MEDICAL AND EPIDEMIOLOGICAL EVIDENCE DRIVING COVID VACCINE HESITANCY OR REJECTION

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Written by Christian theologian Abraham Kuyper amidst the 1880 smallpox epidemic:

"Vaccination certificates will therefore have to go… The form of tyranny hidden in these vaccination certificates is just as real a threat to the nation's spiritual resources as a smallpox epidemic itself."

Our delegation extends thanks for the opportunity to present some views regarding the current issues around COVID, its management and the role of the church in the current milieu. Our preference would have been to have a more dynamic, open dialogue and friendly discussion where questions could be asked and responded to frankly and with a view to find common ground.

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1 – **this document in (unprotected) MS Word .doc form so all graphs can be manually expanded**

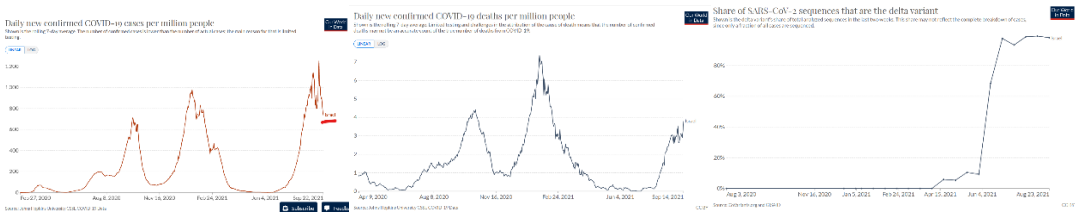
OBJECTIVE AND IMPLICATION OF THIS DOCUMENT

Objective: To demonstrate that COVID vaccine hesitancy or rejection is supported by overwhelming data and science
Implication: The SDA Church's General Conference and all levels of administration beneath it should withdraw any and all support for mandated or coerced current COVID vaccines, explicitly giving equal support to church members who choose to take the vaccine as well as those that don't, and by taking no COVID vaccine position

LIST OF EVIDENCE DRIVING VACCINE HESITANCY OR REJECTION

1. Failure of COVID vaccines to inoculate against infection and spread

Up until COVID, the role of vaccines had been to inoculate individuals against infection, thus halting transmission and spread. Israel is the world's most vaccinated large population in the world, yet the epidemiological data from Israel, where 85% have been vaccinated, shows cases surging. Despite high vaccination status, Israel's data below shows considerable COVID transmission . . .



. . . with the vaccinated overrepresented in most age groups. See also highly-vaccinated Singapore.

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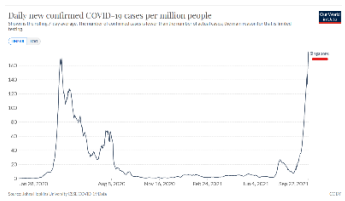

The mRNA and viral vector vaccines have not demonstrated exceptionally high levels of efficacy in disease prevention and transmission and therefore fail in their ability to be used as a widespread protective measure. The question is are they then effective enough for mandating to impinge on other legislation that affects the rights of Australians? The argument that Rapid Antigen Testing would be a far more reliable, adverse event-free means of providing safety in the workplace stands. Further, the risk for transmitting COVID in the workplace is from persons infected with COVID not from unvaccinated persons. Both vaccinated and unvaccinated persons in the workplace may be infected with COVID and be a source of transmission.

Professor Christian Perrone, France's most highly qualified vaccinologist comments:

> ". . . the 'variants' are not very dangerous. All the 'variants' since last year are less and less virulent. That's always the story in infectious diseases."
> ". . . it has never happened that a state or politicians recommend systematic vaccinations for billions of people on the planet for a disease whose mortality is now 0.5%."
> "Unvaccinated people are not dangerous, vaccinated people are dangerous to others. That's been proven in Israel now, where I'm in contact with many physicians."

Geert Van Den Bossche, Belgium's most highly qualified vaccinologist further comments:

> "A vaccine that only prevents hospitalizations and severe Covid-19 disease is not good enough to be used to combat a pandemic."
> "There should be no doubt that non-transmission-blocking vaccines (i.e., so-called 'leaky' or 'imperfect' vaccines) **CAN NEVER EVER CONTROL A PANDEMIC**, even though they may temporarily protect against disease."

Quite clearly, it is the voices of the world's most qualified that helps drive vaccine hesitancy and rejection.

2. Inadequately-tested novel vaccine technologies which are still experimental until 2022/23

a. mRNA vaccines use **man-made RNA** which has only had **very limited use** before in Patisiran's lipid nanoparticle delivery system
b. Viral Vector Vaccines use **man-made segments of DNA** with only **limited experience** in Ebola
c. The Viral Vectors are **Genetically Modified Organisms** (GMOs)
d. The only bio-distribution study (released in Japan under FOI request) for the Pfizer vaccine shows lipid nano-particles escaping the shoulder muscle and appearing in many organs, with **ovaries carrying a higher load proportionately** than other organs
e. **No carcinogenicity studies yet done** (we note early reports of uterine cancers in the vaccinated)
f. **No genotoxicity studies done**
g. **No fertility studies yet done**
h. **Limited data on comorbidities**
i. **No data on children and adolescents done** at time of release
j. **No data on lactation yet available**
k. **No data on interactions with other medicines yet available**
l. **Lack of knowledge** regarding impact of spike protein segment production

Society has historically determined that forced medical procedures are immoral with an international consensus on the Nuremburg Code and Helsinki Agreement, with the implication that uninformed consent falls to the same international judgment. With the lack of data and studies listed above vaccine recipients are *ipso facto* uninformed about the risks of their vaccine. Pfizer's clinical trials are not completed until mid-2023, and Moderna until late 2022. Thus the vaccinated are the unwitting subjects of a grand genetic experiment.

3. Spike protein demonstrably pathogenic

All of the currently available vaccines employ a part of the spike protein as the chosen antigen to generate antibodies. However the science clearly shows that the spike protein is pathogenic (causes disease), such that conditions caused by the vaccine are the same as those from contracting COVID. Studies have shown that:

a. **the spike protein degrades the endothelial layer**, giving the protein access to bodily organs
b. **the spike protein crosses the Blood-Brain barrier,** entailing Central Nervous System disorders

4. Unacceptable numbers of Adverse Reactions

Adverse reactions in past vaccines have been the vector by which their safety has been judged and fate sealed. In 1976 45 million people were vaccinated against the so-called "swine flu". The vaccine was terminated after causing 53 deaths and a 1/100,000 Guillain Barré syndrome rate.

In Australia deaths reported to the TGA, as of 19 September 2021, numbered 556 of which 9 were determined as being tied to their vaccination. The site makes no mention of autopsies despite a detailed discussion of the 9 deaths, which alone signifies a lack of seriousness on the TGA's part in assessing the vaccine's real health impacts. It also states that "The overwhelming majority of deaths reported to the TGA following vaccination occurred in people aged 65 years and older" which obviates the questions about identical deaths being counted into Australia's increasing COVID death totals – totals which drive the country's intervention policies and perceptions of pandemic. The TGA is consequently guilty of special pleading.

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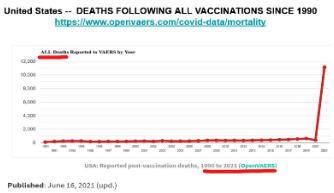


Globally – we first note the Harvard Pilgrim study estimating that the US vaccine adverse events system (VAERS) reports only an estimated 1-10% of actual events, creating significant under-reporting. This is likely to be true of other Western countries. Estimates below reflect a range of totals derived against such under-reporting. The UK (second graph) is universally recognised as having better data. *Clearly these are unacceptable adverse event totals for any vaccine, where all COVID vaccine types contribute to these totals.*

Covid-19 Injection Damage: EU, UK AND US SUMMARY		Estimated Numbers if those reported were just:	
		1%	10%
Region and data entry cut off date	Total Reported	Total	Total
UK Fatalities - 1st September 2021	1,632	163,200	16,320
EUdra Fatalities 11th September 2021	24,528	2,452,800	245,280
US Fatalities -3rd September 2021	14,506	1,450,600	145,060
Total Fatalities	40,666	4,066,600	406,660
UK Injuries -1st September 2021	1,186,844	118,684,400	11,868,440
EUdra Injuries -11th September 2021	2,292,967	229,296,700	22,929,670
US Injuries -3rd September 2021	3,146,691	314,669,100	31,466,910
Total Injuries	6,626,502	662,650,200	66,265,020
UK Reports -1st September 2021	357,956	35,795,600	3,579,560
EUdra Reports -11th September 2021	925,128	92,912,800	9,291,280
US Reports -3rd September 2021	675,299	67,529,900	6,752,990
Total Number of Reports	*1,962,383*	*196,238,300*	*19,623,830*

Please expand tables to view detail

Latest Public Health England data on the Delta Variant to 12th Sept '21

Delta cases England (PHE Data) 1st Feb '21 to 12th Sept '21	Positive Tests	Deaths	% of Deaths
Unvaccinated	257,357	722	28%
Vaccinated	278,212	1,779	70%
Unknown	58,003	41	2%
Total	593,572	2,542	100%
Those 14+ days post 2nd Dose	157,400	1,613	63%

5. Safer alternatives are sufficient to contain and reduce most viral spread, hospitalisation and mortality

The WHO has stated that most people will survive COVID without the need for any medical treatment and cites vaccination as only part of the solution to prevention and transmission. COVID is also significantly less serious for younger, otherwise healthy individuals in the population. By far the majority of hospitalisations and deaths have occurred in those over 70 years old and is uncommon even in the frail in the absence of co-morbidities.

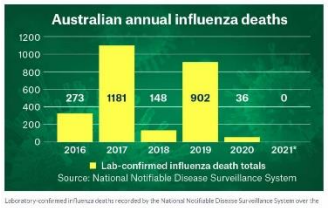
The WHO has long advocated a 3-tier prevention model of care the principles of which are used for all manner of conditions; infectious diseases, non-infectious chronic health conditions, mental health conditions comprising: 1. Primary - teaching about basic health care principles to prevent infection 2. Secondary - early treatment and care to minimise disease progression and complications 3. Tertiary - involves management of complications and rehabilitation that would minimise the long-term impacts and prevent rehospitalisation.

The Australian government has currently neglected health promotion and disease prevention, focusing on vaccination and quarantining, which while somewhat justifiable has led to widespread socio-economic collapse, political upheaval, mental health crises and totalitarian control in an effort to manage a condition that could be more successfully managed using a well-established three-tiered approach.

Our TGA has now historically imposed State control over the doctor-patient relationship, wresting from doctors their ability to make informed patient management decisions and their right of prescribing certain drugs. For instance, Ivermectin has been safely used for more than 30 years for the treatment of parasites in humans and a whole range of other conditions. A single dose of Ivermectin has been shown to decrease the viral load 5000 times. Trials have been conducted using Ivermectin alone and in combination with other medication, where multi-drug therapies are now normally administered. Ivermectin has been shown to be of particular benefit when used in combination with Doxycycline and even as a single drug therapy. A Cochrane Collaboration-protocol Meta-analysis of 15 trials found that Ivermectin reduced the risk of death compared with no Ivermectin. Low-certainty evidence found that Ivermectin prophylaxis reduced COVID-19 infection by an average of 86% - a rolling 65 study meta-analysis has similar excellent results. This 15-trial analysis acknowledged that there may be no benefit for those requiring mechanical ventilation, whereas effect estimates for "improvement" and "deterioration" clearly favoured Ivermectin use. Severe adverse events were rare among treatment trials. This is more current than the TGA's Popp et al (2020) review used to overrule Ivermectin. The TGA has recently published reasons for placing restrictions on prescribing Ivermectin for COVID, none of which are logically defensible. Uttar Pradesh, an Indian State of 241 million people, has credited Ivermectin combinations with defeat of the Delta epidemic where zinc has also featured for its antiviral properties . Alternatively, if this success is from natural immunity, it cannot be from the low vaccination percentage in Uttar Pradesh.

6. Perceptions of a pandemic are driven by an unreliable PCR test with false positives

Kary Mullis, the inventor of PCR tests, has stated that his test was not designed to diagnose illness. He said, "PCR is just a process that allows you to make a whole lot of something out of something. It doesn't tell you that you are sick, or that the thing that you ended up with was going to hurt you . . . ." Accordingly, a 2006 study recorded PCR tests responding to more than one virus, creating false positives and thus defeating their express purpose. A Chinese study found the same patient testing differently in two PCR COVID tests on the one day.



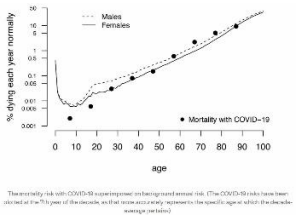
Laboratory-confirmed influenza deaths recorded by the National Notifiable Disease Surveillance System over the past five years.

The unreliability of PCR testing is attested to by the almost total disappearance of the flu and its associated deaths within Australia (see graph) since the advent of COVID. This suggests the PCR test labels flu cases as COVID, driving a false panic regarding COVID numbers and deaths here and in all countries worldwide. The US CDC has recently directed the Drosten PCR be phased out at year end with this - "CDC encourages laboratories to consider adoption of a multiplexed method that can facilitate detection and *differentiation of SARS-CoV-2 and influenza viruses*."

Current COVID PCR testing uses 37-45 cycles to make a diagnosis, but Germany's Robert Koch Institute states that anything over 30 cycles is likely not detecting something infectious. Portuguese and German courts concur.

7. Questionable pandemic of false positives driving suicides, mental illness due to reactionary lockdowns

The median age for COVID deaths are, in most countries, HIGHER than their national life expectancy. This contrasts with Spanish flu which saw a 28% drop in life expectancy. Median age for Australian COVID deaths - 82, Canada – 86, Italy – 82, England – 82, USA – 78, Canada – 86. As per the following graphs for the UK and India there is no real discernible difference between COVID mortality and natural mortality.



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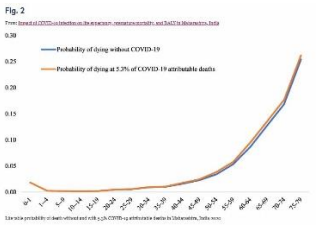


A survey has found that during the Victorian lockdown 1 in 10 seriously considered suicide. Attempted suicide rates by teenagers in Victoria rose by 184%. These are not the elderly, or those with comorbidities but teenagers who have everything before them. The NSW Chief Medical Officer has told citizens not to even talk to each other during the shutdowns. For the hesitant and rejectors, the heavy-handed approaches to a mild 'pandemic' driven by PCR false positives is matched by a totally unfounded overzealousness for mandated vaccines, which is curiously in lockstep across countries worldwide.

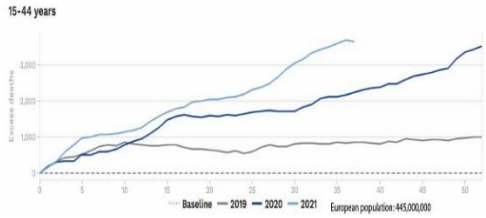
8. Unconscionable for authorities to mandate experimental vaccines on those with COVID risk close to zero

In light of the success of various cheap therapeutics such as Ivermectin and Zinc preventing hospitalisations and death, most of those rejecting COVID vaccine mandates rightly view such risks for them as close to zero. This is attested by COVID mortality rates in Australia and overseas, as per the table of UK rates below, where fatality rates are below 0.2% for those under age 49 even when therapeutics like Ivermectin had not even been used early in the course of disease. The second graph shows European excess deaths for all causes for those aged 15-44, which are not alarming. The third chart of data from Italy shows the percentages of comorbidities in those dying up to 20 March 2020, demonstrating there were very few deaths with no pre-existing conditions.

Table 1: Current estimates of the severity of cases. The IFR estimates from Verity et al.[7] have been adjusted to account for a non-uniform attack rate giving an overall IFR of 0.9% (95% credible interval 0.4%-1.4%). Hospitalisation estimates from Verity et al.[7] were also adjusted in this way and scaled to match expected rates in the oldest age-group (80+ years) in a GB/US context. These estimates will be updated as more data accrue.

Age-group (years)	% symptomatic cases requiring hospitalisation	% hospitalised cases requiring critical care	Infection Fatality Ratio
0 to 9	0.1%	5.0%	0.002%
10 to 19	0.3%	5.0%	0.006%
20 to 29	1.2%	5.0%	0.03%
30 to 39	3.2%	5.0%	0.08%
40 to 49	4.9%	6.3%	0.15%
50 to 59	10.2%	12.2%	0.60%
60 to 69	16.6%	27.4%	2.2%
70 to 79	24.3%	43.2%	5.1%
80+	27.3%	70.9%	9.3%

Mortality rates following Covid-19 infection for different age groups, estimated by researchers at Imperial College London



Number of comorbidities		
0 comorbidities	6	1.2
1 comorbidity	113	23.5
2 comorbidities	128	26.6
3 comorbidities and over	234	48.6

It is clear that adverse events related to the COVID vaccines for many are a higher risk than contracting COVID, particularly for the young. It is precisely this calculation of risk versus benefit that led to the US FDA rejecting a third booster shot for most of its population, where the risk of permanent heart damage for some age-groups was up to 6 times higher than death from COVID. This is no small matter.

9. Unconscionable for authorities to mandate experimental vaccines on those with natural immunity

Given the risks of adverse events for all COVID vaccines, which are now flagged by the FDA, there is no defence for authorities worldwide that have counter-intuitively shown total disinterest in sizeable percentages of their populations that have previously had COVID, with the far superior natural immunity it confers. An Israeli study (not yet peer-reviewed) has demonstrated that natural immunity is 13 times more protective than vaccine.

The worldwide lockstep approach against natural immunity, where 91 million Americans with prior infection are nevertheless forced or pressured to take the vaccine against all known science, evidences a single COVID command centre for all countries. **This central group is clearly not making decisions based on science** but have some other agenda than public health. Most who reject the vaccines are swayed by the evidence found in this document, but many are additionally wary of the apparent science-free agenda of forced experimental vaccines, suppressed therapeutics, indifference to natural immunity and indifference to low-risk age-groups.

10. Considerable evidence driving the worldwide class action against the global pandemic 'fraud'

The legal team of Dr Reiner Fuellmich, the lawyer who led the very successful worldwide class actions against the frauds enacted by VW and Deutsche Bank, has concluded their substantial investigations on what they call 'the greatest fraud against humanity', with 150 interviews with top scientists across a spread of disciplines, with insider whistle-blowers as well as review of leaked memos to various national entities. The class action will sue the World Economic Forum (of the 'Great Reset') and members of the World Health Organisation as coordinators of a fraudulent pandemic. It will allow any person internationally that has lost income due to shutdowns or vaccine mandates to be party to the class action. Various extensive interviews by the Fuellmich team can be viewed (eg Dr David Martin which is heavily evidenced with information that can be readily verified).

SHOULD THE SDA CHURCH BACK COERCED VACCINES?

For millennia it has been the role of governments to coerce, via police and prisons, those behaviours deemed to limit or annul the freedoms of other individuals. So what is the difference with governments coercing vaccines for the common good? Well for millennia there has likewise been universal agreement on core behaviours – stealing, killing, to name some - as CS Lewis has argued in *The Abolition of Man,* which have been considered as morally wrong. It was World War II that galvanised universal opinion on the question of coerced experimental medical procedures that were done without the consent of the individuals involved.

The questions the church must ask, then, before supporting government coercion, are these. Are these vaccines, given the whole picture, for the common good? Are they experimental, or like all other vaccines, tried and tested, studied over a prudent number of years in limited cohorts, to gauge injury or death before rollout? Are they needed, or are there other options that provide equal or better protection? Is there informed consent, particularly when social media are banning any discussion of alternatives which have excellent results? Is there an informed debate throughout the general media? Are they mandated for the common good, or is there evidence that they are a business plan creating astronomical wealth for vested interests? These are empirical questions which need to be sorted through with due diligence. And diligence there must be because Revelation 13 warns of coercion at the end of time which elevates error over truth – so, the final question is this – is our decision based on truth or is it based on error?

Proverbs 18:17 says that the first to state his case seems right until another comes forward and questions him. Both sides of a matter must be fully scrutinised and weighed before taking a position. This means hearing *all* the evidence to make a balanced and educated decision.

While the SDA church has no role in the development of health policy in this country it does participate in the provision of health care through aged care and the Sydney Adventist Hospital. It also owns a recently accredited University which prides itself in providing education excellence and well-developed research programmes. Historically the SDA church has been in the forefront of health, practicing health principles 100 years ahead of established research evidence. It raises questions as to why the church, in the midst of a health crisis, has been silent with respect to health promotion and support not only for its members but the community at large.

Regarding government coercion and whether it is based on truth or error – other denominations have determined that mandatory vaccines and lockdowns are based in error, not truth, and have been vocal in their clear stand against totalitarian edicts. Is the SDA Church's reliance on a position statement on vaccination published in 2015, years before the existence of these current so-called vaccines, relevant? Are the altered mechanisms of action and pharmacokinetics of these treatments the same as traditional vaccines? Adventists are firm on the ill effects and altered cellular function resulting from the effects of alcohol, tobacco, illicit drugs and unclean meat, and yet we as a church might have somehow missed the recognition that a significant proportion of the church body is not in favour of the altered cellular processes and as yet unknown outcomes involved in these novel mRNA and viral vector vaccines. This, of course, can be fixed.

Finally, there is considerable uncertainty concerning the possibility of man-made genetic material contained in these COVID vaccines inserting itself into the DNA contained in the nucleus of our cells. If this were to happen then Dr Mengele would clearly be in charge of the experiment. DNA Pol1 is capable of reverse transcriptase activity. That supports the idea that the vaccines are capable of deliberately genetically modifying the host - not just for transient expression of a viral epitope. These are important considerations.