# COVID-19 Vaccine Mandates and the U.S. Military

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The Pfizer-BioNTech COVID-19 mRNA preparation BNT162b2, now branded as *Comirnaty*™, is being mandated for U.S. military forces. It is virtually identical to the original and still highly controversial Pfizer-BioNTech BNT162b2 mRNA preparation.

On Aug 24, 2021, after consultation with medical experts and military leaders and with the support of the White House, Secretary of Defense Lloyd J. Austin III stated that mandatory COVID-19 vaccinations for service members are necessary to protect the health and readiness of the force.

This policy demonstrates a profound misunderstanding of the SARS-CoV-2 virus, the mRNA vaccines, and the current COVID-19 pandemic. The vaccination mandate will not reliably protect the health of our U.S. Special Operations air and ground forces and the intelligence agencies that support them. Instead, this mandate has the potential to generate both short and long-term incapacitating side effects within the age group that typifies Special Operations soldiers and contractors. Alternatively, it may increase the severity of COVID-19 in some fully vaccinated personnel who are later infected with one of the continuously evolving SARS-CoV-2 viral clades.

## The Evolving Threat and Current Vaccines

The BNT162b2 mRNA preparation and the other mRNA vaccines create only a short-term immunity to the original Wuhan and early Alpha and Beta clades of the SARS-CoV-2 virus, the causative agent of COVID-19. Both the Wuhan and Alpha viral clades are now essentially extinct. They have mutated into other SARS-CoV-2 variants that are now showing ever-increasing mRNA vaccine resistance. The FDA-licensed BNT162b2 preparation, like the other mRNA vaccines, cannot reliably prevent infection with the now dominant Delta clade of the SARS-CoV-2 virus.[1,2] Fully vaccinated individuals who become infected with the Delta clade of SARS-CoV-2 exhibit the same high viral load in their upper airway as unvaccinated individuals with an established COVID infection.[3] Consequently, fully vaccinated individuals who become infected with the current Delta clade of SARS-CoV-2 can infect both the unvaccinated as well as fully vaccinated individuals.[4]

An Israeli study of 2.5 million patients found that fully vaccinated individuals were 6 to 13 times more likely to get infected with some SARS-CoV-2 variants than individuals who developed a natural exposure from a previous COVID-19 infection.[5] In addition, the risk of developing symptomatic COVID was 27 times higher among fully vaccinated individuals compared to individuals with a natural immunity, and their risk of hospitalization was eight times higher.[5]

These findings are not surprising, since infection with the virus induces an immune response to many of the different proteins of the COVID virus, whereas the mRNA vaccines are directed against only one protein target, the spike protein.

There is also now considerable evidence that COVID-recovered individuals may be at a higher risk of adverse effects if they are administered the current mRNA vaccines, compared to those not previously infected.[6-8]

The BNT162b2 mRNA preparation was originally stated to be 90.5% effective (95% CI 61.0–98.9) in preventing symptomatic COVID-19 with an efficacy 88.9% (95% CI 20.1–99.7) with respect to preventing severe disease.[9] These figures are no longer true. Despite an estimated U.S. vaccination rate of 60 to 70 percent, infections and deaths surged in the summer of 2021. The vaccines are clearly not working as advertised. This was noted on the floor of the U.S. Senate at the end of September 2021.[2]

In contrast, an unvaccinated individual who contracts SARS-CoV-2 will develop a dramatically better immunity, with cross-strain reactivity against COVID-19 variants, than an individual fully vaccinated with the Comirnaty mRNA preparation or other mRNA vaccine preparations.[10-12]

## The FDA Is Incapable of Monitoring Vaccine Safety and Efficacy

In August 2021, Acting FDA Commissioner Janet Woodcock, M.D., gave full approval to the Comirnaty vaccine for COVID-19—for individuals 16 and older. Roughly a year earlier, Dr. Woodcock had declared a conflict of interest and had recused herself from all mRNA vaccine decisions. Her summary announcement states that "the public can be very confident that this vaccine meets the high standards for safety, effectiveness, and manufacturing quality the FDA requires of an approved product."[13]

The U.S. Centers for Disease Control and Prevention (CDC) states: "Millions of people in the United States have received COVID-19 vaccines under the most intense safety monitoring in U.S. history."[14]

The FDA and CDC statements on high standards for mRNA safety and effectiveness are untrue.

The original FDA Approval Letter for the Pfizer vaccine had a final vaccine approval date not scheduled until 2024. Yet on Aug 23, 2021, the Pfizer-BioNTech COVID-19 mRNA preparation, BNT162b2/Comirnaty, was FDA approved—***without a panel review***.

This was despite growing evidence of vaccine-induced miscarriages, myocarditis in young males, dissemination of the vaccine nanoparticles from the injection site into the general circulation, vaccine-associated heart attacks and strokes, suggestions of possible antibody dependent enhancement (ADE) of infection, an increasing number of

serious neurological and cardiac conditions, and vaccine-related deaths.

The U.S. lacks an effective surveillance system that can rapidly and accurately detect vaccine injuries and deaths. Instead, the FDA relies on antiquated 32-year-old passive data collection mechanisms, primarily the Vaccine Adverse Event Reporting System (VAERS) to determine whether the experimental mRNA vaccines are causing serious harm.

The accuracy of VAERS in the past has been highly variable depending on the particular vaccine and adverse vaccine effects. For example, VAERS was only able to capture 12 percent of the cases of a serious paralyzing condition (Guillain-Barré syndrome) during the 2012-2013 influenza season, and only an estimated 15 percent to 55 percent detection rate of all the cases occurring during the 2009 H1N1 influenza vaccine administration. The system is typified by gross under-reporting of other adverse vaccine events.[15]

In a letter to Pfizer dated Aug 23, 2021, concerning its COVID-19 mRNA vaccine, the FDA admitted that it was incapable of tracking adverse mRNA vaccine side effects when it stated: ***"Furthermore, the pharmacovigilance system that FDA is required to maintain under section 505(k)(3) of the FDCA is not sufficient to assess these serious risks."***[16]

The FDA has now shifted the responsibility for adverse event detection over to Pfizer as part of its agreement to license the Comirnaty mRNA preparation for COVID-19.[16]

Both the CDC and the FDA are using incomplete data and demonstrating unreasonable bias in their pro-vaccine decisions. They are not erring on the side of caution.

According to its website, "Beginning May 1, 2021, CDC transitioned from monitoring all reported COVID-19 vaccine breakthrough infections to investigating only those among patients who are hospitalized or die, thereby focusing on the cases of highest clinical and public health significance."[17] As a result, the current efficacy of the vaccines in preventing symptomatic illness is unknown because of a lack of data. What is clear is that the Pfizer vaccine preparations are not reliably preventing infection. In response, the FDA downgraded the effectiveness of the Pfizer-BioNTech COVID-19 mRNA preparation BNT162b2/Comirnaty from "providing immunity" to simply helping to protect individuals against the severe composite outcomes of hospitalization and death. This was based on the data that came out of the original initial clinical trials.

Even this is now subject to question. Accumulating data from the UK and other areas indicates the Pfizer-BioNTech COVID-19 BNT162b2/Comirnaty and the other mRNA preparations are not protecting against hospitalizations and death.[18]

Examining weekly surveillance data for the UK, Paul Alexander, Ph.D., notes that Tables 11 and 12 in the 11-week report[19] show that 87 percent of emergency department visits and hospitalizations are happening in vaccinated persons older than 18, and that 90 percent of deaths in persons older than 50 occurring within 60 days of a positive COVID test are in vaccinated persons, with effects most prominent after the third dose. The data suggest that the vaccine is not only driving more infection, but damaging the innate and adaptive immune systems.[20]

"Reports are coming in now that the UK will follow Scotland and not give us the granular data we get weekly, starting in a couple of weeks. This…means the data is showing something they do not want you to see" (P.E. Alexander, personal communication, May 6, 2022).

While the British data appears to have many potential confounders, the trend of increasing deaths with increasing vaccination does appear to be real.

While there is no clear evidence yet of the occurrence of ADE and vaccine-related autoimmunity and immunopathology in early volunteers immunized with the SARS-CoV-2 vaccines, the safety trials to date have not specifically addressed these adverse effects. Given that the follow-up of volunteers did not exceed 2 to 3.5 months after the second vaccine dose, it is unlikely such serious adverse effects would have been observed during clinical trials.[21]

Realizing that their vaccination programs are not working, some countries may drop vaccine passports and halt the practice of making private businesses check vaccine status.

## The Experimental mRNA Vaccine Trials Were Rushed and Incomplete

The now-identified role of SARS-CoV-2 "spike" glycoprotein in inducing the capillary inflammation that is characteristic of COVID-19 infection is extremely relevant given that the BNT162b2/Comirnaty mRNA vaccine and other types of mRNA vaccine preparations induce the manufacture of spike glycoprotein in the cells of its recipients.

The clinical trials ignored the animal biodistribution data submitted to the Japanese government for an mRNA vaccine preparation, which showed rapid spread of the lipid nanoparticles from the initial injection site into other tissues throughout the body.[22] Following vaccine nanoparticle injection, the test animals began to produce spike protein markers on the surface of the cells in the regional lymph nodes, the bone marrow, the lining of the systemic capillaries, lungs, liver, spleen, adrenal glands, and gonads.[22]

The existence and pathological significance of this animal biodistribution data in humans are poorly documented, but the Pfizer/BioNTech vaccines clearly do introduce mRNA into multiple cell types throughout the body, which then make a modified SARS-CoV-2 spike protein on their cell surface to trigger an immune response.

The viral spike protein is linked to several serious pathophysiological developments in COVID-19.[21] This fact was not recognized during vaccine development, and scientists did not understand the human risks of this protein when they included its mRNA code in the products.

What is certain is that the FDA authorization was based on safety data generated from human trials lasting less than 3.5 months. As the U.S. mass vaccination program progressed, it has been accompanied by an abnormally high rate of serious adverse effects, including deaths. Even accounting for the number of vaccines administered, the number of deaths per million doses administered has, according to VAERS, increased tenfold.[21]

As early as February 2021, some scientists were calling for a halt to the mass vaccination program. Despite continuing calls for caution, the risks of SARS-CoV-2 vaccination continue to be minimized or ignored by health organizations and

government authorities.[21] This has raised serious major conflicts between the leadership of the FDA and some of its scientists.[23]

Still-emerging data suggests that the Pfizer mRNA vaccine may have the potential to cause vaccine-driven disease enhancement and a reprograming of the human immune system.[24,25] Additionally, the spike protein may impair endothelial function.[26] These raise serious questions regarding the long-term effects of any vaccine based on the mRNA of the dangerous spike protein.[26]

## Mandated Vaccination in the U.S. Military

The soldiers comprising the air, sea, and ground U.S. Special Operations forces and their supporting military intelligence and technical systems are strategic assets that require months to select and train, and several more years to acquire experience in their specialized operational and supportive tasks. Protecting their health is a national security concern. Mandating COVID-19 vaccination may, however, cause far more damage than the disease.

Unlike the viruses that cause mumps, rubella, measles, smallpox, yellow fever, and polio, which mutate slowly, the virus causing COVID-19 mutates quickly, and unless a universal coronavirus vaccine can be found, the virus will always be one step ahead of new vaccine development.

Currently, there is no relationship between the percentage of population vaccination and the reduction of new COVID-19 cases during an infection cycle. In 68 surveyed nations, new COVID-19 cases are, contrary to expectations, unrelated to the level of national vaccination. In the U.S., increases in new COVID-19 cases are unrelated to the high levels of vaccination across 2,947 surveyed counties.[27] The current COVID mRNA vaccines can neither reliably stop an individual from catching an infection with some new variants of the COVID virus, nor stop them from transmitting this infection to someone else.

Special Operations soldiers require a high standard of individual fitness that should not be compromised by experimental products that lack a guarantee of only minimal side effects. This is especially true when the age group involved has a low incidence of comorbidtites and a low risk for serious injury and death from a COVID-19 infection, a risk that is even further reduced by the use of effective antiviral medications.

Early COVID-19 infection is unequivocally a treatable condition. Early treatment with one of several antiviral drugs at the first onset of symptoms shows a high degree of efficacy in quickly moderating COVID-19 infection.[21,28] Safe antiviral drug prophylaxis is also available for units and dependents.

In addition to currently reported adverse effects, the actual long-term effects of the mRNA products remain unknown, and their existence cannot be ruled out. Questions have been raised about fertility effects, the long post-vaccination syndrome, and immune system reprogramming with the loss of natural killer lymphocyte populations and a possible susceptibility to cancer. All of these questions need urgent research.

Fear of the mRNA products among the Special Operations and military intelligence communities is causing hundreds of soldiers and civilian contactors to leave their units or take early retirement.

Loss of highly trained personnel to adverse effects or separation from service (voluntary or involuntary) could have a seriously detrimental effect on military readiness.

Instead of a vaccine mandate, the U.S. Joint Special Operations Command and National Military Intelligence forces should return to the original U.S. National Pandemic Plan for Respiratory Viruses. This would entail a continuous on-site unit surveillance for early cases of viral outbreak using FDA-certified thermal camera systems and a group soldier/contractor education for COVID signs and symptoms, together with a central 1-800 nurse triage line. This phone triage line would operate in conjunction with a small on-site clinic for rapid PCR diagnosis and rapid early outpatient treatment using safe, effective, antiviral drugs with the brief home quarantine of COVID-19 cases and post-exposure treatment of dependents. Unlike mass vaccination programs with ineffective mRNA products, early drug treatment protocols can control community transmission and minimize infection severity, while allowing personnel to develop a broad, cross-reactive natural immunity to future COVID-19 clades.

## Conclusions

Current mRNA vaccines are not reliably protecting individuals from infection or infection transmission. The rate of occurrence of adverse effects and the wide range of the types of adverse effects reported to date demonstrate the need for a better understanding of the benefits and risks of mass vaccination. Military readiness should be protected with early detection and diagnosis, plus early treatment and prophylaxis with a combination of safe repurposed drugs and immunologic support, rather than mandated use of incompletely tested novel products with potential serious adverse effects.

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