Feature: The scientific case for an immediate halt to covid 'vaccination' of children

Date: 10 November 2021

By Rob Verkerk PhD, founder, scientific and executive director, ANH-Intl

Topline points

- The response of our individual immune systems to exposure to the SARS-CoV-2 virus determines an individual's fate
- We are still learning how different people's immune systems react both to the virus and to covid-19 'vaccines' and we summarise 4 possible outcomes following exposure depending on the reaction of different parts of the immune system, notably the innate and adaptive 'sides' of the immune system
- The dynamics of these interactions are changing rapidly as more people get exposed both to the virus and the 'vaccines'
- There is ever more evidence suggesting vaccine failure and increasing case rates and covid-19 disease among the fully vaccinated. This cannot be explained only by the emergence of immune escape variants.
- The 'vaccines' are designed to trigger an adaptive immune response (neutralising antibodies) and there is emerging evidence that they may seriously disrupt both innate and adaptive immune function which could have serious long-term consequences as well as explain the declining pattern of outcomes among the fully vaccinated
- Emerging evidence reveals that the unvaccinated may be benefiting from the 'training' of their innate immune system from prior exposure to the virus. This suggests that unvaccinated people may provide a very important population reservoir that may be crucial to our emergence from the ongoing pandemic
- This training of innate immunity holds the key to successful immune responses and outcomes but will be sabotaged by repeat exposure to spike-protein based 'vaccines'
- Five mechanisms are proposed to explain the pattern of increased cases among the fully vaccinated and the improving outcomes among the unvaccinated
- Children represent the population group with the most competent innate immunity and damage to this from vaccines may have lasting, even multi-generational, impacts
- Booster jabs may further compromise immunity
- Additional resources are provided to help people exercise their right to informed choice, either for themselves or on behalf of children in their care.

Regardless of whether a person decides, or is forced, to be covid-19 'vaccinated', or whether he or she chooses to avoid 'vaccination' – it is ultimately the response of the human immune system that will determine that person's fate. More than that, it is the way different immune systems in a population respond that determines the fate of the pandemic. In this article, we hope to explain why it is imperative for the sake of humanity the world over to immediately stop the vaccination of children – wherever they are. Similarly, there is a very strong argument to stop pushing boosters on older populations.

The immune system – as any immunologist or vaccinologist will attest – is a system of profound complexity. It also behaves drastically differently in young people compared with older ones, it requires a lot of resources including nutrients to function properly so nutritional deficiencies can seriously compromise its function, and its function also changes dramatically depending on prior exposure to pathogens against which it may or may not have trained itself to attack successfully.

>>> Discover why the immune systems of young people respond differently to exposure to SARS-CoV-2 than older people. Carsetti et al. *Lancet* 2020; 4(6): 414-416 (https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(20)30135-8/fulltext).

In that sense, the human population now faces a very different situation to the one we encountered in early 2020. Back then, the vast majority of the world's population had no prior exposure to SARS-CoV-2. That's no longer the case.

Compounding the dynamics of the pandemic are the greatly varying levels of vaccination take-up (and hesitancy) in different parts of the world, differences in innate immunity (this being dependent on age groups infected and their health status), coupled with the molecular evolution of the virus.

As we write this, daily national statistics collated by Worldometer (https://www.worldometers.info/coronavirus/) show that the USA currently has over 9 million active cases of infection with some 11,000 of these regarded as serious or critical, and the UK around 1.5 million cases, with 1,000 of these being serious or critical. Global cases and mortality rates continue to oscillate and there is increasing evidence that the intensity of vaccination coverage does not consistently or predictably lower prevalence of infection. In fact, the reverse appears to be true.

In a study of 68 countries published in the *European Journal of Epidemiology* in September 2021 (https://link.springer.com/content/pdf/10.1007/s10654-021-00808-7.pdf), which suggests the opposite, a slight positive association has been found between vaccination intensity and infection prevalence (Fig. 1). To clarify, the study shows a trend towards people in a given country being at greater risk of infection when a higher proportion of the population are 'vaccinated'.

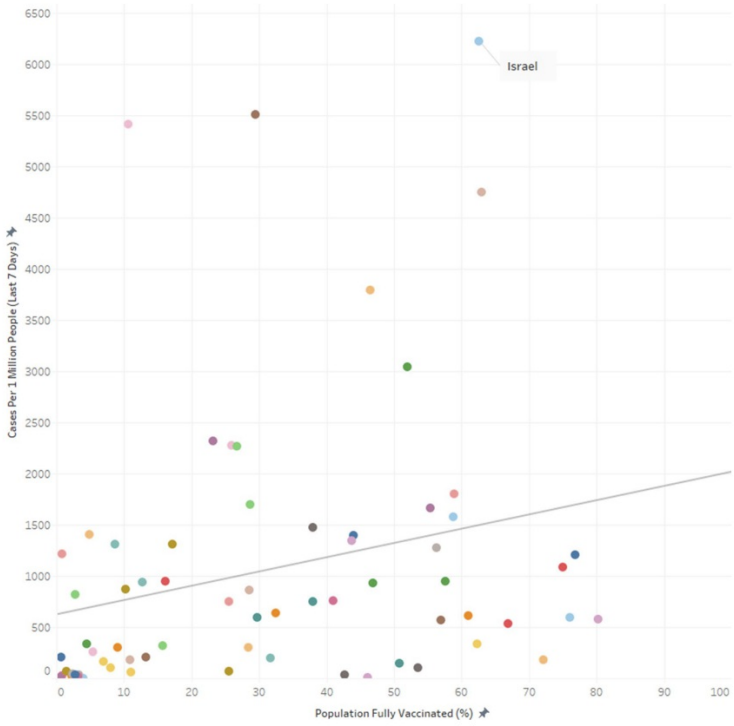


Figure 1. Relationship between cases per 1 million people (last 7 days) and percentage of population fully vaccinated across 68 countries as of September 3, 2021. Source: Subramanian & Kumar, 2021 (https://link.springer.com/content/pdf/10.1007/s10654-021-00808-7.pdf).

A similar trend is revealed in the UK, where 67% of the population (https://ourworldindata.org/covid-vaccinations) has received at least 2 doses of 'vaccines'. The latest data from the UK Health Security Authority (HSA, formerly Public Health England) released on 4 November (Week 44) (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1032671/Vaccine_surveillance_report_-_week_44.pdf) reveal that all adult age groups that were vaccinated had higher rates of confirmed cases compared with those that were unvaccinated.

None of this should be surprising when you look closely at the data from different countries with high or low 'vaccine' coverage. Ireland has one of the highest covid-19 'vaccination' rates in Europe (72% fully vaccinated, 77% partially vaccinated

(https://ourworldindata.org/covid-vaccinations)) – and cases are on the up (Fig. 2). No health authorities we are aware of have provided a plausible scientific justification.

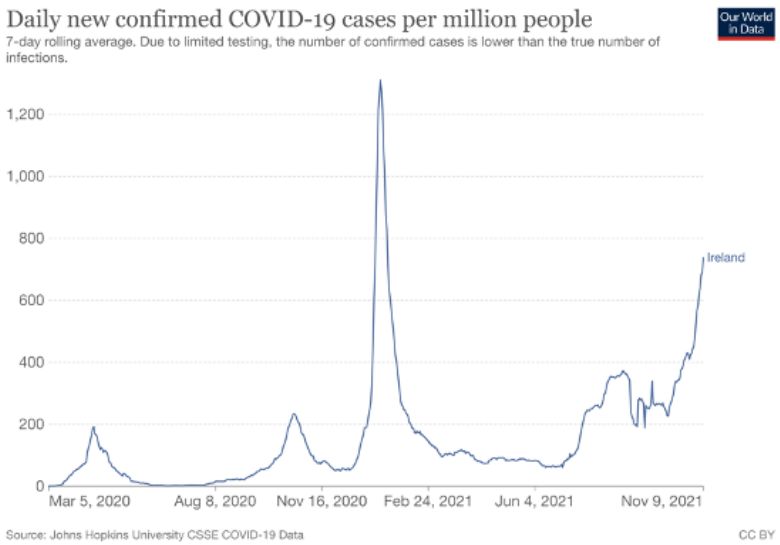


Figure 2. Daily new confirmed covid-19 cases per million population in Ireland. Source: Our World in Data (https://ourworldindata.org/explorers/coronavirus-data-explorer?facet=none&uniformYAxis=0&Metric=Confirmed+cases&Interval=7-day+rolling+average&Relative+to+Population=true&Align+outbreaks=false&country=~IRL).

Ploughing on….regardless (of the consequences)

Despite widespread and increasing evidence of vaccine failure (/news/feature-latest-snapshots-of-a-moving-target-of-a-pandemic-part-one/), the majority of health authorities and governments in the industrialised world remain – somewhat absurdly – steadfastly in support of achieving ever higher levels of vaccine coverage in their respective countries. The change in dynamics since the delta variant became the dominant circulating form of the virus and rising cases among the fully vaccinated have done nothing to cause any change in policy direction.

Most disturbingly, high pressure and coercion are being applied to the youngest age groups, those presently with the lowest rates of vaccination. Similarly, the oldest members of society, those with waning immunity because they were the first to be vaccinated – are similarly being targeted with boosters.

The policy position among those running the global pandemic strategy, including the World Health Organization (WHO) and the Centers of Disease Control and Prevention (CDC), is that vaccines should remain the primary mitigation strategy, this position being unchanged since the early stages of the pandemic (https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32318-7/fulltext).

It is based on the faulty premise that herd immunity can still be achieved using the current crop of spike protein-based vaccine technologies from Pfizer, Moderna, AstraZeneca and Johnson & Johnson, with 130 more in the clinical development pipeline (https://www.who.int/publications/m/item/draft-landscape-of-covid-19-candidate-vaccines).

In reality, countries like the USA and many in Europe that have suffered previous heavy infection pressure, are experiencing an ever greater confluence of naturally-acquired infection and vaccine-induced immunity. In January 2021, one estimate (https://www.medrxiv.org/content/medrxiv/early/2021/01/26/2021.01.24.21250396.full.pdf) suggested SARS-CoV-2 might have infected in excess of 40% of the US population, with the percentage of the entire global population infected estimated at 12.6%. According to Our World in Data (https://ourworldindata.org/covid-vaccinations), while over 50% of the world's population have already received one dose of the 'vaccine', around 70% of the population in many industrialised countries are vaccinated, the proportion dropping to just 4% of the population in low income countries.

Any such estimates are complicated by what appear to be greatly varying rates of innate immune protection from infection (see Fig. 3). Asymptomatic infection, that is always a consequence of effective innate protection, has been shown to vary from 1% to 75% in different studies and locations (https://www.ijbs.com/v17p1119.htm).

As we know from past history with SARS and MERS (https://www.tandfonline.com/doi/full/10.1080/21645515.2020.1796425) spike protein-based vaccines and coronavirus diseases are not necessarily good bedfellows. Antibody-dependent enhancement (ADE) of disease following priming with a 'vaccine' can have catastrophic impacts.

What we will argue below is that unless we come to better respect and understand the intricacies and complexities of the human immune system, as we navigate a reckless speedboat through these uncharted pandemic waters with a new virus and a new technological weapon used experimentally on much of the world's population, we are likely setting ourselves up for a health crisis of unimaginable proportions. The worst part is that is that the problems will emerge slowly and deniers will try vociferously to avoid any link being made. Heart attacks, strokes, cancers, thromboembolic events and 'vaccine'-induced autoimmune conditions will occur at ever greater frequencies.

The last thing we're likely to hear will be a *mea culpa*. We know only too well that leopards don't readily change their spots.

It is now of paramount importance to stop the 'vaccination' of those with the most sensitive innate immune systems – the youngest members of society. That's if we are intent on preventing their ongoing dysregulation by uncontrolled circulation of highly infectious variants. The resulting prolonged suppression of their innate immune systems will erode the system's self-protective capacity and prevent 'training' against other pathogens, as well as likely triggering wide-scale vaccine-induced autoimmunity. Together, this could amount to a disaster that may be felt for generations.

The rise of infection among the vaccinated

In order to understand the real world trends that are ongoing in this dynamic battle between the human immune system and SARS-CoV-2, in both vaccinated and unvaccinated people, we are at the mercy of authorities who are collecting data routinely. As Professor Norman Fenton, a risk analyst from the Queen Mary, University of London, demonstrates in a co-authored piece with colleagues published on 27 October 2021 (http://www.eecs.qmul.ac.uk/~norman/papers/inconsistencies_vaccine.pdf)and even the UK's Office of National Statistics (ONS) datasets (often rated as among the most reliable internationally) show, data that are being used to determine vaccinated and unvaccinated denominator populations in the UK, may dramatically underestimate the number of unvaccinated.

Nonetheless, the leaked Salus Project dataset from Humetrix (https://renz-law.com/wp-content/uploads/DOD-Doc.pdf), exposed by US lawyer Thomas Renz, gave us a window into a 5.6 million-strong cohort of over-65s in the USA. It showed us that by the end of August 2021, vaccine failure (in stopping infection) was rising sharply. In this very large cohort with over 80% vaccinated, 71% of the infections were found to be among the fully vaccinated. The number is likely higher now.

The latest UK data (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1032671/Vaccine_surveillance_report_-_week_44.pdf), mentioned above, paint a similar story. But it is the changing trend that is even more interesting, this having been shown graphically by Dr Mike Williams in his excellent article (https://www.ukcolumn.org/article/what-explains-rising-cases-among-the-vaccinated) published by *UK Column* at the end of October (Fig. 3).

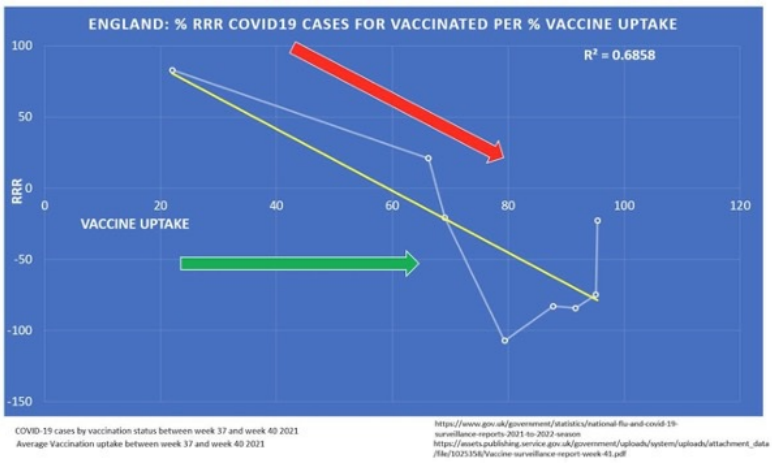


Figure 3. Percentage Relative Risk Reduction in vaccinated versus unvaccinated against percentage vaccine uptake in the population. The yellow trend line shows a clear correlation between increasing risk of SARS-CoV-2 infection in population with progressively high rates of vaccine uptake.

In his article (https://www.ukcolumn.org/article/what-explains-rising-cases-among-the-vaccinated), Mike Williams lands what might be the most likely mechanism for this. It may be complex and theoretical, but the immune system is complex, and when you're sailing uncharted waters, it's always going to be theoretical until proven or otherwise later in time. Most of all, it's highly plausible scientifically. It is also the very mechanism that is being proposed by vaccinologist Geert Vanden Bossche (https://www.geertvandenbossche.org).

In short, the emerging theory suggests that covid-19 'vaccines' disrupt innate trained immunity that would otherwise help

control or prevent infection by SARS-CoV-2. Childhood vaccines also do this, but the negative consequences on impairing this forms of trained innate immunity are not felt in the same way because such vaccination does not also drive additional transmission and expanded populations of immune escape variants (https://badgerherald.com/banter/2021/10/06/covid-19-variants-spikes-so-bad-theyre-now-being-named-after-greek-houses/).

In the process, damaged innate immunity could open the door to a host of other problems, from new infectious diseases, through to cancer, new forms of vaccine-induced autoimmunity, as well as potentially increasing the already sky-rocketing incidence of the 100 plus already described autoimmune diseases (https://autoimmune.org/disease-information/).

Before we go on, a couple of clarifications might be useful. The first, for the less science-minded, is about explaining what innate immunity is, contrasting this with adaptive immunity. The second, for those who are more versed in basic immunology, a little update on immunology; a reminder that the latest immunological science makes quite clear that it is not just the adaptive side of the immune system that can be trained – it is also the innate side. We'll shine some light on both of these points below.

Immune system mechanisms – early pandemic

There has been a long held, textbook view that the two sides of the immune system, namely the innate and adaptive (sometimes referred to as acquired) immune system, while working in tandem, are fundamentally different in their ability to be trained to successfully rid the body of foreign invaders.

The long-held notion was that innate immunity is never specific to individual pathogens, including viruses, but does have a good handle on knowing what's self and non-self. So when it encounters an altered self antigen (protein), that may for example be (e.g., expressed on a pathogen or pathologically altered cell) , it has a good go at trying to eliminate it from the body, something this ancient system has learned to do over the 500 million years (https://europepmc.org/backend/ptpmcrender.fcgi?accid=PMC5793817&blobtype=pdf) its been in existence in vertebrates. In the process, it either neutralises (in case of free-circulating antigens) or kills it (in case of cell-bound antigens).

In encounters with viruses, innate antibodies (mostly immunoglobulin M [IgM]), innate immune cells (e.g. relatively unspecialised monocytes, macrophages, neutrophils and natural killer cells), pattern-recognition receptors (PRRs) (e.g. Toll Like Receptors) and innate immune modulators (e.g. Pathogen-Associated Molecular Patters [PAMPS]) are among the key players. Think of the innate immune system as the first-responder team in the immune system.

>>> Find out more about the innate immune response in relation SARS-CoV-2 in this review (https://www.cell.com/cell/pdf/S0092-8674(21)00218-X.pdf) in the journal *Cell* by Joachim Schultze and Anna Aschenbrenner (2021).

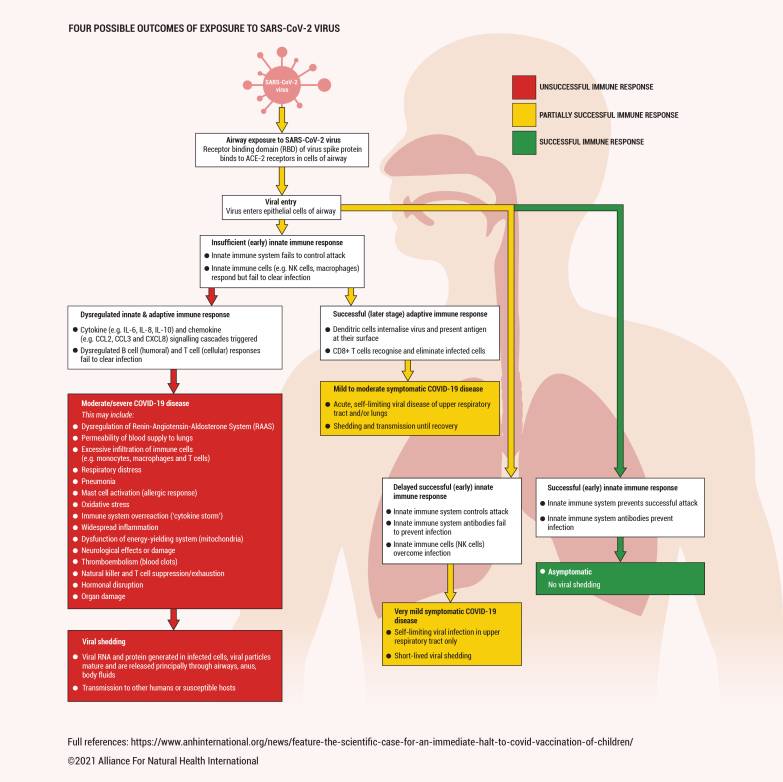
With SARS-CoV-2, the virus usually enters the body via the airways, so the innate immune system will be most active in the mucosal and epidermal layers of the airways. If a virus breaks through the innate immune system because of, say, high infectious pressure and a poorly trained (naive) innate immune that hasn't had past experience of the antigens associated with the virus, the virus will use infected host cells to replicate rapidly. But once released into circulation and body fluids, the antigens will be recognised by circulating B cells of the adaptive immune system.

As the infected tissue cells undergo pathological changes and die, the special forces unit of the adaptive immune system, including antibodies released from B cells originating from bone marrow (= humoral response) and killer T cells originating from the thymus (= cell-mediated response), attempt to clear the infection to enable the host to recover from the disease. It might take several days for the adaptive immune system to rev up sufficiently and learn how to combat the new invader, but once it's learned how to recognise, neutralise or kill a foreign invader, it has memory. That's what provides long-term immunity, in case of SARS-CoV-2, particularly through memory B cells. There's even a bonus: the combined effects of the innate and adaptive immune system should also allow for protection to a broader spectrum of viral variants that are prone to mutation as part of their evolutionary strategy.

So the story goes.

In the following graphic (Figure 4), we show the various outcomes – all 4 of them – that can arise when an individual is infected with SARS-CoV-2. The diagram helps to explain where failures in either the innate or adaptive immune system contribute to different outcomes and severity of disease.

[click on figure below to enlarge]



(/resources/documents/four-possible-outcomes-of-exposure-to-sars-cov-2-virus/)

Figure 4. Four potential outcomes following infection by SARS-CoV-2. *[See References at end of article]*

This is of course an over-simplification. But there's a very important piece of this puzzle that's often left out. It's the fact that the innate immune system can also be trained. It can acquire memory, rather like the adaptive immune system (but differently). Innate immunity is the most primitive part of our immune system and it needs to be fully functional in newborns as they have yet to progressively acquire a learned response from altered self antigens (notably degraded self components) as well as pathogens harbouring altered self antigens that subvert the host immune system. It should also be no surprise that over millennia of evolution, the innate immune system has learned a thing or two about how to adapt to changing environments and unexpected foes that it is increasingly confronted with as the host grows up, ages and becomes exposed to a more diversified spectrum of pathogenic agents.

The more we begin to understand innate immunity, the more we recognise its key role in protecting our bodies from infection, including SARS-CoV-2. It's the reason kids have had so much more protection than older or diseased adults, whose innate immunity tends to be much better trained but is much less armed or experienced to tackle pathogens they've yet to be exposed to — including newly originated pathogens like SARS-CoV-2.

Training of the innate immune system is hard-wired into our evolutionary blueprint. Central to this survival process is the ability to distinguish between degraded bits of self (that need to be eliminated so they can be replaced for growth and development) and external invaders (non-self components, including pathogens). The innate immune system also does clean up, repairing damaged tissues.

What's fascinating is that the training occurs through a molecular re-patterning process that happens epigenetically (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6225771/pdf/nihms-995099.pdf). You may remember epigenetics is the process whereby specific environments leave particular chemical (epigenetic) 'marks' on genes that changes the way they express themselves, with the expectation of aiding survival.

In this way, certain innate immune cells (notably myeloid cells like monocytes and macrophages, as well as natural killer cells) in the innate immune system learn, epigenetically, from previous 'altered self' (or self-like) encounters, including exposure to microbes and other non-self components. (https://www.annualreviews.org/doi/10.1146/annurev-pathmechdis-012418-012718) The changes in gene expression pattern change the function (https://www.nejm.org/doi/full/10.1056/NEJMcibr2011679) of these innate immune cells, helping them to respond more effectively to the same type of pathogen should it be encountered in the future while preserving their capacity to cross-react with other pathogens sharing similar molecular patterns.

The phenomenon is referred to as 'trained innate immunity' (Figure 5) and, for example, in case of SARS-CoV-2, provides protection against a broad and diversified spectrum of coronaviruses, including — of critical importance — all SARS-CoV-2

variants.

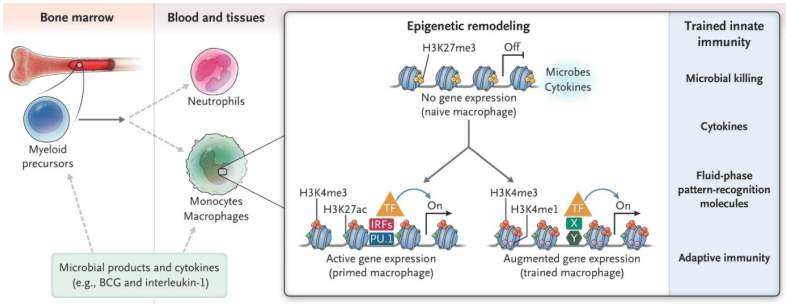


Figure 5. Cellular and molecular mechanisms underlying trained innate immunity. Source: Mantovani & Netea (2020) (https://www.nejm.org/doi/full/10.1056/NEJMcibr2011679).

There's more to it still. Because the training comes from epigenetic remodelling, it's not just microbes that can leave long-lasting impacts on innate immunity. It's also other factors such as chronic stress, that have been shown, also through trained innate immunity, to induce changes that lead to neuroimmune psychiatric disorders and behavioural abnormalities (https://www.nature.com/articles/mp2017186). And chronic stress has been a feature of the last year and half so its impacts on the immune and neurological 'supersystem' should not be ignored.

Since epigenetic marks are imprinted by all aspects of our environment, we should remind ourselves of the impact of our diets and lifestyles on the epigenetic imprinting of our innate immune systems. Our environments and our long-term habits and behaviour will deliver phenotypic changes to our innate immune systems that will last a lifetime. If we care about our health, we need to choose carefully - whether it's our medical, social, familial, dietary and lifestyle choices.

>>> Find out more about ANH's Food4Health guide (/campaigns/food4health-campaign/).

Immune tolerance and Original Antigenic Sin

There are two more important pieces to the puzzle, these relating to specific effects of mRNA (and probably all spike protein-based) 'vaccines'. Firstly, the 'vaccines' can induce what is referred to as 'immune tolerance' by reducing the responsiveness of the innate immune system, by suppressing Toll Like Receptors (TLRs), that are a class of pattern recognition receptors expressed on the membranes of innate immune cells, such as macrophages, natural killer cells and dendritic cells. The Pfizer mRNA vaccine has been shown to suppress these TLRs, so dampening the innate immune response and yielding immune tolerance. This creates the diametrically opposite result of trained innate immunity, which sharpens, as opposed to blunting, the innate immune response.

The final piece to the immunology puzzle is referred to as 'original antigenic sin (https://www.jimmunol.org/content/202/2/335)', a term first coined in the 1960s that explains how the development of immunity against pathogens (and antigens specific to a given pathogen) is shaped by the first exposure to that pathogen, antigen or group of antigens. It's a mechanism

So that's the background. in the following section, we're going to examine how this understanding of immunology might explain increased case rates among the most 'vaccinated' and considerably better, and improving, outcomes among the unvaccinated.

Immune system mechanisms – mature pandemic + mass vaccination

It's clear from the primary and secondary outcome measures of the covid-19 phase 3 clinical trials that the intended purpose of covid-19 'vaccines' has been to activate and prime the humoral response of the adaptive immune system so that antibodies, notably immunoglobulin G (IgG) antibodies produced by B cells, can attempt to neutralise (sterilise) the virus.

It clearly doesn't work as intended which is why the covid-19 'vaccines' have been unable to stop transmission from person to person. The other expectation in the minds of the 'vaccine' designers was that vaccination would also induce long-term immunity, aimed at memory cytotoxic (killer) T cells, that, like B cells, are also cellular components of the adaptive immune system.

So what might happen to a population in which significant numbers are both covid-19 'vaccinated' and unvaccinated when also many have had prior exposure to the virus? That's after all the situation being encountered in most countries in the industrialised world that have had considerable infection pressure.

It is our hope that the background provided thus far, may go a long way to explaining some of the data trends, as counter-intuitive as they might appear to some, that we are now witnessing. We hope this has been given in simple enough terms that our readers who don't have much or any background in matters immunological will be able to grasp it. Yet, at the same time, there's enough detail for the more scientific among you so you won't be too frustrated by the absence of molecular detail (which you will find in the hyperlinked papers!).

The potential Big 5 explanatory mechanisms

Following are five key mechanisms that may, together, or in particular combinations, partially or fully explain the current observations that suggest that vaccinees may be increasingly worse off than the unvaccinated. More than that, the consequences for humanity of not leaving a large pool of unvaccinated may be catastrophic down the road.

1. **Training of innate immunity in the Ag-inexperienced and Ag-experienced.** As naturally-acquired infection also continues to increase among the unvaccinated, this population will likely benefit from trained innate immunity that allows their innate antibody-secreting B cells and monocytes (such as natural killer cells and macrophages) to be progressively more able to counter infection.

   However, antigen-experienced individuals who are exposed to sustained immune pressure from vaccinal antibodies that are boosted further by exposure to circulating, highly infectious variants, will not be able to further expand their antigen experience. Additionally, their SARS-CoV-2-trained innate, self-centred antibodies will not be able to properly match a spectrum of other self-like molecular patterns shared by other infectious pathogens or altered self-molecules that arise from dying, degrading or cancerous (apoptotic) host cells.

   This failure of the innate immune system to fully recognise these antigens is referred to as innate immune tolerance (https://jlb.onlinelibrary.wiley.com/doi/full/10.1002/JLB.MR0318-104R). Because it fails to recognise these self-like antigens, it follows that an increased incidence of other viral diseases (caused by viruses expressing other self-like glycans on their surface) as well as autoimmune conditions and diseases in older and very young children, respectively, might be expected.

   Likewise, antigen-experienced individuals who are exposed to sustained immune pressure that arise when vaccine-induced antibodies are boosted by exposure to circulating, highly infectious variants, will not be able to further expand their antibody experience. At the same time, their SARS-CoV-2-trained innate, foreign-centred antibodies won't recognise the gamut of other foreign-like molecular patterns shared by a number of other pathogens or pathologically altered cells, such as cancer cells. This vaccine-induced dysregulation of innate immunity during a pandemic sets the scene for a potential time bomb.
2. **Immune escape**. This is the primary mechanism by which new variants become more transmissible or virulent (deadly). Such new variants may potentially be selected by, or at least, selected more rapidly, by immune pressure from vaccination with imperfect (partially sterilising) spike protein-based 'vaccines'. Such 'vaccines' deliver only partial immunity in that they do not block infection or transmission — the very situation we face presently.

   The result is that the immune system puts pressure on viral infectiousness without being able to eliminate the virus. Natural selection of immune escape variants (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7723407/) will only lower vaccine effectiveness when these variants expand in prevalence in the population, for example as a result of widespread immune pressure. It is increasingly understood that population level (region wide and global) immune pressure on the spike protein, will promote the propagation of more infectious immune escape variants. It has been well described for certain mutations (https://www.frontiersin.org/articles/10.3389/fimmu.2021.744242/full), including those present in most lineages of the so-called delta variant. It likely that immune escape variants are generated in and circulate to a greater extent in heavily 'vaccinated' populations and countries.
3. **Antibody-dependent enhancement (ADE).** Exposure to SARS-CoV-2 in the presence of antibodies of weak affinity, such as those induced by covid-19 'vaccines' that are only a poor match to the circulating viral variant and/ or due to immature vaccinal antibodies, may induce more severe covid-19 disease via antibody-dependent enhancement (ADE) (https://www.nature.com/articles/s41564-020-00789-5?fbclid=IwAR0MTDI0qIQgLkqnjaYI7vyr-H4Wj2IcNiAQT1hWboXDk0YIldwaCVgr5xg).. Weak affinity antibodies have insufficient neutralising capacity and can bind to viral antigens (e.g. spike protein) without blocking the infection.
4. **Original antigenic sin**. As a reminder, this is the phenomenon that occurs when the immune system responds to what it already knows from its first exposure (https://www.frontiersin.org/articles/10.3389/fimmu.2020.01120/full). If the first exposure an

individual had was a covid-19 'vaccine' not the wild virus, that individual's immune system may not respond adequately or fast enough to exposure to a mutated wild virus (https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/original-antigenic-sin-a-potential-threat-beyond-the-development-of-booster-vaccination-against-novel-sarscov2-variants/C8F4B9BE9E77EB566C71E98553579506), such as the delta, omega or any future variant. This is because the covid-19 'vaccines' which only present the spike protein to the immune system, have been designed to counter the original Wuhan strain of the SARS-CoV-2. By contrast, the delta variant has a mutated spike protein and, as a viable virus, includes a number of other antigens (e.g. nucleocapsid, membrane protein, envelope protein) against which naturally-acquired (as compared with vaccine-induced) immunity presents more robust defence. When exposed to a variant of the original virus, recall antibodies will exert suboptimal pressure on the virus which may lead, under conditions of spike receptor-binding domain-directed immune pressure (https://www.science.org/doi/full/10.1126/science.abh2315), to natural immune selection of more infectious variants.

It is very difficult to imagine how scientists and health policy professionals who are looking closely at the developing trends have not started ringing alarm bells. Perhaps their bells are silent. These bells should, in our view, at the very least signal a halt to the global mass 'vaccination' of children, who while remaining unvaccinated, present a reservoir of normality in terms of a potent and competent immunological response and an invaluable source of genuine herd immunity as – due to their extensive immunological naivety - they provide a huge capacity for virus elimination from the population.

As Geert Vanden Bossche has argued, antiviral chemoprevention targeting the vaccinated population (i.e., those who're no longer able to rely on their innate immune system for providing sterilising immunity) may also be very useful to reduce the infection pressure in the population. In this light, all the work undertaken by doctors and other clinicians on the frontlines that have helped to develop early treatment protocols (https://worldcouncilforhealth.org/wp-content/uploads/2021/09/WCH-At-Home-Treatment-Guide_30-Sept-2021.pdf) spearheads what needs to happen everywhere. Over the last few months we have worked closely with these clinicians in our role as an affiliate of the World Council for Health (http://www.worldcouncilforhealth.com) (and in my own role as co-chair of its Scientific and Medical Sub-committee). Many of these doctors and clinicians are dividing their attention to delivering therapeutic protocols for the unvaccinated, while also treating those with 'long covid' and the vaccinated who increasingly succumbing to covid-19 and other illnesses, including what is now referred to as 'post jab syndrome'.

Proceeding with the administration of leaky 'vaccines' will not only result in more vaccine failure. It will also risk driving the evolution of new, more dangerous variants that develop ever better means of escape from the vaccine-induced antibodies. This implies an even greater potential for harm, either as an immediate result of vaccine-induced immune escape or as a result of recombination and/ or crossing species barriers (e.g. generating animal reservoirs (https://www.aphis.usda.gov/aphis/newsroom/stakeholder-info/stakeholder-messages/wildlife-damage-news/deer-sars)).

It is impossible to accurately predict the consequences of global mass vaccination of children.

But among the potential risks, all of which need to be monitored closely in the coming months and years, that may plausibly occur in intensively covid-19 'vaccinated' populations based on current understandings of potentially disrupted immune mechanisms (as discussed in this article), are substantially increased rates of:

- severe, even life threatening, covid-19 disease
- other infectious (e.g. viral) diseases
- psycho-neurological diseases impacting the ability to work or earn a living
- premature strokes and heart attacks (as well as pericarditis and myocarditis)
- metabolic diseases (e.g. type 2 diabetes, obesity)
- cancer
- infertility, that could impact the future of our species
- clotting disorders
- disrupted menses
- novel covid-19 vaccine-induced autoimmune diseases
- existing autoimmune diseases
- inflammatory disorders
- allergies

Conclusions and actions

As we have described in a previous article (/news/feature-how-safe-are-covid-vaccines-part-two/), when covid-19 'vaccines' provide no benefits

to children, when they erode their innate immune systems, and where there are significant known risks (e.g. myocarditis, pericarditis), what is the basis of coercive efforts to continue to vaccinate children?

But with additional known and unknown risks (see above), and more and more evidence that unvaccinated children may become a crucial immune reservoir that could help humanity emerge from the current pandemic (also above), the evidence would seem to point to a slam dunk for exercising the right of refusal, even for it's a booster that's on offer. For some of course, the decision may be complicated depending on how you value health and what cost you might apportion to being relegated, albeit probably temporarily, into a societal out-group (https://www.jstor.org/stable/3791271).

It is worth noting, given the complexity of information around the risk and benefits of covid-19 'vaccination' on a background landscape of rapidly changing naturally-acquired and covid-19 'vaccine'-induced immunity, there is barely a young soul on this planet that could have received properly informed consent prior to receiving their covid-19 jab. In law, that's already criminal battery or assault (/news/informed-consent-is-this-fundamental-right-being-respected/). Sadly, like the mainstream medical profession and its closely aligned pharmaceutical partners, the mainstream legal profession that is plugged deeply into the corporatocracy has a long way to go before it could be regarded as being transparent, honest or ethical.

In the meantime, given you've got this far, I'd ask you to do what you can to help more people to understand the risks involved in allowing their loved ones, and especially their young ones, to blindly consent for covid-19 'vaccination'. How many have been told as they roll up their sleeves that covid-19 'vaccines' might worsen disease risk (https://pubmed.ncbi.nlm.nih.gov/33113270/)?

Please share this article widely and check out the resources below that will help you exercise your right to medical informed choice.

Resources to support informed choice

- PROMIC (Professionals for Medical Informed Consent & Non-Discrimination) exemption forms page (https://www.promic.info/exemption-forms)
- UK Medical Freedom Alliance template letter section to find relevant template letters (https://www.ukmedfreedom.org/resources/template-letters)(can be adapted for use outside the UK)
- Template letter from Lawyers for Liberty (https://lawyersforliberty.uk/resources/#letters) (can also be adapted for use outside UK).

Acknowledgements

Many thanks to Geert Vanden Bossche PhD (https://www.geertvandenbossche.org/) for emphasising the importance of trained innate immunity, providing some invaluable inputs to the manuscript and his input to Figure 4.

References relating to Figure 4

- Afrin LB, Weinstock LB, Molderings GJ. Covid-19 hyperinflammation and post-Covid-19 illness may be rooted in mast cell activation syndrome. *Int J Infect Dis* 2020; 100: 327-332. Link (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7529115/).
- Augoustides JGT. The Renin-Angiotensin-Aldosterone System in Coronavirus Infection-Current Considerations During the Pandemic. *J Cardiothorac Vasc Anesth* 2020; 34(7): 1717-1719. Link. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7161509/)
- Gupta A, Madhavan MV, Sehgal K et al. Extrapulmonary manifestations of COVID-19. *Nat Med* 2020; 26: 1017–1032. Link (https://www.nature.com/articles/s41591-020-0968-3).
- Lei X, Dong X, Ma R et al. Activation and evasion of type I interferon responses by SARS-CoV-2. *Nat Commun 2020;* 11: 3810. Link (https://www.nature.com/articles/s41467-020-17665-9).
- Lowery SA, Sariol A, Perlman S. Innate immune and inflammatory responses to SARS-CoV-2: Implications for COVID-19, *Cell Host & Microbe* 2021; 29(7):1052-1062. Link (https://www.sciencedirect.com/science/article/pii/S1931312821002328).
- Magro CM, Mulvey J, Kubiak J, et al. Severe COVID-19: A multifaceted viral vasculopathy syndrome. *Annals of Diagnostic Pathology* 2021; 50: 151645. Link (https://www.sciencedirect.com/science/article/pii/S109291342030191X).
- Taefehshokr N, Taefehshokr S, Heit B. Mechanisms of Dysregulated Humoral and Cellular Immunity by SARS-CoV-2. *Pathogens* 2020; Dec; 9(12): 1027. Link (https://pubmed.ncbi.nlm.nih.gov/33302366/).
- Tay MZ, Poh CM, Rénia L. et al. The trinity of COVID-19: immunity, inflammation and intervention. *Nat Rev Immunol* 2020; 20: 363–374. Link (https://www.nature.com/articles/s41577-020-0311-8).
- Yang L, Liu S, Liu J. *et al.* COVID-19: Immunopathogenesis and Immunotherapeutics. *Sig Transduct Target Ther*

2020*;* 5**:** 128. Link. Link (https://www.nature.com/articles/s41392-020-00243-2).

- Zhao Y, Sui L, Wu P, *et al.* A dual-role of SARS-CoV-2 nucleocapsid protein in regulating innate immune response. *Sig Transduct Target Ther* 2021; 6: 331. Link (https://www.nature.com/articles/s41392-021-00742-w.pdf).

>>> ANH **Covid – Adapt Don't Fight campaign** (https://www.covidzone.org)

Return to **Homepage** (/)

#enoughmovement (https://enoughmovement.org/) #enough