kary Mullis, chemistry Nobel Prize winner in 1993:

...[PCR tests] cannot detect free infectious viruses at all [...] The tests can detect genetic sequences of viruses, but not viruses themselves.

The obvious questions, therefore, are: how many other viruses display viral sequences similar to SARS-CoV-2 and then get detected and are wrongly labeled SARS-CoV-2? How many non-pathogenic, non-transmissible viral sequences of SARS-CoV-2 lead to a "positive" PCR test?

Additionally, there is a serious problem with the number of PCR amplification cycles. According to the US CDC, it is virtually impossible to detect any live virus above a threshold of 33 cycles. However, many governments conduct 40, 45 even 50 amplification cycles. For illustration, a positive test at 40 cycles has about a 43% chance of no longer being positive, with a cutoff of 35, and 85% chance with a cutoff of 30.

The antigen test is even worse than the PCR test, leading to 63% more false positives! These tests are so unreliable that even the WHO discourages their use.

3/ Ban of effective treatments:
In Marseilles, France, where early diagnosis and proper treatment - including hydroxychloroquine combined with azithromycin - are administered, the crude mortality rate is 0.01%. 400 miles from there, in Paris, where there’s late diagnosis and the ban on those two drugs is enforced, the overall mortality rate
jumps up to 0.075%. That's a 7.5 fold increase.

Similar to Marseilles, Belarus and Iceland administered proper care and/or conducted early diagnosis, and they are among the countries with the lowest number of COVID-19 deaths, with **1,560** (0.016% crude mortality rate) and **29** (0.008% crude mortality rate), respectively, as of mid-January 2021. In the same vein, in Vietnam, which uses hydroxychloroquine, early diagnosis and implemented no national lockdown, crude mortality due to COVID-19 is 0.000036% (35 deaths among **96** million inhabitants).

**4/ Transfer of flu casualties:**
The southern hemisphere appears to have simply skipped the winter 2020 flu season, where flu deaths showed a 90% drop compared to previous years. According to mainstream media, this drop in flu deaths is due to the lockdown. If this is the case, however, how do we explain that France recorded a surprisingly low number of flu deaths during the flu season 2019-2020 that ended before the lockdown was imposed on March 17th. Indeed, only **3,680** flu deaths were recorded during the winter of 2019-2020. That's a 70% drop in flu deaths compared to the last 10-year average mortality.

Another narrative explaining this sharp and unexpected drop in flu casualties is that the coronavirus prevented the activity of other viruses. But viruses have no difficulties in cohabiting. For example, in Europe alone during the 2019-2020 flu season, there were at least six active flu strains: type A A(H1N1)pdm09, A(H3N2)) A(Unknown), B/Victoria, B/Yamagata and B/Unknown - and we know that SARS-CoV-2 was on the continent since at least December 2nd 2019.

In the northern hemisphere, France was not the only country to experience the disappearance of its annual seasonal flu. The USA and the UK respectively reported a staggering 98% and 90% decrease in deaths attributed to the seasonal flu.

Starting with the hyper-inflated WHO number of COVID deaths, which is 1.7 million as of January 2021, we can deduce the following numbers:

- False positive deaths, patients who didn’t even have COVID, represent - at the very least - 33% of the total number of deaths attributed to COVID-19. That's **700,000** out of 1.7 million.
- Deaths due to comorbidities represent 30% of the total number of deaths attributed to COVID. That's **500,000** out of 1.7 million.
- About 90% of the typical flu death toll was transferred to the COVID tally. That's **300,000** deaths out of 1.7 million.

Depending on the overlaps between those three kinds of non-COVID deaths, the real number of COVID-19 deaths can be estimated at between 300,000 and 1.1 million.

That range doesn't even take into account the 7-fold reduction in mortality
related to proper early diagnosis and adequate treatment. Factoring this parameter in, the total mortality due to COVID-19 with early diagnosis and proper care would drop to somewhere between 40,000 and 140,000 casualties worldwide. Notice that the estimates above are very conservative. We are therefore left to wonder whether SARS-CoV-2 actually directly caused a significant number of deaths at all.

What kind of pandemic induces much less total deaths than the seasonal flu?

Excess mortality

The excess mortality includes deaths attributed to COVID-19 along with the numerous deaths due to the lockdowns. As we will see, it is likely that lockdowns induced many more deaths than COVID-19.

1/ Delayed treatments and diagnosis

Only a third of the excess deaths seen in the care homes and private residences in England and Wales can be explained by covid-19, the remaining two thirds are due to elderly citizens who were denied primary care and "who may well have lived longer if they had managed to get to hospital". This problem is particularly true for cancer patients. In the UK, the denial of cancer diagnosis and medical treatment may lead to 18,000 more cancer patient deaths.

2/ Psychiatric conditions

A meta analysis of the mental health of the general population was published in December 2020. As expected, the "pandemic" significantly exacerbated this situation:

Relatively high rates of symptoms of anxiety (6.33% to 50.9%), depression (14.6% to 48.3%), post-traumatic stress disorder (7% to 53.8%), psychological distress (34.43% to 38%), and stress (8.1% to 81.9%) are reported in the general population during the COVID-19 pandemic in China, Spain, Italy, Iran, the US, Turkey, Nepal, and Denmark [...] The COVID-19 pandemic is associated with highly significant levels of psychological distress that, in many cases, would meet the threshold for clinical relevance.

Source

It should be noted that the life expectancy of individuals suffering from mental illness is about 8 years shorter than the general population.

3/ Suicide

the definitive numbers about deaths in 2020 have not been compiled yet. However, the trend is already clear. According to some studies, suicide increased by 145%. Logically, suicidal tendencies surged alongside actual suicides with, for example, India experiencing a 67.7% increase in reports of suicidal behavior during lockdown. Similarly, in China, the appearance of very frequent suicidal thoughts has been noted while in Canada a 500% increase in suicide is projected.
4/ Alcoholism and drug addictions

Alcohol abuse sharply increased during the "pandemic". In the UK, there was a 500% rise in calls to the British Liver Trust helpline since lockdown began in March. Similarly, Alcohol Change recorded a 242% rise in visits to their advice and support pages on their website during lockdown. Surveys on alcohol consumption tell a similar tale, with 21% of individuals stating they were drinking more often during lockdown. The heavy drinkers were the most affected, 38% of those who typically drank heavily during pre-lockdown said they drank even more during lockdown. In the US, a 54% increase in national sales of alcohol was recorded for the week ending March 21, 2020, compared with the previous year.

Similarly, drug overdoses rose strongly in 2020. For example, in the US, overdoses killed a staggering 81,000 people, a 38% increase in fatal overdoses compared to 2019.

5/ Poverty

According to the Worldbank, the "pandemic" could throw about 100 million additional people into extreme poverty. The difference in life expectancy between an individual in extreme poverty and a wealthy individual is at least 20 years. Notice that most of the deaths induced by the surge in extreme poverty will not happen immediately but in the years, if not decades, following this manufactured global economic crisis.

Despite the number of deaths due to lockdowns and their consequences rather than COVID-19, many countries didn't even see a rise in excess mortality during the so-called pandemic. That is the case in Germany where hydroxychloroquine was used and a lot of early diagnosis was done. Better than that, Iceland - which implemented one of the most effective early diagnosis approaches in the world - shows a mortality rate in 2020 that is lower than its average yearly mortality. But the cherry on the cake is China, where about 55 tons of hydroxychloroquine were consumed in 2020 and where no national lockdown was implemented: as a result, China experienced virtually zero COVID deaths since April 2020.
Daily COVID-19 deaths in China

Even France which banned hydroxychloroquine and azithromycin and implemented extended lockdowns and curfews, experienced a mortality rate during Spring 2020 that was lower than during the 2017 flu season and since May 1st, 2020, no increase in mortality has been noticed.

What kind of pandemic doesn't cause a marked excess in mortality?

Life Expectancy

In France, even before they tested positive for the virus, 80% of alleged COVID-19 victims had a life expectancy lower than one year due to comorbidities and advanced age. Overall, COVID-19 victims had a life expectancy of a mere 3 years and 82% of the victims were more than 70 years old. The average age for a COVID-19 death is 82, that is a few months shorter than the overall life expectancy.

In several countries, the average age of deaths attributed to COVID-19 is even higher than life expectancy. For example, in the UK, the average age for COVID-19 death is 82.6 years old while the average life expectancy is 81.2 years. In Sweden, the average age of those who have allegedly died of COVID-19 is 84 years old, two years more than the average age of death which is 82.
As a result of the very advanced age of the people who allegedly died of COVID-19, many countries didn't experience any drop in life expectancy. This is the case in China that recorded 4,600 deaths attributed to COVID-19 out of a population of 1.4 billion, or Iceland and its 19 COVID victims out of 400,000 Icelandic citizens.

Even in France, where a lot of elderly citizens were left to die in nursing homes, where drastic lockdowns were implemented, where diagnosis and care was delayed for serious conditions and effective medicines against COVID-19 were banned and toxic drugs like Rivotril or Remdesivir were administered instead, life expectancy only decreased by 5 months.

What kind of pandemic doesn't notably decrease life expectancy?

In summary, the typical victim of COVID-19 is an individual in his 80's who lives in a nursing home and has several comorbidities. Typically, such a person died because of the despair of social isolation and the delayed diagnosis and treatment of his serious comorbidities. In many cases, the patient didn't even have COVID-19. However COVID-19 killed him, not directly, but through the isolation and denial of care induced by the well-orchestrated pandemic hysteria.

To recap, we are experiencing a rather peculiar "pandemic" that exhibits a case fatality ratio lower than the seasonal flu, kills less than the usual infectious diseases, didn't trigger marked excess mortality and didn't really lower life expectancy.

Existing Treatment

Not only is COVID-19 a benign disease, it can be cured by numerous treatments that are safe, effective and cheap: artemisia, high dose vitamin C, vitamin D, copper, Zinc, doxycycline, fluvoxamine, bromhexine, colchicine, Ivermectine, azithromycin and, of course, hydroxychloroquine. In addition, the combination of some of those drugs revealed beneficial synergies, in particular a cocktail of hydroxychloroquine + azithromycin + zinc. Notice also that the efficacy of the aforementioned drugs were published in peer-reviewed journals months ago.

A case in point is hydroxychloroquine (HCQ) whose efficacy against COVID-19 has been tested in no less than 195 published papers. The conclusion of the statistical meta analysis of those papers could not be clearer:

**HCQ is effective for COVID-19. The probability that an ineffective treatment generated results as positive as the 195 studies to date is estimated to be 1 in 1 quadrillion** ($p = 0.0000000000000009$).

Source

Another way to ascertain the efficacy of HCQ is simply to check if the research papers received funding from Gilead - the American-Israeli company, laden with conflicts of interests - that produces the now infamous Remdesivir.
When there are conflicts of interest with Gilead, 73% of the papers claim that HCQ doesn't work, if there is no conflict of interest, 83% of the papers conclude that HCQ works. It's that simple.

Despite its repeatedly tested effectiveness, HCQ has been banned in a number of Western countries. In contrast, it took only one bogus paper, (debunked soon after), for states to buy and administer billions of dollars worth of the toxic and ineffective Redemsivir.

The reason for the suppression of known treatments is at least two-fold:

- social: the denial of treatment to deliberately increase deaths and therefore
fear in the population, leading to the reluctant acceptance of vaccines.

- legal: the **accelerated FDA approval** of a new drug is only possible when the targeted disease "has no cure". The suppression of known cures enabled the Pfizer vaccine to be approved after two months of limited testing and a meager trial report, while proper FDA approval requires about 12 years of extensive trials and a **100,000+** page new drug application.

To recap, COVID-19 is a benign disease with numerous safe and effective treatments. In this context, the logical approach would be to increase the early clinical diagnosis and to spread and improve the existing therapeutic strategies. That's not what the elites decided, especially in the Western world. Instead they banned effective treatments and, among all kinds of dubious vaccines, enforced the worst one, the Pfizer RNA 'vaccine' on which we will focus our attention now.

**mRNA Vaccine or Gene Therapy?**

Despite its name, the Pfizer 'vaccine' is more akin to gene therapy, the **definition** of which is: "the utilization of the therapeutic delivery of nucleic acids into a patient's cells". The Pfizer "vaccine" is exactly that, an artificial RNA sequence delivered via nano lipids into the patient's cells, to hijack them and direct them to produce the spike protein found on SARS-CoV-2, or at least on one of its old variants. From there, the host should react to this protein by producing antibodies. Too many antibodies and an **immune storm** happens, not enough antibodies and the triggered immunity is useless.

Notice that gene therapy was never used on a large scale. It was only used in experimental phase 1 **anti-tumoral protocols**. The drugs were so toxic that phase 2 trials were never conducted. **RNA "vaccines"** against MERS and SARS followed the same path of failure.

In 1999, geneticist Alain Fischer, conducted the first clinical trial with some rare positive results in the world of gene therapies. The same Alain Fischer was **nominated** as a vaccine expert by the French authorities. When asked about the Pfizer 'vaccine', Fischer **answered** cautiously, emphasizing that the effects of infectiousness and the duration of immunity were unknown, side effects were unavoidable and the fear of the vaccine was understandable. Obviously Fischer's analysis didn't fit the pro vaccine narrative, since then he no longer enjoys any media exposure.

**Vaccine Useless at Best, Detrimental at Worst?**

The history of vaccines is replete with major scandals. Here are a few examples:

1/ the **Salk polio** vaccine which caused the worst polio outbreak in history, infecting 200,000 people with live polio, of whom 70,000 became sick
2/ the current prevalence of poliomyelitis caused by vaccines compared to naturally-occurring poliomyelitis

3/ the Dengue vaccine triggering the production of antibodies that are not detrimental but beneficial to the Dengue virus, leading to more severe forms of Dengue fever.

4/ And let's not forget Bergamo, Italy where the population experienced a high prevalence of severe forms of COVID-19 among vaccinated people. There's no mystery there, because for years, the flu vaccine has been known to favor and worsen coronavirus infections.

Likewise, vaccines against close relatives of SARS-COV-2 like SARS or MERS, that target the spike protein like the Pfizer 'vaccine', have also been tested but quickly canceled, one major adverse effect was the creation of antibodies that didn't prevent but favored viral infections.

The vaccines against Dengue fever, influenza, SARS and MERS share the same fundamental flaw, which is well known by scientists as antibody-dependent enhancement, where the vaccine, instead of providing immunity, increase vulnerability and the severity of the disease it targets. In this context, it would not be surprising that the RNA vaccines trigger more severe forms of COVID-19.

In addition, like most retroviruses, SARS-CoV-2 is very prone to mutations. The analysis of 10,000 of its genomes revealed a high number of genetic modifications:

2969 missense mutations, 1965 synonymous mutations, 484 mutations in the non-coding regions, 142 non-coding deletions, 100 in-frame deletions, 66 non-coding insertions, 36 stop-gained variants, 11 frameshift deletions and two in-frame insertions.

Source

This substantial number of genomic variation has led to the emergence of, at least 14 distinct variants, including the 'English variant' which displays 23 detectable mutations, 70% of them being located on its spike protein, which is the very target of the Pfizer 'vaccine'.
Coincidentally, or not, the above mentioned Remdevisir has been tested on British patients in at least 15 different health centers and widely administered after its bogus approval. Redemsivir is now known to trigger mutations in SARS-CoV-2, particularly in its spike protein. Given its mutagenic property and its use in the UK, the obvious question is "Did remdesivir play a role in the apparition of the English variant?"

In any case, just in Marseilles no less than 33 patients fell sick twice, from the variant called Marseille 1, then from the variant Marseille 4. Worse than that, still in Marseilles, one patient got infected three times with SARS-CoV-2 variants in just nine months.

Reinfection with SARS-CoV-2 is widespread enough that scientists do not wonder any more if it happens, but how it happens:

the possibility of reinfection with SARS-CoV-2 is not well understood. [...] previous exposure to SARS-CoV-2 does not necessarily translate to guaranteed total immunity. The implications of reinfections could be relevant for vaccine development [...] Genomic analysis of SARS-CoV-2 showed genetically significant differences between each variant associated with each instance of infection.

Source

Those reinfections suggest that natural immunity against COVID-19 could last just a few months, one reason for this short immunity is probably the numerous mutations of SARS-CoV-2. If natural immunity doesn't prevent a quick re-infection, the Pfizer 'vaccine', that, unlike natural immunity only targets a small part of the virus - namely its spike protein, which has substantially changed since the design of the vaccine - should exhibit even poorer results. In conclusion, the Pfizer 'vaccine' is unlikely to confer lasting immunity, if any, especially against current and future variants.

The above is not just theory. For example in Israel no less than 12,400 residents have tested positive for SARS-CON-2 after receiving the Pfizer "vaccine", among them 69 people who had already gotten the second dose.
Pfizer Vaccine Methodology

1/ Irrelevant investigation objectives

A stunning bias in the Pfizer trial was its primary objective: evaluate the frequency of mild to severe forms of COVID-19, 28 days after the first inoculation. Casualty rate, infectiousness, duration of immunity (if any), or even occurrence of mild to severe forms in the long term were not investigated. But, wait a minute, the whole pandemic and vaccine hysteria were built on these very fears of death and contamination, we heard ad nauseam the media injunctions: "people are dying in droves", "get vaccinated to avoid infecting others", "get vaccinated to be immune to COVID-19", "get vaccinated to avoid dying of COVID-19" etc.

2/ Tested group bias

Another striking bias is the trial selection, particularly the age combined with health status. We've shown above that frail and elderly people are by far the most likely to suffer from COVID-19. But only 2% of the Pfizer trial includes patients over 75 years old and with pre-existing medical conditions. In addition subjects of any age with comorbidities are grossly under-represented:

In total, only one out of five of the people appear to have an underlying condition, and for the various individual underlying conditions, the percentage of people suffering from them is often less than 1%.

Source

Also the limited size of the vaccine group (about 20,000 participants) does not exhibit all the age/race/sex/disease/treatment/genetic profile combinations that the general population does. There is no safety data whatsoever about children, immune-compromised individuals or pregnant women because they were excluded from the trial.

Basically Pfizer selected young and healthy subjects for testing a vaccine that is now administered as a priority to old and sick individuals. What is the point of studying healthy young individuals, who, vaccinated or not, are barely affected by COVID-19 anyway? Does this bias minimize side effects and maintain the illusion of a safe 'vaccine'?

3/ Placebo instead of known effective drugs

A new drug is tested against a placebo when the targeted disease has no known cure. In the case of COVID-19, there are several known cures to which Pfizer should have compared its vaccine.

That was the design of the Discovery clinical trial that compared Remdesivir, HCQ and other drugs. When the preliminary results started to show that HCQ was the most effective, it was quickly removed from the trials. Pfizer didn't make the same mistake of testing its
new drug against an effective one. **Instead, they tested their 'vaccine' against a placebo.**

4/ Unilateral design and treatment of data

No third party was involved in the design of the trial, its monitoring, and the treatment of the results. The whole study was designed, conducted, analyzed, published and paid for by Pfizer itself.

As Dutch neurologist Jan B. Hommel said:

"The fact that an independent data and safety committee was able to see the data doesn't change this, simply because they had no say in the design of the research, selection of the participants, the statistics used or the publication. ... I don't need to explain here how such a construction can lead to biased results of scientific research, because it has been extensively researched and published about over the past twenty years."

Benefits

The main marketing argument for the Pfizer 'vaccine' is its alleged 95% efficacy. This figure is the sole claim of Pfizer and it should be taken with a grain of salt because of numerous factors:

1/ Pfizer precedent

First we have to understand the background of the company we are dealing with here. Pfizer is the world's largest pharmaceutical company and it is also the company that has been hit with the second biggest criminal fine in US history for lying about one of their drugs and bribing doctors. This record fine is only one example. Pfizer has been sentenced numerous times for covering up major side effects of *Protonix*, hiding the cancer-inducing properties of *Prempro*, lying about the suicidal behavior induced by *Chantix*, promoting *Depo-Testosterone* as effective and safe while it was ineffective and induces major side effects, and conducting illegal clinical trials for *Trovan* in Nigeria killing 11 children. The list of crimes committed by Pfizer goes on and on.

Let's also keep in mind that Pfizer will cash in $14 billion a year, more than the GDP of Nicaragua, from the worldwide sale of its RNA 'vaccine'.

2/ Relative efficacy VS absolute efficacy

During the Pfizer clinical trial 8 COVID-19 cases were found in the vaccine group of 20,000 and 86 cases in the placebo group of 20,000. This means the attack rate for COVID-19 is 0.0004 in the vaccine group and 0.0043 in the placebo group. Therefore, the **absolute risk reduction for an individual is only about 0.4%** (0.0043-0.0004X100).
The Number Needed To Vaccinate (NNTV) = 256 (1/0.0039), which means that to prevent just 1 Covid-19 case, 256 individuals must get the vaccine; the other 255 individuals derive no benefit, but are subject to the numerous adverse effects of the 'vaccine'.

3/ Exclusion of suspicious cases

The claimed 95% (relative) efficacy was attained by excluding 3410 total cases of suspected, but unconfirmed COVID-19 cases (probably due to false negatives). When those 3410 suspected cases are reintegrated the relative efficacy drops to 19% (which is well below the 50% effectiveness threshold set by regulators) and the absolute risk reduction drops to a ridiculous 0.08%.

4/ Non-replicated results

The cornerstone of any scientific work is its replicability. The results of the clinical trial were published in a journal at the end of 2020, but the clinical trials have not been replicated and they are unlikely to be replicated because no pharmaceutical company will conduct pricey clinical trials for a molecule patented by a competitor. So all we have is the word of Pfizer, who we also see is a repeat offender.

In summary, according to Pfizer, the benefit of its vaccine is a reduction of flu like symptoms in the young healthy population. They don't know, or rather, they don't want us to know, about what really matters: symptoms in the frail and elderly, mortality, infectiousness, or duration of immunity. We're starting to get an idea.

The irony is that the 'vaccine' didn't even reach its primary (and irrelevant) objective that was the reduction of the severe form of COVID-19. In the editorial of the NEJM where the results of the Pfizer clinical trial were published, one can read:

The number of severe cases of COVID-19 (one in the vaccine group and nine in the placebo group) is too small to draw any conclusions about whether the rare cases that occur in vaccinated persons are actually more severe.

Risks of the Pfizer Vaccine

Not much is known about the benefits of the Pfizer vaccine and the little that is claimed is quite irrelevant. But information about the risks is slowly coming in, and it's not a pretty picture.

1/ Adverse effects of the vaccine

According to the FDA, the Pfizer 'vaccine' can cause many serious "adverse effects", and these are only the known adverse effects induced by "traditional" vaccines and their usual adjuvants:
The long term effects of vaccines are known to be the most devastating ones. So, in addition to the list above, it's highly probable that numerous additional serious adverse effects induced by RNA 'vaccines' will be progressively identified, like Lou Gehrig disease, Alzheimer’s, cancer and multiple sclerosis as suggested by Judy Mikovitz.

Infertility will probably be another "unexpected" long term side effect since the targeted spike protein is very similar to sincytin, a protein involved in placental development. When Pfizer tested their 'vaccines' on rats, they reported a 50% drop in reproductive behavior compared to the unvaccinated rats. It's probably to hide this side effect that Pfizer excluded pregnant women from its trial.

Conveniently, the adverse vaccine reactions listed above are increasingly considered by authorities as a consequence of COVID-19. This is true of Guillain-Barré Syndrome (GBS) which, since December 2020 and soon after the beginning of the vaccination campaign, is said to be caused by COVID-19. Until then, no causality between the two was claimed, only a worsening of COVID-19 symptoms in patients with GBS. The same was done for Multisystem Inflammatory Syndrome in Children, which is now considered as being caused by SARS-COV-2, and for the Kawasaki syndrome, a known vaccine reaction now blamed on COVID-19.

To further minimize the potentially devastating effects of the Pfizer 'vaccine', a CDC report labels anaphylaxis as the cause for a growing number of adverse reactions.
It would all be fine and dandy, except when you calculate the incidence percentage for these events you get the following numbers:
Dec.14: \( \frac{3}{679} = 0.4\% \)
Dec.15: \( \frac{50}{6,090} = 0.8\% \)
Dec.16: \( \frac{373}{27,823} = 1.3\% \)
Dec.17: \( \frac{1,476}{67,963} = 2.2\% \)
Dec.18: \( \frac{3,150}{112,807} = 2.8\% \)

As you can see the incidence ratio of "anaphylaxis" keeps increasing. It increased seven-fold from 0.4 to 2.8% over a mere 5 days, which suggests that the vaccine has delayed adverse effects that can take days to manifest. The problem is that anaphylaxis is known to manifest almost immediately after exposure to the allergenic agent:

Symptoms can start within seconds or minutes of exposure to the food or substance you are allergic to and usually will progress rapidly. On rare occasions there may be a delay in the onset of a few hours.

Source

It means that there are probably other (delayed) adverse reactions going on besides (immediate) anaphylaxis.

2/ Negative reactions to the vaccine

On top of the adverse effects we must add the negative reactions. The table below recapitulates reactions to the Pfizer vaccine (according to Pfizer) at the second inoculation:

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Any reaction</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain*</td>
<td>66.1%</td>
<td>47.7%</td>
<td>1.0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Redness*</td>
<td>7.2%</td>
<td>3.8%</td>
<td>3.2%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Swelling*</td>
<td>7.5%</td>
<td>4.1%</td>
<td>3.2%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Fatigue*</td>
<td>59.4%</td>
<td>21.1%</td>
<td>33.7%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Fever</td>
<td>15.6%</td>
<td>9.2%</td>
<td>5.2%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Headache</td>
<td>51.7%</td>
<td>25.6%</td>
<td>22.9%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Chills</td>
<td>35.1%</td>
<td>17.1%</td>
<td>15.9%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Numbness</td>
<td>1.9%</td>
<td>1.3%</td>
<td>0.4%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>10.4%</td>
<td>8.5%</td>
<td>1.7%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Muscle pain</td>
<td>37.3%</td>
<td>15.5%</td>
<td>19.5%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Joint pain</td>
<td>21.9%</td>
<td>9.8%</td>
<td>11.2%</td>
<td>1%</td>
</tr>
</tbody>
</table>

© Vox

Reported reactions to the Pfizer vaccine
There's a caveat though. This table focuses solely on the 18-55 year old subgroup, basically the young and healthy individuals, who seldom develop a severe form of COVID-19 let alone die from it.

The frequency of the side effects is high: 59% experience fatigue, 52% experience headache, 37% muscle pain. Virtually every patient experienced side effects. The severity of the symptoms is quite appalling too. For example, 38% of those young and healthy subjects experienced moderate to severe fatigue and 26% experienced moderate to severe headache. "Moderate" meaning interfering with activity and "severe" meaning preventing daily activity.

In contrast, the general population has a more than 60% probability of having no symptoms after contracting SARS-COV-2. The relatively young and healthy subpopulation selected by Pfizer has about an 80% probability of being asymptomatic. So, on one side we have the Pfizer 'vaccine' with its 100% guaranteed side effects, on the other side we have the 80% symptom-free SARS-COV-2.

Is this vaccine causing more symptoms than the disease it is supposed to cure?

Notice in the table above that, just like the table for adverse vaccine reactions, only negative reactions soon after inoculation are recorded. The occurrence of negative reactions more than two months after the first inoculation were simply not investigated.

It means that we have no idea whatsoever about the medium and long term risks of the 'vaccine'.

3/ Vaccine deaths

Death was listed in the FDA's list of adverse reactions, and the FDA was right. Several deaths occurred soon after vaccination. At first, it seemed like sporadic cases. One death, then a second death occurred in Israel soon after inoculation. Around the same time a similar death occurred in Switzerland. And then a Florida doctor died soon after receiving the Pfizer 'vaccine'.

The case of Norway is more interesting with 2 vaccine deaths in the beginning of January followed by 23 deaths in one elderly home. That's a total of 25 vaccine deaths while about 20,000 doses have been administered in Norway in the weeks preceding the "incidents". So, the vaccine fatality rate is about 0.125% which is comparable to the CFR of COVID-19 mentioned above. And those vaccine-induced deaths are only the early ones and after just one inoculation.

Even more shocking is the case of Nice nursing homes, with 50 excess deaths on January 15th, only 4 days after the start of vaccinations. During those four days, about 16,000 doses of the Pfizer 'vaccine' were administered in the homes. That gives a preliminary vaccine fatality rate higher than 0.3%, which is more than double the CFR of COVID-19 and, again, this death toll is limited to a few days
after the very first inoculation.

Norway and Nice are not isolated cases. After the first inoculation of Pfizer 'vaccine' on 5,847 patients in Gibraltar, 53 of them died within days. That's a vaccine fatality rate of 0.9%. A New York nursing home which had experienced zero COVID-19 death before vaccination, reported 24 deaths right after the vaccination of 193 residents. That's a vaccine fatality rate of 12%. The list of vaccine casualties goes on and on, and this is just after the first dose.

*Is the medicine deadlier than the disease it is supposed to cure?*

Of course, the authorities deny any link between vaccinations and these deaths. They blame comorbidities. When a vaccinated individual with comorbidities dies, it's because of the comorbidities. When an alleged SARS-COV-2 positive individual with comorbidities dies, it's because of the SARS-COV-2. Does that make sense?

**Conclusion**

COVID-19 is a benign disease for which safe and effective treatments exist. But those treatments are banned or suppressed while a dangerous and ineffective RNA vaccine is imposed on us through blackmail: no vaccine = no freedom. **Tens of millions** have already been vaccinated, so, if you must take the vaccine, here is an [article](#) describing therapeutic and nutritional approaches to mitigate its side effects.

The elites don't want to protect us, they want to control us. Those self-proclaimed reality creators manufactured an 'obedience' vaccine which backfired royally and transformed into a 'disobedience' mutant. So, they created out of thin air a fake pandemic in order to impose a vaccine that I believe is designed to cancel the beneficial effects of the 'disobedience' mutant. In addition, this vaccine is deadlier and more harmful than the minor disease it is supposed to cure.

But as we will see in the next installment, instead of putting on a show of preventing a fake pandemic, the RNA vaccine might very well recombine with dormant endoretroviruses and start a very real pandemic in a second epic backfire. If this comes to pass, it would show again that history has a superb sense of irony.

**Notes:** Some of the links in this article lead to videos in French of IHU Lab researchers like Didier Raoult, Louis Fouché, Michel Drancourt or Philippe Parola. Outside China, the IHU Laboratory has published the most papers about SARS-COV-2 to date. These researchers therefore have a unique knowledge of the "pandemic", unfortunately their video presentations are mostly in French.
Pierre Lescaudron

Pierre Lescaudron (M.Sc., MBA) pursued a career in executive management, consulting and post-graduate teaching in high tech fields.

He then became an editor and writer for SOTT.net, fulfilling his dream of researching science, technology and history.

Pierre is a certified Eiriu Eolas instructor and the author of "Earth Changes and the Human Cosmic Connection".