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Bombshell: Proof that the Vaccines Were a Military-Backed Countermeasure

Sasha Latypova | Brownstone Institute May 6, 2023

Here is a high-level review of the manufacturing contracts between US DOD and Moderna.

Moderna's injection, mRNA-1273 is co-owned with the US Government, as the company has been funded by the defense research grants for years and also received intellectual property transfers from the US Government, in addition to preclinical and clinical research work conducted for Moderna by the NIH Vaccine Research Center. The NIH and Moderna each have a separate Investigational New Drug number for this product.

Moderna entered 2 types of contracts with the US Government for Spikevax injection:

- "Vaccine" contract and amendments that specifies R&D projects that the US Government ordered and paid for. Note that in Pfizer's case no R&D activities were ordered or paid for by the US Government, as these were excluded from the scope of the contract.
- "Manufacturing" contract(s) that ordered a large-scale manufacturing. This is different from Pfizer manufacturing contracts as the words "demonstration" and "prototype" are not used. I believe this is because OTA contracts must be for prototypes but FAR contracting doesn't have to be.

Note on redactions. In both Moderna and Pfizer's contracts many areas are redacted indicating a reason for redaction – the "redaction codes." Redacted content has been given codes b (4) and b (6), standing for:

(b) (4) Disclosure of information that would affect the application of advanced technology in a U.S. weapons system,

and

(b) (6) Disclosure of information, including information of foreign governments, that would cause serious harm to relations between the United States and a foreign government or to ongoing diplomatic activities of the United States.

There are several versions of the contract available, plus amendments. The first version was signed on August 9, 2020 and the last available version is June 15, 2021. In one of them the name of the signatory on the Moderna side was redacted with (b)(6). In another version it's unredacted – it was **Hamilton Bennett**, a senior director of vaccine access and partnerships.

This 35-year-old woman seems woefully underqualified, especially to "engineer the vaccine" as her role was described in the press. Moderna's history is notable for high-profile departures of competent and experienced people. Based on press reports and accounts of insiders, Stephan Bancel's toxic management culture led to departures of many qualified scientists including heads of R&D, Oncology, Cardiovascular, Chemistry, Rare Diseases, and even Vaccines (right around the time the company pivoted to vaccines in 2016). **Terminal incompetence** is a prerequisite for terminal fraud.

Unlike Pfizer's and other covid countermeasures contracts, the Moderna contract is not under Other Transactions Authority (OTA) but FAR 43.103(a)(3) and "Mutual Agreement of the Parties." This makes little difference with regard to the product liability and generally ignores pharmaceutical regulations, as described below.

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The total initial amount of contract was $1.5 billion, and this was increased to exactly $8,145,591,662.60 in later **amendments**. Sixty cents – the criminals get points for style and attention to detail! Note that this is in addition to the $1 billion R&D contract for a handful of studies that didn't matter which I discussed in Part 1.

The scope of the contract is "manufacturing of up to 500M doses"

The Department of Defense and Health and Human Services (HHS) require large-scale manufacturing of vaccine doses in support of the national emergency response to the Coronavirus Disease 2019 (COVID-19) for the United States Government (USG) and the US population.

Note this is for "manufacturing" and not demonstration or prototype.

The Objectives

This gets interesting. This paragraph includes feel-good sounding words which cover up the true intent: to declare an unrestricted bio-chemical-radiological and nuclear war on Americans, subvert consumer protections under the pretense of a "pandemic response." Note the words "whole of nation effort:"

> C.1.1.1 Under Operation Warp Speed (OWS), the Department of Defense and HHS are leading a whole of nation effort to ensure development of promising vaccine, diagnostic and therapeutic candidates and ensure that these medical countermeasures are available in the quantities required to reduce SARS-CoV-2 transmission, identify prior and/or current infection, and improve patient care, thereby mitigating the impact of COVID-19 on the nation and its people. The DoD Joint Program Executive Office for Chemical, Biological, Radiological and Nuclear Defense (JPEO-CBRD) is providing expertise and contracting support to HHS, in compliance with PL 115-92 Authorization Letter for DoD Medical Priorities, through an Interagency Agreement, signed April 23, 2020. As OWS products progress to clinical trials to evaluate the safety and efficacy of vaccines and therapeutics, it is critical that, in parallel, the USG supports large scale manufacturing so that vaccine doses or therapeutic treatment courses are immediately available for nationwide access as soon as a positive efficacy signal is obtained and the medical countermeasures are authorized for widespread use.

"Whole of nation" language can refer to the mobilization of a nation at the time of war. In that use, it is for an obvious declared war with a defined external enemy. However, in the new era of unrestricted 5th generation warfare this language seems to be being used to signal an overt takeover of the entire country by a rogue militarized force, typically by pretense of some sort of a manufactured crisis, and typically from the inside.

I found numerous references to this terminology in the press going back several years, in the US related to military things like **cyber warfare**, but also in the Chinese, Singaporean, and **Australian** press. One very interesting and thorough explanation of the "**Whole of Nation Chimera" in a Philippine source** describing the use of this approach by the militarized government regime that took over all government branches, and the entire civil society. In other words, it describes the installation of a fascist/totalitarian structure. I highly recommend readers to visit the link to the Philippine story published in March 2019 above, because remarkably, the language used is extremely similar to the US government pronouncements related to "covid pandemic response" and Operation Warp Speed. Did the US government writers plagiarize Duerte or do the globo-mafia captured cartels signal to each other and their superiors this way?

"Whole of nation" is closely associated with "**whole of government**" terminology. Both presented as feel-good ideas in plain text, but in fact these words signal a usurpation of power by the

militarized executive branch of the government. Public-private partnerships – so beloved by sellouts in academia, pharma, medicine and defense – are another closely associated term.

PL 115-92 refers to Public Law and is discussed below. It's a way to subvert FDA regulations by conscripting it to serve the DOD goals through the mentioned Interagency Agreement. They now have to follow the DOD orders and fake-approve the unapprovable on command and on schedule.

Finally, it is clear that the clinical trials are absolutely irrelevant to the approval of the injections by the FDA, as the large-scale manufacturing of these substances does not depend on them. It is performed in parallel with these fake exercises intended to fool the public.

Compliance with pharmaceutical regulations and Good Manufacturing Practices (cGMP)

The contract cites cGMP laws. However it is in a section "Applicable Documents" – referring to this as a document, not a law.

> C.2 **APPLICABLE DOCUMENTS**
>
> C.2.1 Federal Documents:
>
> C.2.1.1 Title 21 Code of Federal Regulations (CFR), Food and Drugs: Part 210, Current Good Manufacturing Practice in Manufacturing, Processing, Packing, or Holding of Drugs; General; and, Part 211, Current Good Manufacturing Practice In Manufacturing, Processing, Packing, or Holding of Drugs; General. (https://www.ecfr.gov/cgi-bin/text-idx?SID=a95cab20f443897a400bb7e44a27cf4c&mc=true&tpl=/ecfrbrowse/Title21/21cfrv4_02.tpl#0)

And further, in Amendment 1 the contract states: "cGMP manufacturing of 100 million doses, subject to any exceptions established by or the enforcement discretion of the FDA." Therefore, if FDA decides that no cGMP is necessary, then it's not necessary.

Product variations and undisclosed items ordered

The PO contains numerous items other than the mRNA-1273 (Spikevax) vaccine, and all of them are completely redacted with (b)(4)-i.e. "Reveal information that would impair the application of state-of-the-art technology within a U.S. weapon system."

In one of the amendments, the following clause was added: H.19 **Product Variations** (Authority FAR 43.103(a)(3), Mutual Agreement of the Parties), and completely redacted with the "weapons" redaction, including the word "Variations." This may refer to varying toxicity of different batches, but that's just a guess on my part:

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[redacted] Specifically for purposes of adhering to the scheduled delivery dates set forth in this contract for the Base Period, Option 1 and Option 2, schedule shall be deemed to have been met once doses are released by Moderna and are available for order.

H.19 Product [redacted] (as added via P00007)

Specific to CLINs 3001 and 4001, Moderna will deliver to the Government [redacted]

- mRNA-1273 Primary Series (0.2mg/mL, 100ug, 2-dose)

[redacted]

[redacted]

Public Law PL 115-92

Under "Regulatory" the only thing that's defined is that Moderna is the sponsor of the product, IND and BLA. Then it says that the DOD will use this law for the product: "DoD Medical Product Priority. PL 115-92 allows the DoD to request, and FDA to provide, assistance to expedite development of products to diagnose, treat, or prevent serious or life-threatening diseases or conditions facing American military personnel. The contractor recognizes that only the DoD can utilize PL 115-92."

Clearly, the US military invokes pub law 115-92 (ostensibly a measure to fast track countermeasures against military attacks, but which in practice is the DoD directing med regulators [FDA]) in their multi-billion contract w/Pfizer to produce a biowepon.

Here's the relevant text of the law, which quite directly subverts the FDA and it's function in service of DOD ends. Highly problematic to say the least, particularly when applied (as was the case w/covid) beyond the laws remit (i.e., defending military personnel from attacks), but instead used to push secret, dual-use technologies, without proper consumer testing and safeguards on unsuspecting civilian population. Screenshot of the law was provided by a reader:

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(2) ACTIONS.—Upon a request by the Secretary of Defense under paragraph (1), the Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall take action to expedite the development and review of an applicable application or notification with respect to a medical product described in paragraph (1), which may include, as appropriate—

(A) holding meetings with the sponsor and the review team throughout the development of the medical product;

(B) providing timely advice to, and interactive communication with, the sponsor regarding the development of the medical product to ensure that the development program to gather the nonclinical and clinical data necessary for approval or clearance is as efficient as practicable;

(C) involving senior managers and experienced review staff, as appropriate, in a collaborative, cross-disciplinary review;

(D) assigning a cross-disciplinary project lead for the review team to facilitate an efficient review of the development program and to serve as a scientific liaison between the review team and the sponsor;

(E) taking steps to ensure that the design of the clinical trials is as efficient as practicable, when scientifically appropriate, such as by minimizing the number of patients exposed to a potentially less efficacious treatment;

(F) applying any applicable Food and Drug Administration program intended to expedite the development and review of a medical product; and

(G) in appropriate circumstances, permitting expanded access to the medical product during the investigational phase, in accordance with applicable requirements of the Food and Drug Administration.

The PREP Act clause

This clause declares the contractor free of liability and also describes the items and technology as both civil and military applications, i.e. weapons:

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H.8 Public Readiness and Emergency Preparedness (PREP) Act:

In accordance with the Public Readiness and Emergency Preparedness Act ("PREP Act"), Pub. L. No. 109-148, Division C, Section 2, as amended (codified at 42 U.S.C. § 247d-6d and 42 U.S.C. § 247d-6e), as well as the Secretary of HHS's Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19, 85 Fed. Reg. 15198 (Mar. 17, 2020, effective Feb. 4, 2020), and amended on April 15, 2020, 85 Fed. Reg. 21012 (together, the "Prep Act Declaration"):

(i) This Agreement is being entered into for purposes of facilitating the manufacture, testing, development, distribution, administration, and use of "Covered Countermeasures" for responding to the COVID-19 public health emergency, in accordance with Section VI of the PREP Act Declaration;

(ii) Contractor's performance of this Agreement falls within the scope of the "Recommended Activities" for responding to the COVID-19 public health emergency, to the extent it is in accordance with Section III of the PREP Act Declaration; and

(iii) Contractor is a "Covered Person" to the extent it is a person defined in Section V of the PREP Act Declaration.

Therefore, in accordance with Sections IV and VII of the PREP Act Declaration as well as the PREP Act (42 U.S.C. § 247d-6d), the Department of Defense contracting via assisted acquisition on behalf of the HHS, expressly acknowledges and agrees that the HHS Declaration cited above, specifically its language providing immunity from suit and liability is applicable to this acquisition as long as Contractors activities fall within the terms and conditions of the PREP Act and the PREP Act Declaration.

The Government may not use, or authorize the use of, any products or materials provided under this contract, unless such use occurs in the United States (or a U.S. territory where U.S. law applies such as embassies, military and NATO installations) and is protected from liability under a declaration issued under the PREP Act, or a successor COVID-19 PREP Act Declaration of equal or greater scope. Any use where the application of the PREP Act is in question will be discussed with Moderna prior to use and, if the parties disagree on such use, the dispute will be resolved according to the "Disputes Clause" (52.233-1)

The items and technology covered by this Contract are being developed for both civil and military applications.

Defense priority rating

The defense **priority rating was added by amendment on September 11, 2020**. Add a Health Resources Priorities and Allocations System (HRPAS) priority rating of DO-HR to this contract. Add a Defense Priorities and Allocation System (DPAS) priority rating of DO-C9 to this contract to act as the equivalent to the HRPAS priority rating of DO-HR. Add FAR 52.211-15, Defense Priority and Allocation Requirements This is a rated order certified for national defense, emergency preparedness, and energy program use, and the Contractor shall follow all the requirements of the Defense Priorities and Allocations System regulation (15 CFR 700).

Rated order memo in attachment signed by General Perna COO of OWS:

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DEPARTMENT OF DEFENSE
OPERATION WARP SPEED TASK FORCE
200 INDEPENDENCE AVENUE
WASHINGTON, DC 20201

OWS-COO 03 September 20

MEMORANDUM FOR Vaccine Contractor Moderna

SUBJECT: Health Resources Priorities and Allocations System (HRPAS) Rating for Department of Defense Contract W911QY20C0100

1. Department of Defense Contract #W911QY20C0100 has been rated under the Health Resources Priorities and Allocations System (HRPAS) regulation (45 C.F.R. part 101) supporting Operation Warp Speed (OWS). The purpose of this rating is to promote national defense by ensuring this contract, as well as its subcontracts, are prioritized over other orders. This means orders, including meeting delivery dates, under this contract, and supporting contracts are legally required to take precedent over other unrated orders for the same product.

2. Acceptance and rejection of rated orders (101.33). Mandatory acceptance is required unless the delivery date is at issue. If unable to meet that date, inform the Contracting Officer (CO) of the earliest date on which delivery can be made and offer to accept the order on the basis of that date. Scheduling conflicts with previously accepted lower rated or unrated orders are not sufficient reason for rejection under this section. Do not accept a DO rated order for delivery on a date which would interfere with delivery of any previously accepted DO or DX rated orders. However, you are required to notify the CO of the earliest delivery date otherwise possible. See 101.33 for justifications for Optional rejection. This is a rated order placed for the purpose of emergency response and notice of acceptance or rejection of this HRPAS priority rating is required by the CO within 48 hours.

3. You are required to place rated orders with your suppliers/subcontractors for items necessary to fulfill the requirements under this contract. You must inform suppliers/subcontractors that your orders will be prioritized over other unrated orders.

4. Supplies acquired pursuant to this rating may ONLY be used to fulfill the requirements of this contract and cannot be used for other efforts. Use of supplies acquired under the order for any other purpose will be considered a breach of the terms of this contract and subject your company to adverse contract action and remedy. In addition, violations of the provisions of the Defense Production Act may subject the offender to civil and criminal penalties, to include fines up to $10,000, imprisonment for up to one year, or both.

5. Please contact your contracting officer if you have any questions on information in this letter.

/GUSTAVE F. PERNA
General, USA
Chief Operating Officer

*Republished from the author's **Substack**.*

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The Worst Atrocity in the History of the World Has Been Confirmed

Dr. Robert Malone April 23, 2023

HHS documents obtained through FOIA requests reveal aims to create mutant COVID and MERS viruses with gain of function research.
552 pages show Dr. Anthony Fauci lied to Congress and pandemic wasn't natural, but a preventable man-made disaster.

The World Health Organization estimates that (worldwide) there have been 763,740,140 confirmed cases of COVID-19, including 6,908,554 deaths as of April 19, 2023.

This does not include additional components of the excess mortality during the COVIDcrisis being documented by many in western nations, for which scientists and the various governments seems to not know what the causative agent is and no government seems to want to investigate... Although most will agree privately that these deaths are also related to COVID-19 "public health" policies in some way or another. These include deaths from lockdowns (famine, suicide, violence, alcohol and drug abuse), long COVID, vaccine deaths, lack of medical care for cancer and other diseases, etc. All told, the estimate for total deaths from the COVIDcrisis is probably around ten million people or more. Ten million people is a very big number. It is hard to even fathom.

This disaster was man made.

A **list of genocides** on Wikipedia shows that there have been no single human atrocities in the history of mankind that have come close to the deaths caused from the COVID crisis.

How do we "know this"? Because we have the receipts thanks to *Judicial Watch*, as well as the Congressional investigations – still ongoing.

This week, **Judicial Watch received 552 pages** from the U.S. Department of Health and Human Services (HHS). These documents include the initial grant application, biosketches, budgets and annual reports to the NIH from **EcoHealth Alliance**. They describe the specific aims of the project, which include creating mutant viruses SARS (and MERS viruses) "to better predict the capacity of our CoVs [coronaviruses] to infect people."

I spent the afternoon reading these documents and **the 552 pages are a gold mine of information**. But the specific aim 3 of the contract is particularly important. It reads in full:

Specific Aim 3: Testing predictions of CoV inter-species transmission. We will test our models of host range (i.e. emergence potential) experimentally using reverse genetics, pseudovirus and receptor binding assays, and virus infection experiments in cell culture and humanized mice. **With bat-CoVs that we've isolated or sequenced, and using live virus or pseudovirus infection in cells of different origin or expressing different receptor molecules, we will assess potential for each isolated virus and those with receptor binding site sequence, to spill over. We will do this by sequencing the spike (or other receptor binding/fusion) protein genes from all our bat-CoVs, creating mutants to identify how significantly each would need to evolve to use ACE2, CD26/DPP4 (MERS-CoV receptor) or other potential CoV receptors. We will then use receptor-mutant pseudovirus binding assays, in vitro studies in bat, primate, human and other species' cell lines, and with humanized mice where particularly interesting viruses are identified phylogenetically, or isolated.** These tests will provide public health-relevant data, and also iteratively improve our

predictive model to better target bat species and CoVs during our field studies to obtain bat-CoV strains of the greatest interest for understanding the mechanisms of cross-species transmission.

Later, they write (page 195):

we will assess potential for each isolated virus and those with receptor binding site sequence, to spill over. **We will do this by sequencing the spike (or other receptor binding/fusion) protein genes from all our bat-CoVs, creating mutants to identify how significantly each would need to evolve to use ACE2, CD26/DPP4 (MERS-CoV receptor) or other potential CoV receptors.**

It is important to understand that, although these quotes are technical and well beyond many to understand, the bottom line is that this project was and is gain of function research. In contrast to Dr. Fauci's sworn testimony to Congress.

It is important to pull out these sections highlighting the gain of function research conducted that led to the deaths of millions of people. This is the only way I know of to make scientists, the courts and policy makers aware that this is not a conspiracy theory. This is real. That these deaths were caused by manslaughter.

The only question now is was this an accidental or intentional release of the man made virus? Was it manslaughter or murder?

According the 552 pages released, the Wuhan Institute of Virology was so safe, there were assurances made to this effect and the facilities were never inspected by the US government. The risk of mutant viruses escaping the laboratory was never even discussed in the risks associated with conducting this research.

If it was so safe, doesn't the intentional release of this mutant virus have to be considered?

This only gets worse. The year 2 report (2016) clearly states that AIM 3 for year 3 had been expanded to also include conducting gain-of-function research using the MERS virus!

Specific Aim 3: Testing predictions of CoV inter-species transmission. The following experiments will be undertaken in Year 2 (page 197)

-An infectious clone of full-length MERS-CoV will be constructed using reverse genetic method. Using the S sequence of different MERS-related viruses identified from Chinese bats, the chimeric viruses with S gene of bat MERS-related coronaviruses and backbone of the infectious clone of MERS-CoV will be constructed to study the receptor usage and infectivity of bat MERS-related coronavirus.

The MERS virus (MERS-CoV) is **highly pathogenic**. During the 2012 outbreaks, there were about 2,500 known cases and 800 deaths. If these numbers are correct, this would be a case fatality rate of 31%! MERS-CoV did not appear to be highly infectious, unlike SARS-CoV-2-WIV (the virus created by Ralph Baric/EcoHealth/WIV).

Note that the above passage includes references to creating new chimeric variants and linking them to the infectivity of MERS! Could you imagine if they also created a more highly infectious MERS virus, that they spread through out the world, like SARS-CoV-2-WIV? The devastation would be like nothing the world has ever seen.

Moving on to the 2017 report (page 253):

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In Year 3, we successfully isolated Rs4874 from the single fecal sample. Using the reverse genetic system we previously developed, we **constructed two chimeric viruses with the WIV1 backbone replaced with the S gene of Rs7327 and Rs4231, respectively**. Vero E6 cells were respectively infected with Rs4874, WIV1-Rs4231S and WIV1- Rs7327S, and efficient virus replication was detected by immunofluorescence assay in all infections. To assess the usage of human ACE2 by the three novel SL-CoVs, we conducted virus infectivity studies using Hela cells with or without the expression of human ACE2. All viruses replicated efficiently in the human ACE2-expressing cells. The results were further confirmed by quantification of viral RNA using real-time RT-PCR (Fig.11).

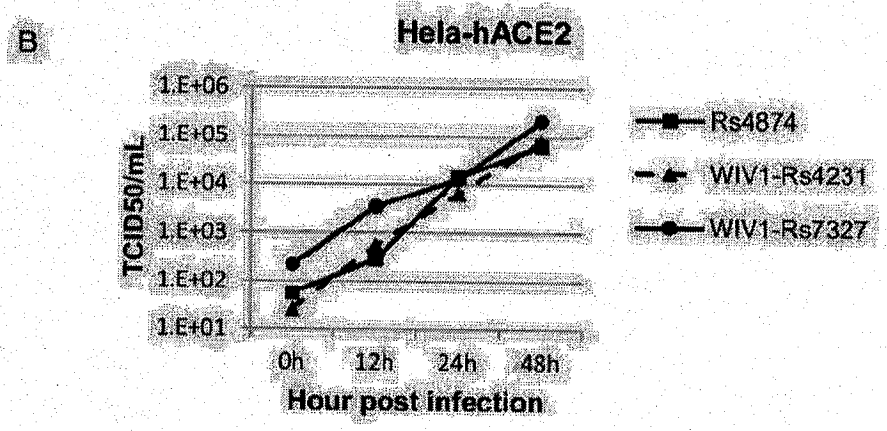

Figure 11. Analysis of receptor usage by immunofluorescence assay (A) and real-time PCR (B).

The full-length infectious eDNA clone of MERS-CoV has been successfully constructed. The full-lengthS gene of 12 different novel bat MERS-related coronaviruses have been amplified and cloned into the T-vectors. In Y4, we aim to use the reverse genetic method, and construct chimeric viruses with the backbone of MERS-CoV and the S genes from diverse newly identified bat MERS-related coronaviruses, to examine the pathogenicity of bat MERS-related coronaviruses on cell and animal levels.

More gain of function research.

Moving on to Year 4 (page 275):

Specific Aim 3: **Testing predictions of CoV inter-species transmission**.

In Vivo Infection of Human ACE2 (hACE2) Expressing Mice with SARSr-CoV S Protein variants

Using the reverse genetic methods we previously developed, infectious clones with the WIV1 backbone and the spike protein of SHC014, W IV16 and Rs4231, respectively, were constructed and recombinant viruses were successfully rescued. In Year 4, we performed preliminary in vivo infection of SARSr-CoVs on transgenic mice that express hACE2. Mice were infected with 105 pfu of full-length recombinant virus of WIV1 (rWIV1)and the three chimeric viruses with different spikes. Pathogenesis of the 4 SARSr-CoVs was then determined in a 2-week course. Mice challenged with rWIV1-SHC014S have experienced about 20% body weight loss by the 6th day post infection, while WIV1 and rWIV-4231S produced less body weight loss. In th emice infected

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with rWIV1 -WIV16S, no body weight loss was observed **(Fig. 35a).** 2 and 4 days post infection, the viral load in lung tissues of mice challenged with rWIV1-SHC014S, rWIV1-WIV16S and rWIV1-Rs4231 S reached more than 106 genome copies/g and were significantly higher than that in rWIV1-infected mice **(Fig. 35b). These results demonstrate varying pathogenicity of SARSr-CoVs with different spike proteins in humanized mice.**

In the year 2020, it appears that the grant was revised and extended for an additional FIVE years!

Notice of Award

RESEARCH
Department of Health and Human Services
National Institutes of Health

Federal Award Date: 07/13/2020

NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES

Grant Number: 2R01AI110964-06 REVISED
FAIN: R01AI110964

Principal Investigator(s):
PETER DASZAK, PHD

Project Title: Understanding the Risk of Bat Coronavirus Emergence

Dr. Daszak, Peter
PD/PI
460 West 34th Street
Suite 1701
New York, NY 100012320

Award e-mailed to: (b) (6)

Period Of Performance:
Budget Period: 07/24/2019 – 06/30/2021
Project Period: 06/01/2014 – 06/30/2025

For this period (2020-2025, it appears that AIM 3 on the cover page was re-written to remove any gain-of-function research from the proposal front page. It is as if they might think that they could be blamed for having conducted gain of function research that resulted in development of a virus that was released onto the global population! Seriously, the complete rewrite of AIM 3 on the new contract cover page to remove all allusions to the creation of mutant viruses has the appearances of a cover-up of one of the most highly lethal atrocities in the world.

Aim 3. In vitro and in vivo characterization of SARSr-CoV spillover risk, coupled with spatial and phylogenetic analyses to identify the regions and viruses of public health concern. We will use S protein sequence data, infectious clone technology, in vitro and in vivo infection experiments and analysis of receptor binding to test the hypothesis that % divergence thresholds in S protein sequences predict spillover potential. We will combine these data with bat host distribution, viral diversity and phylogeny, human survey of risk behaviors and illness, and serology to identify SARSr-CoV spillover risk hotspots across southern China. Together these data and analyses will be critical for the future development of public health interventions and enhanced surveillance to prevent the re-emergence of SARS or the emergence of a novel SARSr-CoV.

It is interesting that deeper into the text, the proposal is a little more specific about AIM 3.

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Aim 3: In vitro and in vivo characterization of SARSr-CoV spillover risk, coupled with spatial and phylogenetic analyses to identify the regions and viruses of public health concern. We will characterize the propensity of **novel SARSr-CoVs** to infect people in vitro using primary human airway epithelial cells and in vivo using the transgenic hACE2 mouse model. We will use mAb and vaccine treatments to test our hypothesis that SARSr-CoVs with 10-25% divergence inS protein sequences from SARS-CoV are likely able to infect human cells. and to evade mAb therapeutics and vaccines. We will then map the geographic distribution of their bat hosts and other ecological risk factors to identify the key 'hotspots' of risk for future spillover.

Note the use of the word "novel." It is unclear if these novel mutants have already been "developed" (gain of function research) in prior years or whether they are to be developed.

Farther into the documents, they write (page 496):

3.3 Virus characterization: 3.3.a Construction of chimeric SARSr-CoV viruses: Infectious clones with the S gene of novel SARSr-CoVs and the SARSr-CoV WIV1 genome backbone using the reverse genetic system developed in our previous R01 (24). The correct infectious BAC clones will be screened by BAC DNA digestion with appropriate restriction enzyme or PCR amplification. The chimeric viruses will be rescued in Vero cells and then verified by sequence analyses.

The proposal goes on to describe how the chimeric viruses will infect primary epithelial cells and humanized mice (pages 496-497).

Yep! Nothing has changed. Deep in the text is the gain of function research that they still have left to do! It is just removed from the front page of the proposal.

The are no more annual reports – so whatever research has been conducted subsequently is not known past the 2019 annual report.

This research has to stop now. Congress must stop the funding immediately. There must be accountability. There must be justice for the injured and the dead.

There are ten million people dead from this research "project". Do we need another man-made outbreak to fully grasp how dangerous this type of research is?

17-1

FDA Posts Tweet Warning about Dangers of Online Disinformation – Then Reality Comes Back Hard and Bites Them in the Horse's Ass

Jim Hoft May 22, 2023

The Food and Drug Administration (FDA) on Monday decided it was a good day to remind Americans of the dangers of "misinformation."

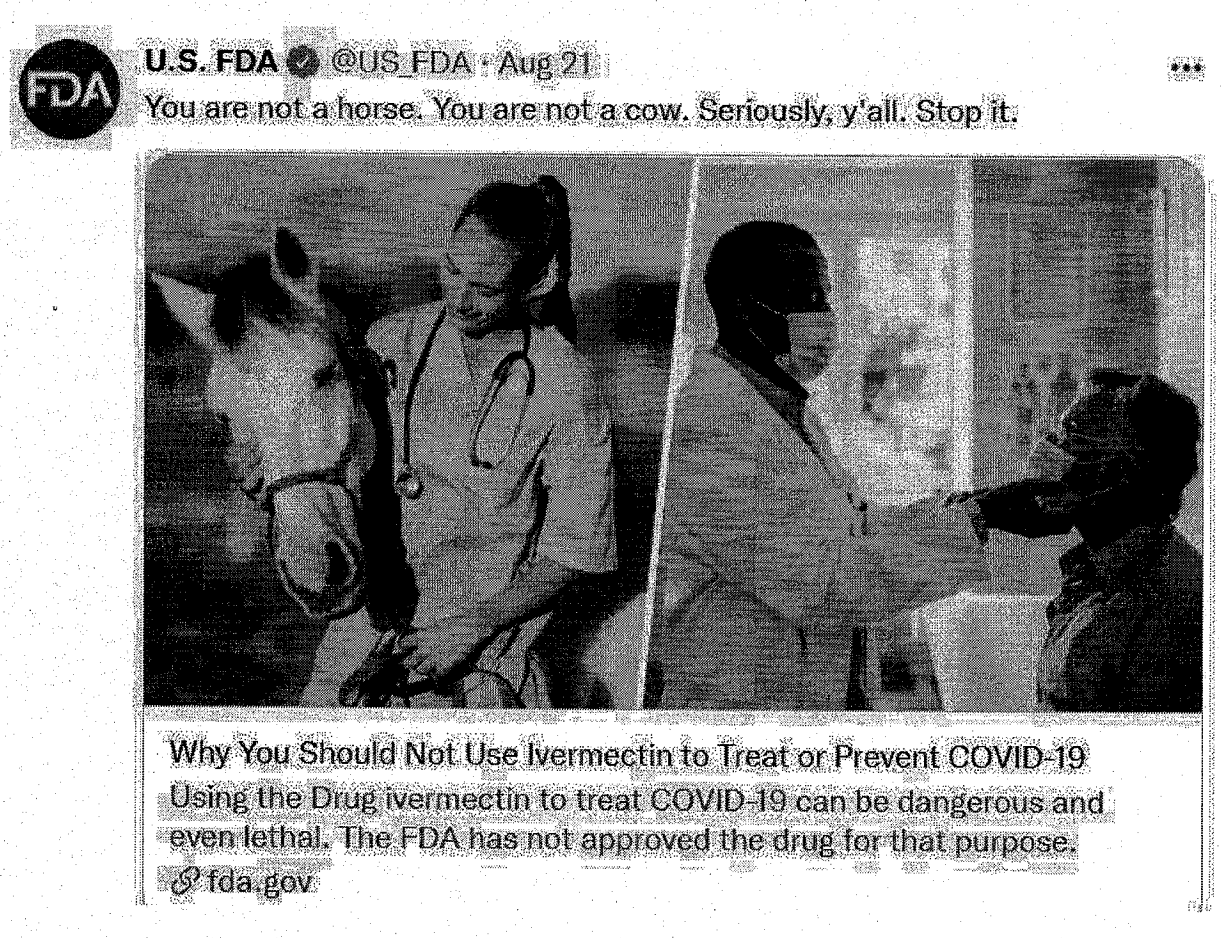
The FDA posted a video of how misinformation goes viral online.

The FDA claims misinformation spreads six times faster than facts.

They ought to know.

In August 2021 the FDA posted a tweet where they claimed award-winning Ivermectin was a drug for horses and cows.

They were afraid Americans would use the cheap drug as a prophylactic to ward off a serious COVID-19 infection.



Of course, Ivermectin is a drug FOR HUMANS and animals and has shown **amazing success** in treating COVID-19. Studies have shown up to an **85% improvement for patients** who used Ivermectin early on.

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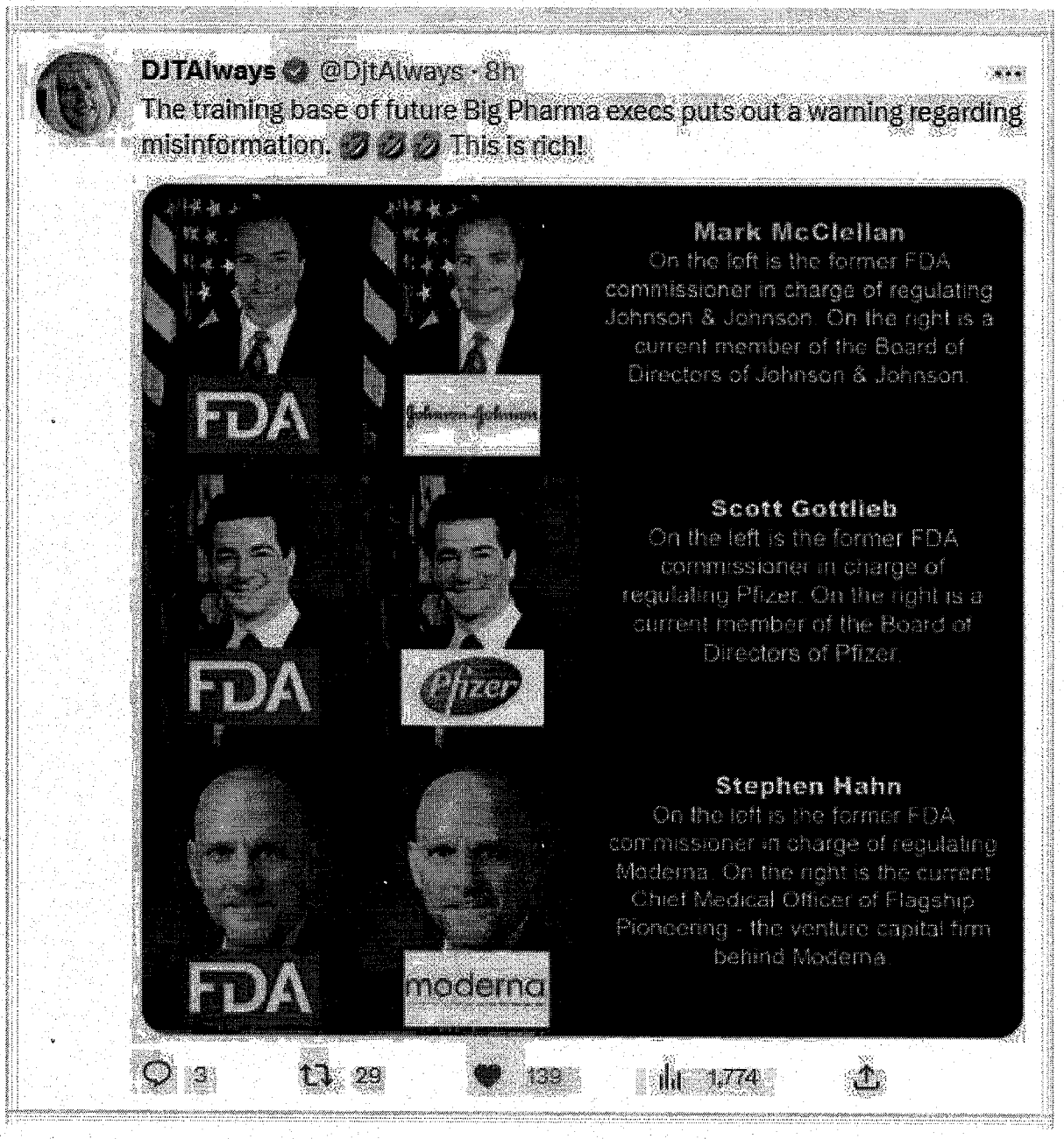
The FDA later backtracked and later claimed not taking Ivermectin was merely a recommendation.

It is also important to note that top FDA officials frequently go work for Big Pharma after leaving their government posts.

DJTAlways posted this today:



18-1

IT WAS ALL A LIE: How your Government tricked you into taking part in a Deadly Experiment that killed Millions via Midazolam Poisoning & COVID Vaccination

THE EXPOSÉ APRIL 6, 2023

The world was thrown into chaos when a new virus, Covid-19, was declared a pandemic by the government. Fear propaganda was broadcasted non-stop on television and radio, all paid for by the government and they used the pandemic as an excuse to pass laws that restricted civil liberties and bribed the public with furlough payments to not go to work.

As the pandemic progressed, the government's true motives were revealed, as they were found to be putting vulnerable individuals into end-of-life care and administering a drug called midazolam to kill them, while lying to the public by claiming that their deaths were due to the virus.

The consequences of vaccination were also revealed as it was not actually a vaccine, but an experimental gene therapy that had never been used on humans before; and not without good reason.

Tragically, as things began to settle, the true consequences of the Covid-19 injection roll-out were realised.

The fully vaccinated accounted for over 9 in every 10 deaths associated with the virus, and mortality rates per 100,000 were lowest among the unvaccinated and highest among the vaccinated in every age group.

Two years after the initial roll-out, 20 million deaths had been recorded in the "Five Eyes" countries and 26 other countries in Europe, resulting in 2 million excess deaths. This was a huge increase on deaths recorded throughout the pandemic prior to the vaccine roll-out.

In Europe, there was a huge increase in excess deaths among children aged 0 to 14, as soon as the vaccine was approved for children by the EMA. The very "vaccine" that was supposed to protect them had the opposite effect, and many parents were left devastated after falling for the coercive lies which resulted in the loss of their children's lives.

Meanwhile, by week 40 of 2022 in the USA, half a million deaths among children and young adults were recorded following the Covid-19 injection roll-out, resulting in 120,000 excess deaths. This highlights the severe impact that the vaccine had on the young and healthy and the devastating loss of life caused by the vaccine.

19-1

Dr. Simon Goddek: Ten Explosive Revelations That Unmask the Covid Pandemic as an Orchestrated Event

J.D. Rucker • Jun. 12, 2023

Our readers are very much aware — and have been for some time — that Pandemic Panic Theater has been one of our top concerns since the Plandemic was rolled out in 2019. In recent weeks, we've dedicated fewer stories to the subject because it seems to be less prominent in conservative and alternative news.

But as with so many bad things happening in the world today, we're confident this isn't over. Whether we see a resurgence of Covid, a renewed push for more jabs, or something new, we expect there to be more gaslighting and medical tyranny in our near future. That's why the post below by Dr. Simon Goddek is so important. We cannot forget what they did. We cannot ignore what they continue to do. And we cannot become complacent as the next states of their plan unfold.

Here's the list from Dr. Goddek:

1. **Fear-mongering the Public**: Instead of reassuring the populace during the crisis, our media and politicians had them living in perpetual dread, contradicting historical wisdom.
2. **Vaccine Data Manipulation**: A brave whistleblower recently exposed the distorted data behind the BioNTech/Pfizer vaccine approval. Rather than probing the vaccine's benefits and efficacy, nations rushed to make booster shots mandatory.
3. **Pressurizing the Healthy**: Despite minimal risk to children, teens, and healthy adults from Covid, they were strongly urged to take an experimental drug to "protect others." Non-compliance often led to job loss, and some countries even considered detention.
4. **Shifting Vaccine Narrative**: Vaccines, once advertised for self-protection, were suddenly everyone's obligation to "protect yourself and others," despite similar transmission rates amongst the vaccinated and unvaccinated. Troublingly, getting vaccinated seemed to raise the likelihood of dying with or from Covid.
5. **Questionable PCR Test Peer-Review**: The speedy peer-review process for the Covid PCR test publication, whose author was conveniently on the journal's editorial board, raised eyebrows. Circumventing the peer-review process might be classified as scientific fraud. Furthermore, the author, Christian Drosten, was reported to receive external briefings, casting a shadow on his credibility.
6. **Mask Misinformation**: A historical study during the Spanish Influenza deemed masks ineffective and potentially unhygienic if worn all day. Recent research mirrored these findings, concluding that masks might pose significant health risks without reducing transmission. It seemed like an attempt to muzzle the public under a politically motivated guise.
7. **The Death-Age Paradox**: The average age of those who died with or due to Covid matched the general life expectancy, unlike during the Spanish Influenza where these figures greatly differed.
8. **Demonizing Dissenters**: Publicly branding dissenters as "terrorists" and "tyrants" felt like a ploy to revoke the unvaccinated individuals' rights to bodily integrity and human dignity.
9. **Undermining Immunity**: Governments closed gyms, sports clubs, and banned social interactions during lockdowns, thus neglecting essential factors for a strong immune system such as sunlight (Vitamin D), physical exercise, social interaction, gut health, and exposure to pathogens.
10. **Silencing the Experts**: Social media platforms were actively blocking and restricting accounts of scientists and experts who disagreed with the mainstream narrative, curbing their freedom of speech in a flagrant affront to the principles of an open society.

20-1

EcoHealth Docs: Development of Covid "Vaccine" Bioweapon and the Plan to Infect Populations

Mac Slavo May 22, 2023

According to Karen Kingston, a medical-legal advisor, and biotech analyst with 25 years of experience, EcoHealth Alliance's own documents have shown that the development of the COVID-19 "vaccines" were the real pandemic. The cause of the pandemic was a biological attack using so-called "bat vaccines" which are spike protein nanoparticles developed in a laboratory by EcoHealth.

Kingston argues that the gene sequences for these "bat vaccines" were subsequently used in the FDA-approved Pfizer covid "vaccines" for humans. She also claims COVID-19 is not a virus, but an "attack" with "nanoparticles."

"Residents of Wuhan and other cities of China, Italy, and the United States, were victims of a coordinated nanoparticle bioweapon attack, a bioweapon attack using the same nanoparticles that are in all covid-19 mRNA vaccines. Most victims became infected with the nanoparticles via a direct aerosol attack, surface transmission, or food and beverage contamination," Kingston said.

Throughout 2021 and 2022 she's invested thousands of hours reviewing documents such as EcoHealth's Alliance pitch to DARPA, peer-reviewed publications regarding the ground zero attacks in China, Italy, and the US, scientific publications and manufacturer's documents regarding nanoparticle technologies, Pfizer's private and government contracts, dozens of patents, nanoparticle and SynBio forecasting reports, and reviewed many DARPA communications regarding the current and future applications of nanoparticle technologies. Using EcoHealth Alliance documents and peer-review publications, she detailed in a Substack article how covid-19 was a pre-planned global bioweapon attack that used aerosolised mRNA nanoparticles to cause a pandemic. -Daily Exposé

Kingston's article, titled: *mRNA Vaccines are a Sham. People are Being Injected with Nanotech*, exposes the ruling classes' plans to dominate, depopulate, and control the human population through manufactured fear, nanoparticles, and "vaccines."

Everything we were told about the hoax "virus" and what the mRNA "vaccines" ARE is a misnomer and a lie, down to the very term mRNA vaccine. The COVID-19 injections are not mRNA vaccines. The COVID-19 mRNA shots are nanotechnology injections.

For example, the lipids and phospholipids in the mRNA injections are not lipids. Lipids are are naturally occurring molecules that make up fatty compounds such as fats and cholesterol. Lipids are part of our cells' membranes to help control what goes in and out of cells. The 'lipids' in the mRNA injections are electronically charged synthetic molecules (not natural) and can host electromagnetic fields. They are electronic devices. –mRNA Vaccines are a Sham. People are Being Injected with Nanotech, Karen Kingston

Pfizer's own website even states these "lipids" are not biological. In fact, without the cationic lipid (electronic nanotechnology) there, "could be no Pfizer-BioNTech mRNA vaccine."

The cationic liposome nanotechnologies are being used to introduce non-human DNA into the cells of adults and children to turn their cells into disease-causing, toxic spike-protein bioweapon factories.

The concept of the invention of "mRNA vaccine technology" is a misnomer and a sham. The term "mRNA vaccine" is a cover for nanotechnologies that are being used as gene-editing technologies and agents of biowarfare on U.S. and global citizens, Kingston writes.

21-1

Texas Medical Board Suspends Doctor for Choosing to Do No Harm

Paul Dowling April 4, 2023

Hippocrates wrote, in *Of the Epidemics*, "The physician must.... have two special objects in view with regard to disease, namely, to do good or to do no harm." After all, the goal of medical care is to relieve pain and discomfort -- to make life easier for the patient. The Texas Medical Board, however, does not see it that way. Because Dr. Eric Hensen of Palestine, Texas, did not universally force his ear-nose-and-throat patients to block their airways by masking, the TMB has suspended his medical license. So, the medical tyranny of the TMB continues. (Earlier this month, the TMB declared war on Dr. Mary Talley Bowden for prescribing Ivermectin off-label.)

Dr. Hensen earned his medical degree at the Michigan State University College of Osteopathic Medicine in East Lansing, Michigan. The good doctor then completed two residency programs: "one in general surgery at Ascension St. John Hospital in Detroit, Michigan, and the other in ENT and oro-facial plastic surgery at the Tulsa Regional Medical Center in Oklahoma." Paul Davis, Hensen's lawyer, defended Hensen, declaring, "This arbitrary ridiculous order by the Texas Medical Board required him to put masks on all his ears, nose and throat patients, who already have difficulty breathing. So, bottom line, the Texas Medical Board is taking a doctor's license in the state of Texas, shutting down his practice, because he refused to do harm to his patients." Hensen has said he will file suit. (Although Dr. Hensen's battle with the medical board involved masks for himself and his patients, for suspension purposes, the Board narrowed the suspension charge to address only Dr. Hensen's refusal to place a mask on his own face.)

Hypercapnia and Hypoxia

One issue, when it comes to masking, is the fact that -- especially in the cases of those who are already having trouble breathing -- the practice can lead to hypercapnia (aka hypercarbia), an affliction caused by the re-inhalation of carbon dioxide from one's previously-exhaled breath; this is easily caused by wearing a mask snug enough to prevent carbon dioxide from being fully expelled prior to the patient's next breath. According to the Cleveland Clinic, the symptoms of hypercarbia are these: shortness of breath, headaches, sluggishness, disorientation, confusion, paranoia, depression, and seizures.

The reduction of oxygen in the bloodstream that can occur as a result of hypercapnia is known as hypoxia, a condition that can cause harm to the brain, eyes, ears, heart, skin, and other organs of the body. Symptoms of hypoxia are wheezing, coughing, shortness of breath, and sweating. These symptoms occur as the heart struggles to pump blood more quickly, in order to force enough oxygenated blood out to the organs of the body to sustain them.

Both hypercapnia and hypoxia are considered serious enough to require immediate medical attention. So, why would an ENT doctor wish to force his patients with breathing problems to block their air passages?

Bacterial Pneumonia

It was Dr. James Meehan who, during the time of COVID, sounded the alarm that all maskers were being exposed to well-known medical risks: "I'm seeing patients that have facial rashes, fungal infections, bacterial infections. Reports coming from my colleagues, all over the world, are suggesting that the bacterial pneumonias are on the rise." And, indeed, it was

bacterial pneumonia that did most of the killing during the Spanish Flu Pandemic of 1918. In fact, Dr. Anthony Fauci and his coauthors, in a now-famous article on this very subject, claimed the following:

> The majority of deaths in the 1918-1919 influenza pandemic likely resulted directly from secondary bacterial pneumonia caused by common upper respiratory-tract bacteria. Less substantial data from the subsequent 1957 and 1968 pandemics are consistent with these findings... Pandemic planning needs to go beyond addressing the viral cause alone (e.g., influenza vaccines and antiviral drugs). Prevention, diagnosis, prophylaxis, and treatment of secondary bacterial pneumonia, as well as stockpiling of antibiotics and bacterial vaccines, should also be high priorities for pandemic planning.

This danger of deadly bacterial infection (exacerbated by masking) is why Azithromycin has been prescribed by knowledgeable doctors -- along with the antiviral Hydroxychloroquine (and later Ivermectin) -- in the treatment of COVID patients. And, by providing a breeding ground for germs, masks cause their wearers to inhale whatever bacteria may have nested there.

Masking Is Ineffective Against Viruses

According to the Association of American Physicians and Surgeons, SARS-CoV-2, the virus that causes COVID-19, has a diameter of 0.125 microns. But, because the holes in a surgical mask measure 100 microns across, a surgical mask cannot block a particle with a diameter smaller than 100 microns, a diameter that is 800 times greater than that of the COVID virus. In other words, COVID goes through surgical masks like sand through chicken wire. (The purpose of a surgical mask is to protect patients' open wounds against unsanitary particles that may drop from the nose, mouth, or skin of a surgeon.)

So, not only is the Texas Medical Board guilty of injustice in their sanctioning of Dr. Hensen, but they are also responsible for prescribing treatment that amounts to nothing less than medical malpractice. If this author can uncover the research reported in this article, why is it that the twelve members of the Texas Medical Board are ostensibly so inept as to be unable to do the same? Perhaps doctors like Eric Hensen and Mary Talley Bowden should be running the TMB, rather than those who would willingly do harm to patients via the unexampled one-prescription-fits-all protocol of a universal masking mandate.

***Updates and corrections**: This article was prepared for publication on April 3, so that it could be published on April 4. Unbeknownst to us, on April 3, Dr. Hensen's suspension was removed, with that information made public on April 4. This essay has also been updated to reflect the fact, although Dr. Hensen's battle with the medical board involved masks for himself and his patients, for suspension purposes, the board narrowed the suspension charge to address only Dr. Hensen's refusal to place a mask on his own face.*

22-1

Primary Care Providers Receive Incentives to Push the COVID-19 Vaccine

Jim Hoft April 14, 2023

Primary care and family medicine doctors and others were given incentives to push us to receive the experimental COVID-19 shot, which has been linked to a number of very serious adverse events and side effects.

Back in 2021, healthcare providers received an increase in the Medicare payment rate for administering the COVID-19 vaccine.

"The goal of the payment boost is to "support important actions taken by providers that are designed to increase the number of vaccines they can furnish each day," Centers for Medicare & Medicaid Services (CMS) said in its **news release**.

Payment to providers increased to $40 per dose from $28 for single-dose vaccinations. Vaccines that require two doses will now cost $80, up from $45, **according** to HFMA.

"These updates to the Medicare payment rate for COVID-19 vaccine administration reflect new information about the costs involved in administering the vaccine for different types of providers and suppliers, and the additional resources necessary to ensure the vaccine is administered safely and appropriately," CMS said.

"These resources are designed to increase the number of providers that can administer the vaccine, ensure adequate payment for administering the vaccine to Medicare beneficiaries, and make it clear that no beneficiary, whether covered by private insurance, Medicare or Medicaid, should pay cost-sharing for the administration of the COVID-19 vaccine."

Below is an example from Anthem Blue Cross and Blue Shield Medicaid (Anthem) **COVID-19 Vaccine Provider Incentive Program**:

Payment thresholds summary

- **See the below table for a quick summary of thresholds for both initial and final payments:**

Percent of Anthem members vaccinated	Initial payment for existing vaccinated (per member)	Final payment for incremental vaccinated (per member)
30%	$20	$100
40%	$45	$150
50%	$70	$175
60%	$100	$200
75%	$125	$250

Below are the "tips for talking with your patients about COVID-19 vaccinations."

22-2

Tips for talking with your patients about COVID-19 vaccinations (cont.)

Acknowledge patient concerns without judging

- Empathy reduces the perception that you approve or disapprove of someone.

Patient's statement	Clinician response
I don't really know what's in the vaccine.	The information is just starting to come out, so having questions is normal. Could you say more about your concern?
How did they do it so fast?	I realize that this is happening faster than anyone predicted, so having questions is normal. The people who developed this vaccine have been working on vaccines for two decades. It's been in the making for a long time.
I just don't trust vaccines.	I have heard other people say they are worried about the vaccine. Could you say more about your concern?

6

Tips for talking with your patients about COVID-19 vaccinations (cont.)

Avoid criticizing the patient's information sources; cite your experience and/or point them to high quality sources

- Instead of trying to argue against misinformation, provide high quality information from a positive frame.

Patient's statement	Clinician response
I just think this has gotten really political.	You are right, it has gotten political. Here's what I can say. I've looked at the results of the vaccine we have to offer. This vaccine does really protect people from COVID. I want you to have the benefit of it.
You just never know what the side effects will be.	Yes, it is true that there have been some side effects. The most common side effect is some soreness at the injection site. There have been a couple of people who have had severe allergic reactions that were treated successfully. In the trials, more than 40,000 people were treated, and the serious side effects were very rare. The vaccine that we have is proven to be safe, and I have taken it.
I read on social media that the risk of COVID is not that high.	It is true that COVID can affect people mildly or severely. My colleagues and I are seeing enough severe cases of COVID that our hospitals are so full that they cannot do everything they would like to do for patients. There is a daily newsletter from the department of health that shows the latest numbers that I can share with you.

6

22-3

Tips for talking with your patients about COVID-19 vaccinations (cont.)

Show awareness of your status as a messenger, especially for people of color and members of other underserved groups

- Who you are as a messenger matters, and your awareness of that contributes to your authenticity and trustworthiness. Use examples of other messengers who resemble your patient.

Patient's statement	Clinician's response
I am not sure that the needs of people like me have been taken into account.	I recognize the injustices that have happened in the past. We are handling the COVID vaccine differently. It has been tested in people of all different backgrounds, and it is proven to be safe for all. At this clinic/hospital we are offering the vaccine according to someone's risk of getting COVID.
I don't trust the government to tell the truth about the COVID vaccine.	I recognize that many people for various reasons have a mistrust in government. This COVID vaccine is different. It has been proven to prevent infection, and I have taken it myself. Are people in your family, church, or close circle getting the vaccine?

7

Tips for talking with your patients about COVID-19 vaccinations (cont.)

Link vaccine acceptance to the patient's hopes and goals

- Showing how the vaccine is a stepping-stone towards a future the patient wants can motivate them.

Patient's statement	Clinician's response
I'm just going to wait.	Of course, this is your decision. I do think that the vaccine is a step towards a social life with fewer restrictions. And you mentioned that you want to visit your friends/family. The vaccine will help you and all of us do that sooner.
I want some other people to take it first.	You mentioned that you're concerned about your family members who have high risk conditions. The vaccine is a step towards protecting them as well as protecting you.
I just don't think I'm going to get COVID. I'm careful.	I'm glad you are being careful. That is still important. However, even patients who have been careful can still get COVID, and COVID can be fatal even for healthy people. That's why the vaccine is worth considering.

8

22-4

All throughout 2021, US states also used incentives to push COVID-19 vaccination.

"Twenty-seven states including the District of Columbia (53%) offered at least 1 lottery, guaranteed cash payment, and/or scholarship incentive to the general public, covering 55% of the US population. Twenty-one states (41%) offered 2 or more incentive types. We identified 24 lottery programs in 23 states (45%), 19 guaranteed cash payment programs in 12 states (24%), and 23 scholarship programs in 19 states (37%)," according to research published in JAMA Network.

Twenty (83%) of 24 Democrat-led states offered at least 1 lottery, guaranteed cash payment, and/or scholarship incentive vs 7 (26%) of 27 Republican-led states. Twenty-six (96%) of the 27 states with incentives implemented at least 1 non-incentive COVID-19 mitigation policy vs 15 (63%) of the 24 non-incentive states.

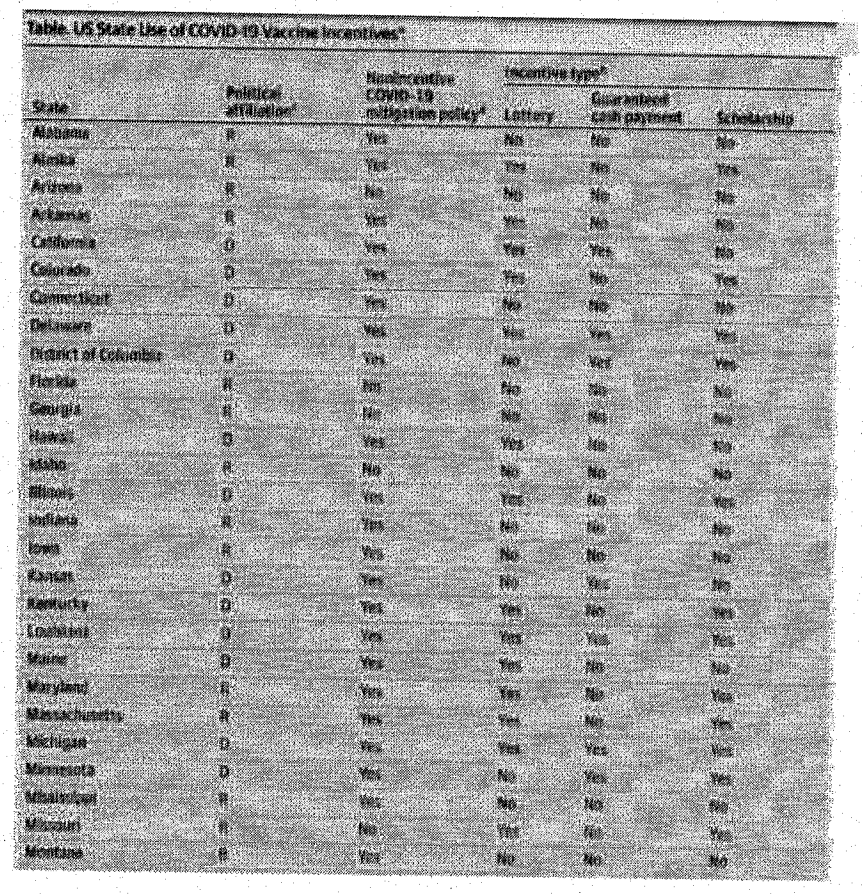


Table. US State Use of COVID-19 Vaccine Incentives[a]

State	Political affiliation[b]	Non-incentive COVID-19 mitigation policy[c]	Incentive type[d]		
			Lottery	Guaranteed cash payment	Scholarship
Alabama	R	Yes	No	No	No
Alaska	R	Yes	Yes	No	Yes
Arizona	R	No	No	No	No
Arkansas	R	Yes	Yes	No	No
California	D	Yes	Yes	Yes	No
Colorado	D	Yes	Yes	No	Yes
Connecticut	D	Yes	No	No	No
Delaware	D	Yes	Yes	Yes	Yes
District of Columbia	D	Yes	No	Yes	Yes
Florida	R	No	No	No	No
Georgia	R	No	No	No	No
Hawaii	D	Yes	Yes	No	No
Idaho	R	No	No	No	No
Illinois	D	Yes	Yes	No	Yes
Indiana	R	Yes	No	No	No
Iowa	R	Yes	No	No	No
Kansas	D	Yes	No	Yes	No
Kentucky	D	Yes	Yes	No	Yes
Louisiana	D	Yes	Yes	Yes	Yes
Maine	D	Yes	Yes	No	No
Maryland	R	Yes	Yes	No	Yes
Massachusetts	R	Yes	Yes	No	Yes
Michigan	D	Yes	Yes	Yes	Yes
Minnesota	D	Yes	No	Yes	Yes
Mississippi	R	Yes	No	No	No
Missouri	R	No	Yes	No	Yes
Montana	R	Yes	No	No	No

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Nebraska	R	No	No	Yes	No
Nevada	D	Yes	Yes	No	Yes
New Hampshire	R	Yes	No	No	No
New Jersey	D	Yes	No	No	No
New Mexico	D	Yes	Yes	Yes	No
New York	D	Yes	Yes	No	Yes
North Carolina	D	Yes	Yes	Yes	Yes
North Dakota	R	Yes	No	No	No
Ohio	R	Yes	Yes	No	Yes
Oklahoma	R	No	No	No	No
Oregon	D	Yes	Yes	No	Yes
Pennsylvania	D	Yes	No	No	No
Rhode Island	D	Yes	Yes	No	No
South Carolina	R	No	No	No	No
South Dakota	R	No	No	No	No
Tennessee	R	No	No	No	No
Texas	R	Yes	No	No	No
Utah	R	Yes	No	No	No
Vermont	R	Yes	No	No	No
Virginia	D	Yes	No	No	No
Washington	D	Yes	Yes	Yes	Yes
West Virginia	R	Yes	Yes	Yes	Yes
Wisconsin	D	Yes	No	Yes	No
Wyoming	R	Yes	No	No	No
Total No. of states	NA	43	25	17	19

Abbreviations: D, Democratic Party; NA, not applicable; R, Republican Party.

[a] State use of 3 types of COVID-19 vaccine incentives (lotteries with cash prizes, guaranteed cash payments, and scholarships) from January 1 to December 1, 2021.

[b] Which incentive types, if any, states implemented to promote COVID-19 vaccination.

[c] The political party affiliation of the state's governor (or mayor for Washington, DC) in 2021.

[d] Whether states implemented at least 1 COVID-19 mitigation policy (mask requirements, travel restrictions, and/or vaccine mandates) in 2021.

23-t

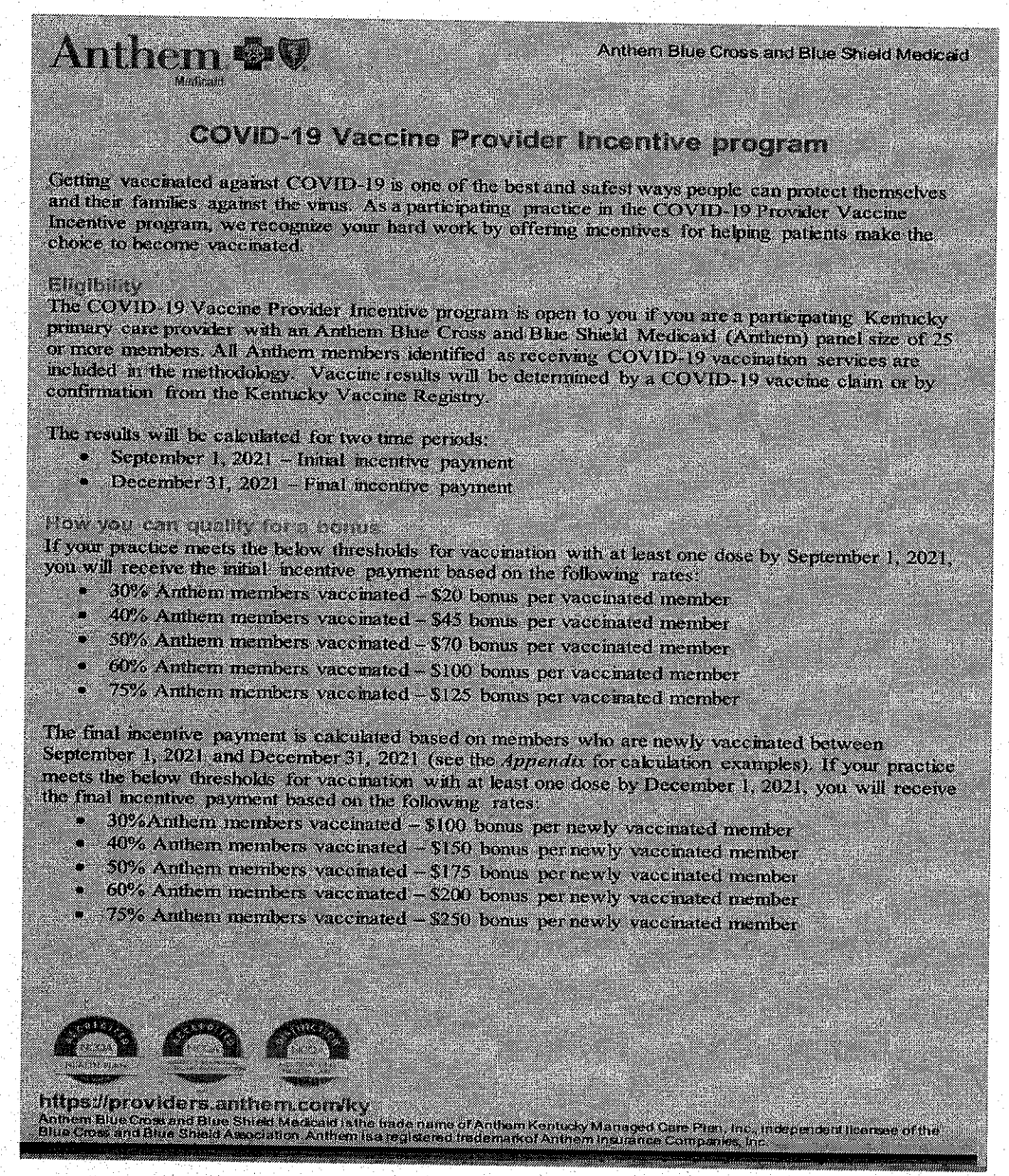
Doctors Were Bribed for Covid Jab Coercion

Dr. Joseph Mercola April 27, 2023

As detailed in "How COVID Patients Died for Profit," hospitals were financially incentivized to diagnose patients with COVID and treat them with protocols known to be lethal, in part to "protect" the staff from infection.

As if that weren't bad enough, primary care providers across the U.S. were also bribed to coerce patients into getting the toxic COVID shot. The following document was posted to Twitter in mid-April 2023 by Rep. Thomas Massie, an award-winning scientist and Republican Congressman for Kentucky.1

"Ethically, shouldn't doctors disclose when they're profiting by recommending a drug or treatment — especially a drug or treatment for which there is no medical malpractice liability?" **Massie said.2**



Anthem Medicaid

Anthem Blue Cross and Blue Shield Medicaid

COVID-19 Vaccine Provider Incentive program

Getting vaccinated against COVID-19 is one of the best and safest ways people can protect themselves and their families against the virus. As a participating practice in the COVID-19 Provider Vaccine Incentive program, we recognize your hard work by offering incentives for helping patients make the choice to become vaccinated.

Eligibility

The COVID-19 Vaccine Provider Incentive program is open to you if you are a participating Kentucky primary care provider with an Anthem Blue Cross and Blue Shield Medicaid (Anthem) panel size of 25 or more members. All Anthem members identified as receiving COVID-19 vaccination services are included in the methodology. Vaccine results will be determined by a COVID-19 vaccine claim or by confirmation from the Kentucky Vaccine Registry.

The results will be calculated for two time periods:

- September 1, 2021 – Initial incentive payment
- December 31, 2021 – Final incentive payment

How you can qualify for a bonus

If your practice meets the below thresholds for vaccination with at least one dose by September 1, 2021, you will receive the initial incentive payment based on the following rates:

- 30% Anthem members vaccinated – $20 bonus per vaccinated member
- 40% Anthem members vaccinated – $45 bonus per vaccinated member
- 50% Anthem members vaccinated – $70 bonus per vaccinated member
- 60% Anthem members vaccinated – $100 bonus per vaccinated member
- 75% Anthem members vaccinated – $125 bonus per vaccinated member

The final incentive payment is calculated based on members who are newly vaccinated between September 1, 2021 and December 31, 2021 (see the *Appendix* for calculation examples). If your practice meets the below thresholds for vaccination with at least one dose by December 1, 2021, you will receive the final incentive payment based on the following rates:

- 30%Anthem members vaccinated – $100 bonus per newly vaccinated member
- 40% Anthem members vaccinated – $150 bonus per newly vaccinated member
- 50% Anthem members vaccinated – $175 bonus per newly vaccinated member
- 60% Anthem members vaccinated – $200 bonus per newly vaccinated member
- 75% Anthem members vaccinated – $250 bonus per newly vaccinated member

https://providers.anthem.com/ky

Anthem Blue Cross and Blue Shield Medicaid is the trade name of Anthem Kentucky Managed Care Plan, Inc., independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

23-2

Doctors Were Incentivized to Jab Babies Too

Once the U.S. Food and Drug Administration authorized the COVID shot for children, similar vaccination incentives were extended to them as well. As detailed in an Anthem Blue Cross and Blue Shield Medicaid provider bulletin3 dated July 2022, doctors received $50 for each Medicaid patient aged 6 months and older, who got the experimental shot.

Anthem Medicaid

Anthem Blue Cross and Blue Shield Medicaid

Provider Bulletin
July 2022

COVID-19 Vaccine Provider Incentive Program ages 6 months+

Getting vaccinated against COVID-19 is one of the best and safest ways people can protect themselves and their families against the virus. As a participating practice in the COVID-19 Provider Vaccine Incentive Program, we recognize your hard work by offering incentives for helping patients make the choice to become vaccinated.

Eligibility
The COVID-19 Vaccine Provider Incentive Program is open to you if you are a participating Kentucky primary care provider with an Anthem Blue Cross and Blue Shield Medicaid (Anthem) panel that includes members 6 months of age and older. All Anthem members identified as receiving COVID-19 vaccination services are included in the methodology. Vaccine results will be determined by a COVID-19 vaccine claim or by confirmation from the Kentucky Vaccine Registry.

How you can qualify for a bonus
As you continue to help guide patients toward COVID-19 vaccination, your practice will receive $50 per Anthem member 6 months of age and older vaccinated by December 31, 2022.

When you will receive your bonus
You will receive payment on or before January 31, 2023.This will include payment for Anthem members enrolled in Medicaid 6 months to 4 years of age and ages 12 and older vaccinated between January 1, 2022, and December 31, 2022, and Anthem members enrolled in Medicaid ages 5 to11 vaccinated from June 2022 through December 31, 2022. The payment will be sent by electronic funds transfer or check based on the payment method used for claim reimbursement on or before January 21, 2023. Please allow seven to 10 business days to receive payment. If you have not received it within that time frame, reach out to a Provider Experience consultant at **800-205-5870, option 3.**

Hospitals Received at Least $100 Billion From Taxpayers

In late March 2020, the U.S. Congress passed the Coronavirus Aid, Relief and Economic Security (CARES) Act.4 Within this $2 trillion stimulus package, $100 billion was earmarked for hospitals and local health centers that treated COVID patients.5

And, rather than simply agreeing to pay COVID patients' bills, the government decided to pay hospitals extra — a lot extra — over and above the standard bill, provided they treated patients in a certain way. By the end of October 2020, $96 billion had already been disbursed.6

Ostensibly, the additional bonuses for COVID patients were supposed to help hospitals recoup revenue that was lost due to the cancelation of elective procedures. But hospitals were supposedly filled to the brim with COVID patients, so just how much revenue was lost?

The bonuses were also supposed to cover additional costs associated with caring for COVID patients, such as additional personal protective equipment (PPE) and sanitation, but that could have just as easily been covered as an extra line item, rather than a flat double-digit percentage over and above the actual cost of the treatment.

COVID-Positive Medicare Patients Worth 20% More

As reported by KGNS.TV, a local Nebraska news station, in late March 2022:7

23-3

"According to the state, since COVID hit Webb County in March of 2020, about 85,000 people have contracted the virus, with roughly half of them serious enough to be admitted into the hospital. Almost immediately, the federal government stepped in to help pay for their care with millions of dollars.

KGNS took a deeper look into this to answer the question, 'Is there a difference in how much hospitals get paid back by the government when caring for a positive COVID patient versus a non-COVID patient?' The answer to that is 'yes.' People on government programs, such as Medicare, are worth more.

According to section 3710 of the Cares Act, hospitals are reimbursed by the government an extra 20% for each hospitalized Medicare patient. The only criteria for that extra money? A positive COVID test.8 9 10
For instance, hospital Medicare patient with pneumonia — without COVID — is worth about $7,700 to the hospital. But with COVID, that reimbursement jumps to over $9,200.

A Medicare patient with Acute Respiratory Distress Syndrome requiring a ventilator? Without COVID, the bill is around $34,000. But with COVID, that Medicare patient now worth almost $40,000. And the list goes on."

On top of those incentives, the federal COVID-19 Treatments Add-On Payment program also paid hospitals bonuses for every COVID-19 patient treated with emergency authorized COVID medications (Remdesivir, convalescent plasma, Baricitinib, Molnupiravir and Nirmatrelvir) and mechanical ventilation.11

It doesn't seem like decisionmakers considered the possibility that incentivizing hospitals to diagnose patients as having COVID might impact patient care, outcomes and/or COVID statistics, but it most certainly did. To presume hospitals would think twice about treating patients with a particular drug or put them on a ventilator when they get reimbursed top dollar for it is naïve in the extreme. Especially when all they needed was a positive PCR test to justify it.

Throughout 2020, evidence mounted showing the PCR test is incredibly unreliable above 35 cycles, and health agencies instructed labs to use 40 to 45 cycles. In essence, we had an epidemic of false positives, and financial incentives then drove hospitals to mistreat and kill countless patients, many of whom may not even have had COVID.

Former CDC director Robert Redfield and Brett Giroir, assistant secretary for health in the U.S. Department of Health and Human Services, have both stated they believe financial incentives drove up the COVID-19 death rate in the U.S.12

Vented COVID Patients Earned Hospitals 300% Upcharge

I strongly suspect the reason why so many COVID patients died was because they were forced onto mechanical ventilation, and the reason for that was because hospitals received a 300% bonus for patients requiring ventilation! That's no minor incentive. As reported by USA Today back in April 2020:13

"Sen. Scott Jensen, R-Minn., a physician in Minnesota, was interviewed by 'The Ingraham Angle' host Laura Ingraham on April 8 on Fox News and claimed hospitals get paid more if Medicare patients are listed as having COVID-19 and get three times as much money if they need a ventilator ...

Jensen took it to his own Facebook page April 15, saying, in part 'How can anyone not believe that increasing the number of COVID-19 deaths may create an avenue for states to receive a larger portion of federal dollars? Already some states are complaining that they are not getting enough of the CARES Act dollars because they are having significantly more proportional COVID-19 deaths.'

On April 19, he doubled down on his assertion via video on his Facebook page. Jensen said, 'Hospital administrators might well want to see COVID-19 attached to a discharge summary or a death certificate.

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Why?

Because if it's a straightforward, garden-variety pneumonia that a person is admitted to the hospital for — if they're Medicare — typically, the diagnosis-related group lump sum payment would be $5,000. But if it's COVID-19 pneumonia, then it's $13,000, and if that COVID-19 pneumonia patient ends up on a ventilator, it goes up to $39,000.'

Jensen clarified ... that he doesn't think physicians are 'gaming the system' so much as other 'players,' such as hospital administrators, who he said may pressure physicians to cite all diagnoses, including 'probable' COVID-19, on discharge papers or death certificates to get the higher Medicare allocation allowed under the Coronavirus Aid, Relief and Economic Security Act ...

USA TODAY reached out to Marty Makary, a surgeon and professor of health policy and management at Johns Hopkins Bloomberg School of Public Health, about the claim. Makary said in an email April 21 that 'what Scott Jensen said sounds right to me.'"

Why Did Government Continue Paying for Deadly Protocol?

Why wasn't the 300% bonus payment eliminated once it became apparent that putting COVID patients on ventilators was a death sentence? As early as April 9, 2020, Business Insider reported14 that 80% of COVID-19 patients in New York City who were placed on ventilators died, which caused a number of doctors to question their use.

Somewhere between 50% and 86% of all ventilated COVID patients died, yet government never dropped the financial incentive to use ventilators. Why?

The Associated Press15 also publicized similar reports from China and the U.K. A U.K. report put the figure at 66%, while a small study from Wuhan, China, put the ratio of deaths at 86%. Data presented by attorney Thomas Renz in 2021 showed that in Texas hospitals, 84.9% of patients died after more than 96 hours on a ventilator.16

The lowest figure I've seen is 50%.17 So, somewhere between 50% and 86% of all ventilated COVID patients died, yet government never dropped the financial incentive to use ventilators. Why?

Incentives Put Nursing Home Patients at Risk Too

Nursing homes in some states also received incentive payments if they accepted hospital discharges. For example, in Wisconsin, the Department of Health Services (DHS) paid out $2,900 for every admission a nursing home received directly from a hospital.18

This, even though by then, it was well-known that more than 80% of deaths occurred in nursing homes, assisted living facilities and live-in rehab centers. More than 90% of residents of these centers have at least one chronic disease and more than 70% have two conditions, which in turn can weaken their immune systems.19

They also live in close quarters and share staff, which facilitates the spread of pathogens. But rather than protecting the elderly by NOT admitting potentially infected patients, the DHS paid these facilities to take them in.

Incompetence or Malice?

In the final analysis, it's quite clear that the COVID pandemic was grossly mishandled. Either U.S. health agencies and political decisionmakers were inept and unqualified for the job at hand, or they acted with malice, and the outcomes of their financial incentivization of bad medicine were intended ones.

Either way, their strategies were ill-conceived and resulted in needless death and suffering. Adding insult to injury, billions of taxpayer dollars were used to pay for it all. Financially incentivizing doctors and pediatricians to inject an experimental gene therapy into babies is, in my view, completely unconscionable, and should never have happened, but the same can be said for the continued use of ventilators.It seems medicine during the COVID pandemic became all about maximizing profits, without regard for health outcomes, and that is something that our health agencies must be held to account for.

24-1

Is This Why Pediatricians Push "Vaccines"?

Dr. Joseph Mercola May 23, 2023

In April 2023, I reported how primary care providers across the U.S. were bribed with incentive programs to coerce patients into getting the toxic COVID shot. Since there was no medical malpractice liability, doctors profited while patients risked their lives as participants in an unprecedented medical experiment, all while being lied to about the safety and effectiveness of these injections.

Even more egregiously, once the U.S. Food and Drug Administration authorized the COVID shot for children, similar vaccination incentives were extended to pediatricians as well. As detailed in an Anthem Blue Cross and Blue Shield Medicaid provider bulletin1 dated July 2022, doctors received $50 for each Medicaid patient aged 6 months and older, who got the experimental jab.

Pediatricians Are Financially Incentivized to Vaccinate

As it turns out, doctors have been financially incentivized to vaccinate children for a long time. According to a 1999 JAMA Pediatrics article,2 the average patient load of American pediatricians is 1,546, although the number of patients was "significantly higher in less populated areas and solo practices."

Of these, 8.3% were younger than 1 year, 9.5% were 1 year old and 8.6% were 2 years old.3 That means approximately 26.4% of the average pediatrician's patients were 2 years old and younger. More recent data,4 published in 2021, show 75% of pediatricians have between 1,000 and 1,800 patients and 21% have around 1,200 patients; most practices, 65%, are in the 1,000 to 1,500 range.

As shown in the 2016 provider incentive program document from Blue Cross Blue Shield below,5,6 pediatricians were getting $400 for each pediatric patient that completed all the 10 vaccinations listed — 25 doses in all7 — before their second birthday. (Keep in mind that incentives can vary by state. The example provided is part of Michigan's Blue Cross Blue Shield Performance Recognition Program.)8

How Much Money Is at Stake?

The math from there is pretty straight-forward (although keep in mind that we're dealing with presumed averages and aged statistics here). Just multiply the number of patients under age 2 times $400. Using the average statistics from 1999, if a pediatrician has 1,000 patients, 264 can be expected to be 2 years old or younger. If all are fully vaccinated, the pediatrician would be eligible for a $105,600 year-end bonus.

24-2

HEALTH CARE OUTCOMES: PREVENTIVE HEALTH

CHILDHOOD IMMUNIZATIONS – COMBO 10	
Product lines	BCN Commercial
Source	HEDIS
Description	The percentage of children 2 years of age who meet the combination 10 criteria on or before their second birthday: • (4) DTaP* vaccinations • (3) IPV* vaccinations • (1) MMR vaccination • (1) VZV vaccination • (3) HiB* vaccinations • (3) Hepatitis B vaccinations • (4) PCV* vaccinations • (1) HepA vaccination • (2 or 3) RV* vaccinations • (2) Influenza** vaccinations *Vaccinations administered prior to 42 days after birth are not counted as a numerator hit. **Vaccinations administered prior to 180 days after birth are not counted as a numerator hit.
Continuous enrollment	Must be continuously enrolled 12 months prior to child's second birthday
Age criteria	Children who turn 2 years of age during 2016
Exclusionary criteria	Children who are documented with an anaphylactic reaction to the vaccine or its components
Numerator	The number of children who completed vaccinations as defined above
Denominator	The eligible population
Level of measure	Provider level
Target: COMM	63%
Payout: COMM	$400 per Combo 10 completed for each eligible member

While $400 per fully vaccinated child might seem incentivizing enough, there's an added pressure here, because Blue Cross Blue Shield also has (or at least had, in 2016) a "target" level of 63%.

This means that if the pediatrician fails to vaccinate 63% of his eligible patients, he or she gets nothing. So, the pediatrician has a VERY high incentive to get as many toddlers fully vaccinated as possible, so as not to miss that target. It's not just $400 that is at stake when parents decline one or more shots. Tens of thousands of dollars could be on the line. As noted by Dr. Bob Sears:9

24-3

"Such incentives ... end up forcing a doctor to consider the financial implications of accepting patients who even just want to opt out of one vaccine ... Maybe a few such families wouldn't make them fail the chart reviews, but if they have too many, there goes their year-end bonus."

Why Pediatricians Become Adversaries

Anytime financial incentives are part of the equation, one can reasonably assume that the lure of self-enrichment will win. With tens of thousands of dollars at stake, pediatricians can easily be lulled into complacency when it comes to digging deeper into the science.

After all, who wants to see evidence that what they're doing is causing more harm than good? These kinds of incentives also encourage pediatricians to simply toss questioning parents out of their practice, to make room for more compliant patients that don't put their income at risk. As reported by Children's Health Defense back in 2018:10

"... the 11 well-child visits recommended by the AAP over a child's first 30 months (with annual visits thereafter through age 21) ensure a steady stream of repeat customers and revenue for pediatricians.
In accordance with the Centers for Disease Control and Prevention's vaccine schedule, pediatric practices are expected to administer vaccines (often as many as six at a time) at about half of well-child visits through the adolescent years, making vaccination a foundational bread-and-butter component of pediatricians' job description ...
It is quite common for pediatricians (and family doctors) to encounter parents who refuse one or more infant vaccines, most often due to safety concerns. These concerns also mean that pediatricians frequently get requests to modify or delay the vaccine schedule — nearly three-fifths (58%) of pediatricians reported such requests in a 2014 AAP survey ...
Rather than recognize the validity of parents' safety concerns or admit to their own ambivalence about some of the newer vaccines, many pediatricians — nearly two in five according to some estimates — choose to boot uncooperative families out of their practice ...
Ultimately ... subtle and not-so-subtle financial incentives and social pressures are likely to maintain widespread adherence by pediatricians to the vaccine schedule — even in instances where contraindications are present. Although pediatricians have a legal duty to fully inform patients about vaccine risks and side effects, the lure of monetary perks and the desire to fit in may lessen their motivation to do so."

Patients Are Bribed Too

In addition to the financial incentives given to physicians, "client and family incentives" also exist. A nongovernmental panel of public health and prevention experts called the "Community Preventive Services

24-4

Task Force"11 in 2015 published a guide12 on how to boost vaccination rates using incentive rewards for patients.

The task force was established by the U.S. Department of Health and Human Services in 1996 "to develop guidance on which community-based health promotion and disease prevention intervention approaches work and which do not work, based on available scientific evidence."13 As explained by this task force:14

"The Community Preventive Services Task Force recommends client or family incentive rewards, used alone or in combination with additional interventions, to increase vaccination rates in children and adults.

Client or family incentive rewards are used to motivate people to obtain recommended vaccinations. Rewards may be monetary or non-monetary, and they may be given to clients or families in exchange for keeping an appointment, receiving a vaccination, returning for a vaccination series, or producing documentation of vaccination status. Rewards are typically small (e.g., food vouchers, gift cards, lottery prizes, baby products)."

The scientific evidence supporting bribery of patients with food vouchers, gift cards and other products of limited value was said to be 4 out of 4, meaning very strong. In other words, incentives, even near-worthless ones, work.

Indeed, we saw this during COVID-19 as well. People were lining up for experimental COVID shots in return for a doughnut, hamburger and fries or even a free lap dance at the local strip club. The pattern is the same. Throw the patient a bone and they'll agree to things that bring others big profits.

As patients, we need to get savvier about these kinds of tricks and interpret them for what they are. These kinds of "gifts" are not given out of kindness or concern for your well-being. It's a compliance bribe, and your compliance is making someone rich. Meanwhile, any risks involved are on you.

Bribery and Vaccine Mandates

Bribery is also par for the course when it comes to vaccine mandates. As detailed in a previous article, Pfizer paid undisclosed sums to front groups that advocated for COVID jab mandates, thereby hiding their conflict of interest. In part due to the fake "grassroots" work of these groups, Pfizer was able to rake in a record-breaking $100 billion in sales in 2022.15

Of course, the U.S. government also paid news media a staggering $1 billion to promote and build public confidence in the jab, and Pfizer itself spent $2.8 billion on ads in 2022 alone.

But the pressure from consumer groups, civil rights groups, patient groups and doctors' groups — all of which had been paid off — was probably why COVID jab mandates could even be officially considered by the government. They created a false consensus that people desperately wanted vaccine mandates to keep everyone "safe."

24-5

Special interest groups paid by Pfizer16 to push for COVID jab mandates and coercive vaccine policies included the Chicago Urban league (which argued that the jab mandate would benefit the Black community), the National Consumers League, the Immunization Partnership, the Advertising Council and a long list of universities and cancer, liver diseases, cardiology, rheumatology and medical science organizations.

Pfizer didn't have to take a prominent stand to argue for vaccine mandates, which would have been an obvious conflict of interest. They paid others to push the mandates for them.

Each of these organizations received anywhere from several thousand to hundreds of thousands of dollars from Pfizer in 2021 alone. Is it any wonder, then, that more than 50 major health care organizations called for vaccine mandates that year, including for their own workers?17

Childhood Vaccination Rates Tanked During COVID

While the COVID-19 pandemic furthered many globalist goals, it inadvertently tanked childhood vaccination rates, as many parents ended up missing routine well-child visits due to clinic closures, lockdowns and fear of taking their children outside. As reported by the American Medical Association (AMA) in November 2021:18

"... recently published research sheds new light on how the COVID-19 pandemic has disrupted some of those routine vaccinations, as parents and their children didn't just stay home — they stayed away from the doctor. The JAMA Pediatrics study19 ... found that vaccine-administration rates were significantly lower across all pediatric age groups as the pandemic first surged in the U.S. ... For example, only 74% of infants turning 7 months old in September 2020 were up to date on their vaccinations, a drop from 81% in September 2019. And just 57% of infants who hit the 18-month mark in September 2020 were up to date, down from 61% the year before. The proportion of children up to date for routine vaccinations was lowest among Black children, with inequities more pronounced in the 18-month-old group."

The Big Catch-Up Initiative

To get childhood vaccination rates back on track, Chelsea Clinton is now making the rounds promoting a new vaccine initiative called "The Big Catch-Up." In a recent interview with Fortune Magazine,20 Clinton promised it would be "the largest childhood immunization effort ever." Over the next 18 months, this initiative will attempt to "catch as many kids up as possible," she said.

Partners in this effort include the World Health Organization, UNICEF, Gavi, the Vaccine Alliance, the Bill & Melinda Gates Foundation, Immunization Agenda 2030, and several other "global and national health partners." As reported by the WHO, April 24, 2023:21

24-6

"The pandemic saw essential immunization levels decrease in over 100 countries, leading to rising outbreaks of measles, diphtheria, polio and yellow fever. 'The Big Catch-up' is an extended effort to lift vaccination levels among children to at least pre-pandemic levels and endeavors to exceed those ...

While calling on people and governments in every country to play their part in helping to catch up by reaching the children who missed out, The Big Catch-up will have a particular focus on the 20 countries where three quarters of the children who missed vaccinations in 2021 live ...

The 20 countries where three quarters of the children who missed vaccinations in 2021 live are: Afghanistan, Angola, Brazil, Cameroon, Chad, DPRK [Democratic People's Republic of Korea], DRC [Democratic Republic of the Congo], Ethiopia, India, Indonesia, Nigeria, Pakistan, Philippines, Somalia, Madagascar, Mexico, Mozambique, Myanmar, Tanzania, Viet Nam."

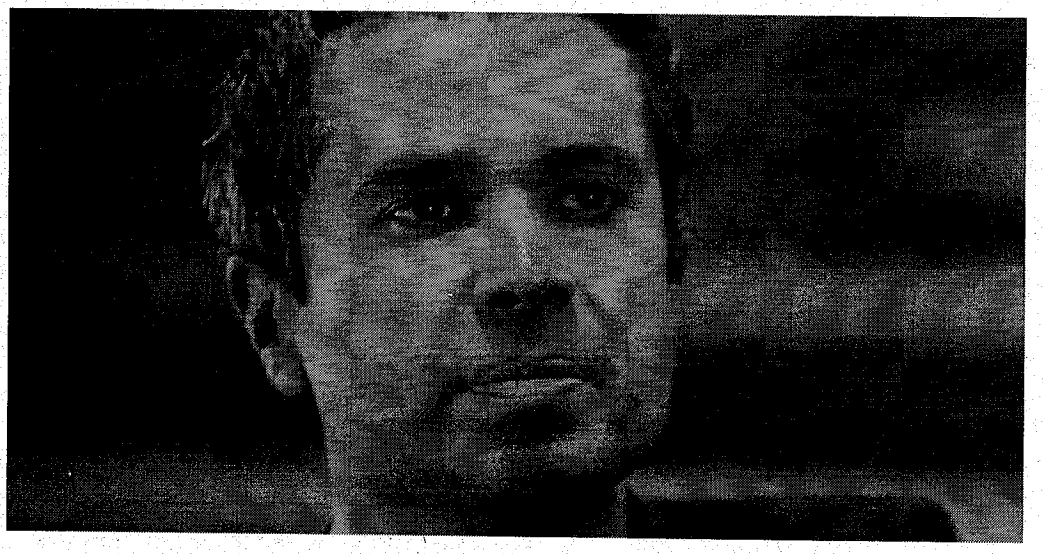
Vaccine Program Is Run 'Soft Mafia' Style

When you look at all these areas of bribery and financial incentives, doesn't it seem as though the entire vaccine program runs on financial coercion? A sort of "soft mafia" kind of operation, where the threats and promises all revolve around money and public/professional shaming versus accolades.

What would happen if all financial incentives were removed? All the performance bonuses paid to doctors, the freebies given to patients, the "charitable donations" to industry-friendly organizations and payments to front groups?

What would happen if parents were simply given unbiased evidence and no one was financially driven to pressure them either way? I don't have the answer. It's a thought experiment. But I suspect that vaccination rates would drop dramatically.

25-1



Dr. Aseem Malhotra: Psychotic "Delusion of Benefit" Blinding Millions to Vaxx Risks

J.D. Rucker • Apr. 23, 2023

Dr. Aseem Malhotra has gone from vaccine-pushing cardiologist to one of the most prominent voices against Covid jabs in the world. He has put his career and his future on the line by putting a huge target on his back for the vaxx-pushers and their cronies to hit. But the truth is the truth and he is determined to get it out to the masses.

On a recent interview with GBNews host Neil Oliver, Dr. Malhotra explained from his expert perspective why the Covid jabs should never have been injected into a single human.

"In my whole career in medicine, Neil, with all the academic work I've done looking at all different areas of medicine, specifically also related to cardiovascular disease, **I have never seen such high, overwhelming quality of evidence of harm of any drug and such poor efficacy," he said.**

One would think that with the overwhelming evidence, much of which we've discussed ad nauseam here, there shouldn't be a single lucid person on the planet who is still willing to get jabbed. It definitely seems that more people are waking up, but there are still millions of Americans and hundreds of millions worldwide who wholeheartedly embrace the jabs and can't wait to get another booster in their arm.

According to Dr. Malhotra, this can be attributed to indoctrination and ignorance, but there's another factor at play. A psychosis Dr. Malhotra calls "Delusion of Benefit" has prompted many people to willfully ignore the evidence of against the "safe and effective" narrative in favor of justifying their poor decisions. Watch: