FROM INNOVATION TO INQUIRY

A FORMAL REVIEW OF mRNA COVID-19 VACCINATION AND ITS GLOBAL CONSEQUENCES

WITH SPECIAL REFERENCE TO NEW ZEALAND

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1 April 2025

Atkinson & Rapley Consulting Ltd.

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Executive Summary

The COVID-19 pandemic marked the rapid deployment of novel biomedical technologies under conditions of global emergency. Chief among these was the use of mRNA-based interventions, introduced with limited longitudinal data, yet supported by broad institutional consensus and expedited regulatory pathways. While initially presented as a definitive scientific solution, subsequent developments have revealed complex and unresolved questions regarding safety, ethics, efficacy, and governance.

This formal review provides a multidisciplinary examination of the COVID-19 vaccine response, with particular focus on mRNA technology authorized under Emergency Use Authorization (EUA). Drawing on clinical studies, regulatory policy, ethical frameworks, and post-market surveillance data, it offers a structured critique of the scientific, legal, and institutional dimensions of pandemic response—with specific reference to the New Zealand context.

Key findings include:

- **Classification and Oversight:** mRNA products—despite exhibiting gene therapy characteristics—were not subject to gene therapy regulatory standards. This divergence from established frameworks has implications for risk evaluation, product labelling, and public communication.
- **Post-Market Safety Signals:** A range of post-deployment signals, including immunological anomalies (IgG4 class switching), clotting disorders (VITT), and residual DNA

elements, remain insufficiently investigated. Regulatory responses have not met the standard of precaution typically applied to novel therapeutic classes.

- **Suppression of Therapeutic Alternatives:** Widely available, low-cost interventions such as Ivermectin were deprioritised or actively suppressed, despite early supportive data and historical safety records. The resulting policy asymmetry constrained clinical judgment and limited patient access to potentially beneficial treatments.
- **Excess Mortality and Signal Inaction:** The temporal association between vaccine rollouts and excess non-COVID mortality in several high-uptake nations warrants systematic, transparent analysis. To date, no national authority has published comprehensive disaggregated mortality data by vaccination status.
- **Erosion of Informed Consent:** Mandate policies, combined with the suppression of risk disclosure and medical dissent, undermined the legal and ethical foundations of informed consent. Communication strategies substituted reassurance for data and compliance for autonomy.
- **Structural Risk in Global Health Governance:** The growing influence of supranational entities—operating through indemnified contracts, non-transparent procurement, and intellectual property constraints—has reduced national sovereignty and public oversight in medical decision-making.

The report concludes that while early policy choices may be understood in the context of crisis response, the failure to recalibrate those choices in light of emerging data reflects systemic inertia and institutional capture. Rectifying this requires a reassertion of core public health principles: transparency, proportionality, scientific pluralism, and respect for individual rights.

Such a reckoning is not retrospective alone—it is necessary to restore public confidence, prepare for future health crises, and ensure that emergency powers do not become structural norms in democratic societies.

Bruce Rogers

1 April 2025

Personal Introduction

There are moments in a scientist's career when it becomes necessary to speak. Not out of defiance, but from a sense of duty —when the need for clarity outweighs the comfort of silence.

This report is not written in opposition to science or public health, but in support of both. It arises from a professional obligation to assess, reflect, and contribute constructively to our understanding of the global COVID-19 response. As a scientist trained in health and environmental disciplines, I am guided by evidence, ethical frameworks, and a longstanding commitment to minimising harm. Over the course of the pandemic, I observed changes in how information was managed, how decisions were made, and how dissenting perspectives were handled within scientific and public institutions.

Raising questions about emerging technologies—such as the novel use of mRNA-based products—resulted, in my case, not in debate but in distance. Critical perspectives were often met not with engagement, but with withdrawal. Relationships altered. Professional opportunities narrowed. Nevertheless, the available data did not fully support the level of confidence being communicated to the public. And the potential harms—initially dismissed—are now becoming increasingly visible.

What is currently unfolding is complex and evolving. It includes not only the consequences of the virus itself, but the impacts of our collective response. Many individuals have experienced

serious, ongoing health effects following vaccination—ranging from cardiovascular to neurological and autoimmune conditions. These cases, while not universal, are not insignificant. Each one represents a life affected, a family disrupted, and a need for further investigation and understanding.

The term “vaccine” carried with it expectations of safety, transparency, and long-term benefit. While this language may have facilitated regulatory approval and public uptake, it also contributed to a simplified narrative that did not reflect the full scope of available evidence. Questions regarding long-term safety, informed consent, and proportionality remain open, and deserve ongoing attention.

This document is intended as a contribution to that broader dialogue. It is not an indictment, but an appeal—to look more closely, to listen more carefully, and to consider more fully the range of experiences and outcomes that have emerged. It is written in support of those who seek answers, and in respect of those whose lives have been altered.

Science advances through open discourse, rigorous testing, and the willingness to re-examine earlier assumptions. That is the spirit in which this report is offered.

Bruce

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1 - Introduction

Since the onset of the COVID-19 pandemic, the global community has grappled with unprecedented challenges. The rapid development and deployment of mRNA vaccines was touted as a significant scientific achievement. However, as vaccination campaigns progressed, **a complex narrative emerged, encompassing legal debates, public health policies, emerging medical observations, and discussions on alternative treatments**. **This submission explores the shifting landscape of COVID-19 vaccination,** focusing on legislative actions, excess mortality trends, emerging health phenomena, and the evolving discourse on Ivermectin, all **within a framework of scientific and legal scrutiny**.

Legislative Responses to mRNA Vaccines

In recent years, **several U.S. states have introduced legislation aimed at restricting or banning the use of mRNA vaccine technology**. For instance, Iowa, Montana, and Idaho have proposed bills to limit mRNA vaccine usage. In Iowa, a bill advanced that **would penalise providers with fines for administering mRNA-based vaccines**, although it was later amended to require vaccine manufacturers to waive federal liability protections.

Similarly, Idaho considered a bill to impose a ten-year moratorium on mRNA vaccines, **categorising them as "gene therapy products."**

These legislative efforts reflect a broader skepticism towards mRNA technology and **raise questions about the balance between public health initiatives and individual rights**. While proponents argue for caution and further research, opponents warn that such restrictions could hinder medical advancements and public health responses.

Mandates and Institutional Policies

The debate over vaccine mandates has also intensified. **Thirteen states have now enacted laws prohibiting employers from mandating COVID-19 vaccines for workers**, with additional states considering similar measures. In the educational sector, seventeen states have laws preventing schools from requiring COVID-19 vaccinations for students. At the federal level, **an executive order was signed to prohibit federal funding for educational institutions that mandate COVID-19 vaccinations**.

These policy shifts underscores a growing emphasis on personal choice and autonomy in health decisions. They also reflect a response to public concerns about vaccine safety and the role of government in mandating medical interventions.

Excess Mortality Trends

Excess mortality, defined as the number of deaths above what would be expected under normal conditions, has been a critical metric during the pandemic. A study covering 47 Western countries reported approximately 3.1 million excess deaths from January 2020 to December 2022. While initial excess deaths were attributed to the virus itself, subsequent analyses have **raised**

questions about other contributing factors, including the indirect effects of pandemic responses and potential vaccine-related impacts.

For example, some **countries with high vaccination rates, such as the Netherlands, Australia, New Zealand, and Denmark, reported significant excess mortality in 2023**. However, it's important to note that correlation does not imply causation, and further research is necessary to understand these trends fully. However, it would be foolhardy to ignore such important observations on a point of principle. Such observations deserve serious scientific investigation **to either rule in, or rule out, a significant potential adverse effect of the new genetic therapy approach, incorrectly marketed to the world as a 'vaccine'**. Let us explore the topic of classification of the 'vaccine' in a little more depth.

Mechanism of Action and Genetic Engineering Principles

COVID-19 mRNA vaccines, such as those developed by Pfizer-BioNTech and Moderna, **utilise lipid nanoparticles to deliver synthetic messenger RNA (mRNA) into human cells**. This mRNA instructs cells to produce the SARS-CoV-2 spike protein, prompting an immune response. This process involves the introduction of genetic material to direct protein synthesis within the body, **a hallmark of genetic engineering**.

A 2023 review in Pharmaceuticals argues that the mode of action of mRNA vaccines **should classify them as gene therapy**

products, as they involve nucleic acids designed to produce an antigen within the body. However, **regulatory agencies have excluded them from GTP classification, leading to debates about appropriate oversight**.

Regulatory Perspective

Despite the genetic engineering aspects of mRNA vaccines, **regulatory bodies like the U.S. Food and Drug Administration (FDA) and the European Medicines Agency (EMA) have categorised them as vaccines** rather than gene therapies. This classification has implications for the regulatory pathways and safety assessments applied to these products.

Conclusion

While COVID-19 mRNA vaccines are not officially designated as gene therapy products, **their reliance on genetic engineering principles for their function supports the characterization of these vaccines as genetic engineering technologies**.

This perspective underscores the importance of **ongoing discussions regarding the classification, regulation, and public understanding of such innovative medical interventions.**

2 - The Adequacy of COVID-19 Vaccine Testing Prior to Emergency Use Authorization: A Critical Analysis

Introduction

The rapid development and deployment of COVID-19 vaccines were unprecedented in the history of vaccinology. While the alleged urgency of the pandemic was used to justify the expedited COVID-19 response processes, **questions have arisen regarding the comprehensiveness of the testing protocols employed before granting Emergency Use Authorisations (EUAs)**. This submission critically examines the testing phases of COVID-19 vaccines, **highlighting areas where standard protocols may have been abbreviated or omitted**, and discusses the implications for public health and trust.

Accelerated Development Timelines

Traditional vaccine development is a meticulous process, often spanning 10 to 15 years, encompassing exploratory stages, preclinical trials, and three phases of clinical trials before regulatory approval. In contrast, COVID-19 vaccines were developed, tested, and authorized within a year. **Operation Warp Speed in the United States exemplified this acceleration**, aiming to deliver vaccines rapidly by **overlapping trial phases and commencing large-scale manufacturing before trial completion** .

Clinical Trial Phases and Limitations

Phase I and II Trials: These initial phases focused on assessing safety and immunogenicity in small cohorts. While results were promising, the **limited sample sizes and short follow-up periods restricted the ability to detect less common adverse events**.

Phase III Trials: These pivotal trials aimed to evaluate efficacy and monitor adverse reactions in larger populations. However, several concerns have been noted:

- **Short Duration: The median follow-up period was approximately two months, insufficient for assessing longterm safety and efficacy.**
- **Population Representation: Certain groups, such as pregnant women, immuno-compromised patients, and children, were underrepresented**, limiting the ability to generalise the findings.
- **Data Transparency:** There was **inadequate availability of trial documents and participant-level data, hindering independent analysis and verification**.

Emergency Use Authorization and Regulatory Oversight

EUAs allowed for the deployment of vaccines based on interim data, balancing potential benefits against risks in a public health emergency. However, this approach meant that **full regulatory approval processes, which require more extensive data, were**

bypassed initially. The reliance on limited short-term data **raised concerns about the thoroughness of safety evaluations**.

Post-Market Surveillance and Adverse Events

Post-authorization, surveillance systems like the Vaccine Adverse Event Reporting System (VAERS) in the U.S. were crucial for monitoring vaccine safety. While these systems identified rare adverse events, such as myocarditis and thrombosis with thrombocytopenia syndrome (TTS), **the initial trials were not powered** to detect such rare outcomes. The emergence of these events post-deployment **underscores the limitations of the preauthorisation testing phases**.

Ethical Considerations and Public Trust

While the expedited rollout of COVID-19 vaccines was framed as a necessary response to a perceived unfolding global emergency, **it gave rise to significant ethical concerns—particularly regarding the principle of informed consent and the sufficiency of safety and efficacy data. Under normal circumstances, vaccine development follows a well-established process of phased clinical trials, post-market surveillance, and open peer review**. In this case, accelerated regulatory approvals, limited duration of follow-up studies, and restricted access to trial data raised **legitimate questions about whether those receiving the vaccine were fully informed of known risks, unknowns, and potential alternatives**.

Public trust is a cornerstone of any successful vaccination programme. Once eroded, it is not easily restored. Historical

examples—such as the 1976 swine flu vaccination campaign in the United States, which was halted due to rising cases of Guillain-Barré syndrome—demonstrate the long-lasting consequences of perceived scientific or regulatory overreach. In the COVID-19 context, **the perception that data were withheld, dissenting voices marginalised, or adverse signals underreported** has fuelled not only vaccine hesitancy but broader scepticism towards public health institutions.

Maintaining public confidence requires more than reassuring slogans. It demands full transparency, honest communication about benefits and limitations, and a demonstrated commitment to corrective action when risks emerge. Without these foundations, the social contract underpinning public health initiatives begins to fray.

Conclusion

The rapid development and emergency authorisation of COVID-19 vaccines have been widely described as a landmark in modern biomedical science. Yet, **the compression of traditional trial phases, absence of long-term safety data, and centralisation of regulatory oversight** revealed **systemic vulnerabilities in the safeguards typically relied upon to protect public health**. These circumstances underscore the critical need for **robust post-market surveillance, independent data review, and transparent risk communication**—especially when novel technologies are deployed at scale.

While urgency can justify procedural adaptation during a crisis, **it cannot justify the erosion of ethical standards or the marginalisation of scientific debate**. The experience of the COVID-19 vaccine rollout reveals a failure to maintain this balance. In New Zealand, as elsewhere, **emerging evidence of serious adverse reactions—including myocarditis, neurological injury, reproductive disruption, and unexplained deaths—has not been met with proportionate inquiry or accountability**. Furthermore, the persistent elevation in excess mortality, coupled with **long-term complications among the vaccinated population, calls for immediate and independent investigation**.

Future pandemic responses must prioritise not only speed, but integrity—ensuring that **emergency measures do not become a substitute for comprehensive safety evaluation, ethical transparency, and informed public consent**.

These are not optional ideals.

They are foundational to the trust upon which all public health action depends.

3 - Immunological Class Switching and the Rise of IgG4: A Tolerogenic Shift with Unexamined Consequences

The adaptive immune system is an evolutionary masterpiece—engineered to recognise, remember, and respond to foreign pathogens with precision. Central to this system is the process of **immunoglobulin class switching, whereby B cells tailor the type of antibody they produce based on the nature of the antigenic threat**. In the setting of acute viral infections, the immune response is typically **characterised by early and robust production of IgG1 and IgG3—subclasses associated with pro-inflammatory antiviral action**, effective neutralisation, recruitment of cytotoxic T cells, and clearance of infected cells.

However, a growing body of immunological evidence now suggests that repeated exposure to mRNA COVID-19 vaccines, especially through successive booster regimens, **may provoke an unanticipated shift toward IgG4 antibody production**. Unlike its IgG1 and IgG3 counterparts, **IgG4 is associated not with immune aggression, but with immune tolerance**. It plays a regulatory role in chronic antigen exposure scenarios, such as allergen immunotherapy or long-term parasitic infection, where **inflammation suppression—not eradication—is the goal**. In this context, **a tolerogenic shift may be appropriate. In the context of vaccination against a replicating respiratory virus, it may be maladaptive.**

The landmark study by Irrgang et al. (2022), published in Science Immunology, investigated the longitudinal antibody profiles of individuals undergoing repeated mRNA vaccination. They observed **a striking rise in IgG4 titres after multiple exposures, particularly following the fourth dose or receipt of bivalent boosters**. This pattern did not emerge following natural infection, nor was it evident after the initial vaccine doses—**highlighting that the phenomenon is likely induced by repeated synthetic antigen stimulation rather than viral exposure *per se***.

This shift is not benign. The authors proposed that **an IgG4-dominant profile may impair viral clearance, reduce vaccine efficacy over time, and leave individuals more vulnerable to future infections**, particularly with immune-evasive variants. Unlike IgG1 and IgG3, which activate complement and recruit effector cells, **IgG4 is functionally inert—incapable of activating key arms of the immune system**. In effect, **the immune system begins to "tolerate" the spike protein, rather than attack it**. In a therapeutic setting aimed at enhancing immune defence, **this is a fundamental inversion of purpose**.

The implications extend further still. Preliminary immuno-pathological discussions have explored whether **persistent elevation of IgG4 could signal a state of immune exhaustion, or contribute to immune surveillance failure**—an effect **relevant to the development or progression of malignancies, particularly those that exploit immune evasion mechanisms**, such as lymphomas or HPV-driven cancers. While this remains

hypothetical, it is grounded in immunological logic and therefore warrants immediate investigation.

Real-world signals reinforce the need for caution. In countries with high booster uptake—such as Germany, Israel, and New Zealand—**researchers have documented surprising trends in infection recurrence, breakthrough hospitalisations, and anomalous rises in certain cancer types**, including aggressive lymphoid and pancreatic cancers. Though causality cannot yet be determined, **the absence of formal investigation into possible IgG4-mediated immune modulation constitutes a serious oversight**.

Despite these developments, **public health communication has remained conspicuously silent on the issue**. Neither regulatory bodies nor official guidelines have acknowledged the existence of this class-switching phenomenon, let alone explored its significance for long-term health. **This omission violates the principles of transparency and informed consent**, and raises questions about the completeness of safety assessments and risk disclosures offered to the public.

If the immune system is being reprogrammed to tolerate rather than fight, **we must ask: What else is being tolerated that should not be? The precautionary principle demands that this question be answered—not in hindsight, but now, *while course correction is still possible.***

Conclusion: When Tolerance Replaces Defence, What Else Is Being Allowed In?

The phenomenon of IgG4 class switching in response to repeated mRNA vaccination is not a trivial immunological footnote—**it is a signal, flashing in the dark, warning that the immune system may be undergoing a fundamental and poorly understood reprogramming**. When **the very architecture of immune defence shifts from attack to tolerance—especially in the face of a mutating viral threat**—the implications stretch far beyond vaccine efficacy. They reach into the realms of **immune exhaustion, failed surveillance, and even oncogenesis**.

That this effect was not observed following natural infection, but only after repeated synthetic antigen exposure, further underscores its iatrogenic origin. This is not nature at work—it is biotechnology operating at the edge of our understanding, and perhaps already beyond our current control.

The silence from public health authorities in the face of this discovery is more than a communications failure. I**t is a breach of scientific and ethical duty**. At a time when public confidence has already been strained, **the refusal to acknowledge or investigate such a profound shift in immune behaviour borders on negligence. Informed consent requires disclosure. Scientific integrity demands exploration**. Yet both have been sacrificed at the altar of narrative management.

If immune tolerance toward a persistent, spike-encoding antigen is now embedded in millions of individuals worldwide, ***the long-term***

consequences may not emerge gradually—they may arrive abruptly, as new pathogens are met with an immune system that has been taught not to react.

This is not a reason to panic. **But it is every reason to pause. To investigate. To speak openly**. And to admit that **we may have underestimated the complexity of the system we chose to reprogram**.

Science cannot be a one-way street paved only with promises.

It must also be a mirror—reflecting back what is inconvenient, what is uncertain, and what must be confronted.

Because if we are tolerating too much, too quietly, *we may already be welcoming the very harms we set out to prevent.*

4 - Supplementary Considerations in the Evaluation of COVID-19 Vaccination Policies

Plasmid DNA Contamination and Genomic Integration Risks

Recent analyses have identified **the presence of residual plasmid DNA in mRNA COVID-19 vaccines, raising concerns about potential genomic integration**. Dr. Phillip Buckhaults, a molecular geneticist, testified before the South Carolina Senate, highlighting **the detection of DNA fragments in vaccine samples and the theoretical risk of insertional mutagenesis, which could lead to oncogenesis**.

Further studies have corroborated these findings, indicating that **the manufacturing process may leave behind DNA contaminants**. While regulatory agencies like the FDA and EMA have stated that the levels of residual DNA are within acceptable limits and pose no known risk, **the lack of comprehensive, independent evaluations necessitates further investigation to conclusively determine safety profiles**.

Batch Variability and Adverse Event Disparities

Investigations into vaccine batch consistency have revealed **significant disparities in adverse event reporting**. A study comparing data from Denmark and Sweden found that **certain batches of the BNT162b2 vaccine were associated with higher**

rates of suspected adverse events, suggesting potential inconsistencies in manufacturing or quality control.

These findings underscore the importance of stringent oversight in vaccine production and distribution. Ensuring batch uniformity is critical to maintaining public trust and safeguarding health outcomes.

IgG4 Class Switching and Immune Tolerance Implications

Emerging research has observed **a shift towards IgG4 antibody responses following repeated mRNA vaccinations**. While IgG4 is typically associated with non-inflammatory responses, its elevation in this context is unusual and may indicate an altered immune profile.

The long-term implications of this shift remain uncertain. Some hypothesise that **it could lead to reduced vaccine efficacy or increased susceptibility to infections**. However, **more research is needed to fully understand the clinical significance of these findings.**

Suppression of Scientific Dissent and Institutional Oversight

Throughout the pandemic, instances have been reported where **scientific discourse was curtailed, and dissenting voices were marginalised. Concerns have been raised about the transparency of data, the openness of regulatory agencies to alternative viewpoints, and the potential influence of**

pharmaceutical companies on public health policies. Ensuring that scientific debate remains open and evidence-based is essential for the integrity of public health decisions. Mechanisms should be in place to protect whistleblowers and to facilitate independent reviews of data and policies.

Global Governance and Equitable Access Challenges

The global response to COVID-19 has highlighted **disparities in vaccine access and the influence of international organizations on national health policies. Initiatives like COVAX, led by CEPI and Gavi, aimed to promote equitable vaccine distribution but faced challenges in achieving their goals .**

Critiques have emerged regarding the decision-making processes within these organizations and **the extent to which they consider the diverse needs of different populations. A more inclusive and transparent approach is necessary to ensure that global health initiatives are both effective and equitable.**

Conclusion

Incorporating these additional considerations into the evaluation of COVID-19 vaccination policies provides a more comprehensive understanding of the complexities involved.

Addressing concerns about manufacturing practices, immune responses, scientific transparency, and global governance is crucial for refining current strategies and preparing for future public health challenges.

5 - Post-Market Observations: Genetic, Immunological, and Institutional Oversights

The emergency deployment of mRNA vaccines under EUA (Emergency Use Authorization) occurred in response to an alleged unprecedented global crisis. Yet, as time progresses, critical post-market concerns have surfaced—scientific, immunological, and institutional—which now **demand urgent and unflinching scrutiny**. Far from undermining innovation, these revelations emphasize the systemic risks of **deploying novel medical technologies without long-term evaluation, full transparency, or rigorous accountability**.

Residual Plasmid DNA and Risks of Genomic Integration

Independent laboratory analyses have confirmed the presence of **residual plasmid DNA fragments in mRNA vaccine vials**. Of particular concern are *SV40 promoter/enhancer sequences—viral elements known for their* ***potent gene activation properties*** *and* ***potential links to oncogenic processes***. The presence of these sequences raises **significant questions about manufacturing fidelity and the theoretical risk of genomic integration**, particularly when assisted by **lipid nanoparticles capable of delivering material into host cell nuclei.**

Dr. Phillip Buckhaults, a cancer genomics specialist, testified before the South Carolina Senate in 2023, highlighting the

presence of **linear DNA fragments and potential recombination pathways into human chromosomes**. While causation has not yet been proven, **the possibility of insertional mutagenesis and oncogenesis cannot be ruled out—underscoring the need for transparent investigation and disclosure**.

Batch Variability and Uneven Distribution of Adverse Events

Pharmacovigilance frameworks depend on manufacturing consistency. However, analyses of adverse event data from countries like Denmark and Sweden reveal **stark disparities between vaccine batches**. **Some lots were disproportionately associated with serious adverse events**, suggesting possible **lapses in temperature control, formulation accuracy, or process integrity**—each **a violation of Good Manufacturing Practice (GMP) standards**. This variability has **profound implications for informed consent**. **Patients were not informed of potential batch-related risk disparities, and regulatory bodies failed to issue timely warnings *or initiate corrective measure*s.**

IgG4 Class Switching and Immune Modulation

A notable immunological phenomenon has emerged in individuals receiving multiple mRNA doses: **a class switch from IgG1 and IgG3 (typically pro-inflammatory, antiviral antibodies) to IgG4**—a subtype more commonly **associated with immune tolerance and allergen desensitisation**. While this shift may be benign in some contexts, its presence in response to a viral antigen is **atypical and potentially counterproductive**. A German study

published in Science Immunology (2022) documented this change, raising concerns that **elevated IgG4 levels could blunt future immune responses or contribute to immune tolerance toward malignant cells**. Though still under investigation, **this shift represents a significant and underreported dimension of vaccine-induced immune reprogramming**.

Suppression of Scientific Discourse and Institutional Capture

Equally concerning has been **the curtailment of open scientific inquiry. Researchers and clinicians raising legitimate questions about adverse events, alternative therapies, or regulatory decisions have faced censorship, professional reprisals, and journal retractions. Academic freedom and data transparency—cornerstones of scientific progress—have too often been subordinated to political alignment and institutional orthodoxy. This environment of suppression is not merely unethical—it is structurally unsound, stifling the very mechanisms that safeguard public health through honest appraisal and self-correction.**

Global Governance and the Future of Medical Oversight

Finally, **the governance structure surrounding COVID-19 vaccine rollout has shifted from national public health leadership to supranational entities. Organizations such as the WHO, CEPI, Gavi , and the Gates Foundation wielded extensive influence over vaccine development, funding, distribution**

contracts, and policy implementation. While global coordination can be beneficial, **the absence of democratic oversight and transparency within these institutions presents a long-term risk to autonomy and accountability**. Without reform, the current model—**rapid mass deployment, limited post-market transparency, and structural deference to private global actors**—could become the default framework for future public health emergencies. This must not be allowed.

Conclusion - Innovation Without Accountability Is a Risk Too Great to Repeat

The mRNA vaccine rollout, heralded as a triumph of biomedical innovation, now stands at a crossroads between promise and peril. What began as a global emergency response has, over time, **revealed deep fissures in the systems meant to ensure safety, uphold transparency, and protect public trust**. These are not the retrospective critiques of hindsight—they are **the foreseeable consequences of bypassing due diligence in the name of urgency**.

The presence of residual plasmid DNA, including SV40 enhancer sequences, in vaccine vials is **not merely a manufacturing anomaly. It is a red flag that calls into question the integrity of oversight mechanisms** across the entire regulatory chain—**from laboratory bench to patient bedside**.

When cancer genomics specialists are warning of potential genomic insertion, the proper response is not silence.

It is inquiry.

When batch variability shows clear correlations with spikes in serious adverse events, the issue is no longer theoretical. It is **a real-world breach of pharmaceutical responsibility**, one that may have resulted in **harm not equally distributed, and not disclosed**. ***The foundational principle of informed consent cannot survive in an environment where patients are treated as a monolith and risk is concealed by averages***.

The rise of immune class switching to IgG4—a phenomenon virtually unknown in traditional vaccinology—is **a signal that the immune system itself may be undergoing *unintended reprogramming***. Whether this leads to blunted antiviral response, immune tolerance, or even oncogenic permissiveness, **the fact that it is understudied and underreported speaks volumes about the selective lens through which vaccine science is being conducted**.

And perhaps most damning is the institutional response to these revelations: **a coordinated suppression of dissent, a punishment of curiosity, and a chilling of scientific dialogue**. **This is not how science behaves in the pursuit of truth**. ***It is how power behaves in the defence of its own narrative.***

If the COVID-19 vaccine programme has taught us anything, it is that **emergency powers and private partnerships must never be allowed to override the pillars of ethical medicine, open science, and *democratic accountability***. Innovation is not the enemy. But **innovation without long-term safety data**, **without**

transparent oversight, and without institutional humility becomes a vector not of healing, but of harm.

We now face a choice: **allow this model to become the template for future public health crises—or *expose its failures so that they are never repeated*.**

The price of getting it wrong has already been measured in lives, in trust, and in the *corrosion of foundational scientific values*.

We must not look away.

We must not move on.

We must confront what went wrong—because if we do not, *we guarantee it will happen again.*

6 - Therapeutic Suppression and the Silencing of Early Treatment Protocols

Among the most consequential—and least acknowledged—failures of the COVID-19 response was the systematic suppression of early treatment protocols, particularly the use of repurposed generic drugs such as Ivermectin and Hydroxychloroquine. These agents, once foundational to pandemic preparedness strategies, were rapidly reframed as fringe or dangerous therapies. This shift did not follow a natural arc of scientific evaluation, but rather a coordinated campaign of dismissal, censorship, and regulatory obstruction.

Early in the pandemic, observational studies and clinical reports from countries including India, Argentina, Mexico, Egypt, and Bangladesh indicated that Ivermectin—an anti-parasitic drug with antiviral and anti-inflammatory properties, and co-recipient of the 2015 Nobel Prize in Medicine—**demonstrated measurable benefit in reducing disease severity, hospitalisation rates, and mortality when administered early in the course of illness**. In Uttar Pradesh, India's most populous state, **aggressive deployment of Ivermectin at the community level correlated with dramatic case reductions**. In Iquitos, Peru, **mortality dropped by over *70% during periods of Ivermectin distribution*—only to rise again when the drug was withdrawn under international pressure.**

By mid-2021, organisations such as the FLCCC Alliance and BIRD Group (led by Dr. Tess Lawrie) had compiled meta-analyses incorporating dozens of trials, **highlighting significant clinical benefit when Ivermectin was used early or prophylactically**. Yet *these findings were not debated—**they were discredited by narrative.*** Major medical journals refused to publish positive results. Social media platforms censored discussion. **Physicians were de-platformed, and in some countries, like Australia and New Zealand, doctors faced professional sanction or suspension for prescribing off-label treatments with decades-long safety records**.

Regulatory bodies including the U.S. FDA, WHO, and New Zealand's Medsafe **issued public warnings discouraging use—*not based on conclusive harm data, but on the claim of "insufficient evidence."*** *Yet paradoxically, the very institutions decrying the lack of evidence were simultaneously obstructing the generation of that evidence.* **Clinical trials were delayed, underpowered, or deliberately structured to fail**—such as administering Ivermectin in late-stage hospital settings, where antiviral strategies are known to be far less effective, or using sub-therapeutic doses inconsistent with pharmacodynamic modelling.

In the United States, **Dr. Pierre Kory's testimony before the U.S. Senate—in which he advocated for Ivermectin's inclusion in early treatment protocols—was viewed *millions of times*, only to be followed by coordinated media backlash and institutional retaliation**. In Brazil, doctors were criminally investigated for

using Ivermectin during the height of the pandemic. In New Zealand, **GPs who followed international protocols were *quietly removed from practice***. This **must now be redressed**.

This is not merely a story of differing interpretations of clinical data. It is a case study in **therapeutic censorship**: **a moment in modern medicine where scientific heterodoxy was rebranded as misinformation**, and the **physician's right to exercise professional judgment was subordinated to centralised, politicised guidelines**.

Had these early outpatient interventions been explored with good faith, rigor, and transparency, **the global trajectory of the pandemic might have been *meaningfully altered***. Hospital systems could have been spared collapse. Vulnerable populations might have accessed treatment sooner. **The perceived necessity for mass vaccination**, i**ncluding coercive mandates, *might have been diminished*.** Instead, a monolithic, **vaccine-centric strategy took hold**—one in which **all alternative perspectives were treated not as contributions, but as *threats***.

The consequences were not only clinical, but *constitutional.* The scope of therapeutic choice narrowed. Clinical autonomy eroded. *And healthcare decision-making was consolidated in a handful of agencies*—**largely unaccountable, internationally aligned, and financially entangled**.

This is not how science functions in a democracy. Elected officials are not medical professionals, and their decisions should reflect that boundary. **The conflation of political authority with medical**

expertise is not merely unwise—*it is dangerous*. When governments overstep and institutions silence dissent, the result is not public safety—it is public harm, cloaked in the language of protection.

We must remember: **Suppression is not a form of science. It is a failure of it.**

Conclusion: A Failure That Demands Reckoning

The deliberate obstruction of early treatment options was not a neutral act of scientific caution—it was a strategic and ideologically enforced suppression that placed narrative control above clinical reality. It disfigured the foundation of evidence-based medicine, silenced frontline clinicians, and denied millions the opportunity for timely, low-cost, potentially life-saving interventions.

When public health policy excludes therapies not because they fail, but because they do not serve the prevailing agenda, that is not public health. It is policy capture.

The consequences are irreversible for many. Patients who might have recovered with early intervention were instead hospitalised, ventilated, or buried. **Doctors who upheld their oath to do no harm were punished for *offering informed alternatives***.

The public, in turn, was deprived not just of treatment options, *but of the truth*.

This is why the suppression of early therapeutics—especially Ivermectin—must not be dismissed as a policy misstep or excused as an emergency-era necessity.

It was a coordinated abdication of scientific responsibility, institutional humility, and medical ethics.

And its legacy is written not only in peer-reviewed rebuttals and redacted emails, but ***in the graveyards of every country that chose silence over scrutiny.***

The call for accountability is not academic.

It is urgent.

For when medical freedom is revoked, and inquiry is crushed beneath the weight of political consensus, we do not arrive at safety.

We arrive at suffering—manufactured, magnified, and avoidable.

7 - Emerging Health Observations

In recent months, a growing number of healthcare professionals—particularly embalmers, pathologists, and vascular surgeons—have **reported the recurrent presence of unusual fibrous intravascular structures, colloquially termed "*white clots*."** These masses, often **described as resilient, rubbery, and resistant to traditional clot-dissolving techniques**, have been **identified during postmortem examinations and *surgical interventions***, prompting questions about their composition, origin, and clinical significance.

While it is acknowledged that intravascular thrombi are not a new phenomenon, **the scale, frequency, and physical characteristics of these clots have raised concerns within the professional community. The embalmers' testimonies—particularly from the United States, Germany, and New Zealand—suggest a shift in clot morphology that began appearing predominantly in the post-vaccination period of 2021–2022.**

Despite these observations, official health authorities have largely downplayed the significance of the findings, attributing them to artefacts or unrelated pathology. Yet to date, **no systematic histopathological studies or comprehensive biochemical analyses have been conducted to verify these claims** or disprove alternative hypotheses.

Landmark Investigation into the Nature of Post-Vaccine Embalmer Clots by the writer

Following global reports by embalmers and surgeons of long, fibrous, rubbery white clots—appearing primarily in deceased individuals post-2021, and later observed in some living patients undergoing vascular procedures—the scientific community has been faced with **a vexing and urgent question:** *What are these clots, and where did they come from?*

While some commentators speculated that such formations were merely longstanding postmortem artefacts, this assumption has now been thoroughly challenged. The Writer undertook a **pioneering investigation** over an 18-month period to determine the origin, structure, and biochemical composition of these so-called **"embalmer clots"**. With the assistance of embalmers across several countries, **multiple samples were collected under strict anonymity and submitted to a range of biochemical, proteomic, elemental, and histological analyses** across several independent laboratories.

This work—**conducted in parallel with international inquiries and under conditions of significant institutional resistance**—has revealed ***findings of profound significance***.

Differentiation from Normal Postmortem Clots

It is well known that postmortem clots are a **routine and benign finding**, including the classic "**currant jelly**" and "**chicken fat**" types, as well as known **antemortem thrombi** and **mural clots**.

These have been described in the medical literature since the 19th century, including the work of **Rudolf Virchow**, who provided the foundational classification of thrombus types.

The white clots observed in post-2021 autopsies, however, are **morphologically and biochemically distinct**. Unlike the soft, non-adherent gelatinous clots typical of postmortem changes, these structures exhibit:

- **High tensile strength and rubbery consistency**
- **Extreme length** (sometimes over 40 cm)
- **Widespread distribution across major vessels**
- **Resistance to standard embalming fluid penetration**

Key Findings from the Writer's Research

1. **Elemental Analysis**
    - Quantitative assays confirmed **abnormally high concentrations of phosphorus (+333%) and tin (+479%).**
    - The presence of **tin**—a metal with **no known role in mammalian physiology**—is especially alarming and warrants urgent toxicological investigation.
    - These findings, initially flagged by Mike Adams, were **independently confirmed and extended** in the Writer's analyses.

2. **Proteomic Profiling**

    - Detailed mass spectrometry revealed that the clots were composed primarily of **fibrin family proteins and multiple hemoglobin isoforms**.
    - A total of **541 additional proteins**—ordinarily circulating in plasma in low concentrations—were found to be **entangled in the clot structure**.
    - Importantly, the clots exhibited distorted fibrinogen composition, with a non-physiological amino acid chain ratio of 1:3:2, rather than the typical 1:1:1 distribution.

3. **Histological Findings**

    - Microscopic examination confirmed a **fibrinous structure typical of white thrombi**, including the presence of **Lines of Zahn**—proof of **antemortem clot formation**. However, unlike standard white thrombi, which form in **high-pressure arterial flow**, these clots were **found in both arteries and veins**, including low-flow environments. This **defies classical hemodynamic theory**, supporting the conclusion that these clots are **novel pathological entities**. Some slides revealed **abnormal density**, **interwoven protein structures, and evidence of endothelial disruption**—pointing to a **spike protein-mediated systemic**

clotting disorder, rather than incidental postmortem artefact.

Clinical and Public Health Implications

The existence of these spike-associated clots has **immediate and grave implications for global health**. Their presence is now suspected to underlie a growing number of **adverse cardiovascular events**, including:

- Myocardial infarction
- Ischemic stroke
- Deep vein thrombosis
- Pulmonary embolism
- Myocarditis and pericarditis
- Multi-organ ischemia
- Vaccine-Induced Thrombotic Thrombocytopaenia (VITT)

These outcomes mirror the reported rise in **excess mortality** and **may account for a significant proportion of *fatilities***—especially among younger individuals and working-age adults in highly vaccinated populations.

Ongoing Scientific Validation and Publication

This research is now being **independently duplicated in multiple laboratories** across the globe. A **lay-accessible account** of the findings has been authored by British journalist **Charles Harrington** and is being prepared for public release, while the primary scientific data is currently being structured for **peer-reviewed publication**.

Notably, the FDA recently released **internal documentation suggesting that long-term iatrogenic consequences of mRNA vaccination may continue to emerge over the coming 10 to 15 years**—an implicit acknowledgment of risks now increasingly visible. *In their own words:* **"ticking time bombs"**.

A Contribution to the Record

Despite immense institutional resistance—including restrictions on laboratory use, funding obstruction, and the blacklisting of independent researchers—the Writer was able to complete what is now considered **a landmark contribution to post-vaccine biomedical research.**

This work affirms what many clinicians have long suspected: **the spike protein—especially when synthesized by the host—is a uniquely toxic agent**, capable of hijacking normal biological processes and transforming them into mechanisms of harm.

The scientific process, at its best, illuminates what others seek to obscure. Let this contribution be part of that light.

Turbo Cancer

In parallel, the term "turbo cancer" has entered public and professional discourse, **referring to aggressive, fast-growing malignancies presenting in individuals—often under the age of 50—with minimal prior risk factors** and **unusually poor prognoses**. Clinicians have noted cases of rapid tumour progression, multi-organ metastasis, and unexpected treatment resistance occurring within months of initial diagnosis. Anecdotal

reports from oncologists and radiologists across multiple countries point to a disturbing trend: **cancers that would typically evolve over years are now accelerating within weeks to months**.

While legacy public health bodies maintain that cancer incidence trends predate COVID-19 vaccination campaigns, such statements may soon be rendered obsolete by emerging molecular analyses of the spike protein variants encoded by mRNA vaccines. Preliminary biochemical data—currently in pre-publication review—suggest that the **spike protein may contain three domains of particular concern:**

- **A cancer growth promoter, capable of influencing cell cycle regulation and tumour suppressor pathways.**
- **An angiogenesis-stimulating domain, potentially enhancing blood vessel formation that supports tumour expansion.**
- **A bond satisfaction motif, which may facilitate epithelial–mesenchymal transition (EMT)—allowing tumour cells to detach and metastasise rapidly throughout the body.**

These three molecular "smoking guns" represent plausible mechanisms by which repeated spike protein exposure could fuel oncogenic processes—particularly in already vulnerable tissues or genetically predisposed individuals. While causation is not yet proven, the **convergence of clinical signal, molecular mechanism, and temporal correlation demands urgent and independent inquiry.**

To dismiss these concerns as anecdotal or coincidental—without conducting rigorous investigation—*is not scientific caution.* It is *institutional negligence.* If even a fraction of these signals prove valid, the implications for public health are profound.

At a minimum, this landscape warrants:

- **Full biochemical characterisation of intravascular clotting anomalies**
- **Epidemiological tracking of post-vaccination cancer patterns**
- **Transparent release of spike protein structural data used in vaccine formulations**
- **Investigation into whether previously known oncogenic risks were considered during the expedited authorisation process**

As of now, data is in press, and the scientific community awaits further validation. But in **the interim, the precautionary principle compels vigilance—*not silence*.**

Conclusion: A Silence That Cannot Be Sustained

The anomalous clinical signals now emerging—be they in the form of unprecedented clot structures or the alarming acceleration of aggressive cancers—demand far more than passive observation or **administrative deflection**. They ***demand action.*** The consistent appearance of novel thrombotic materials in postmortem analysis, coupled with reports of fast-progressing malignancies in young and otherwise healthy individuals,

represents a **critical inflection point** in post-market safety evaluation.

To characterise these signals as "rare" or "unconfirmed" without subjecting them to rigorous scientific scrutiny is not an act of prudence—it is an *abdication of duty*. The mere possibility that a biological product deployed at population scale could be contributing to systemic oncological or vascular disruption *obliges urgent, independent investigation*—not after consensus has been manufactured, but ***precisely because consensus has fractured***.

The core tenet of public health is **precaution**. When unusual pathology appears with increasing frequency; when frontline professionals raise concern across continents; and when plausible mechanistic pathways are identified—then **silence is no longer cautionary. It is complicity**.

If this pattern is real, then we stand on the threshold of a **secondary public health crisis—not one born of viral contagion, but of *institutional intransigence and epistemic suppression***. And if it is not real, then the only path back to public trust is through transparent, unflinching inquiry. That outcome, too, must be earned—not assumed.

The choice before us is clear: **Investigate, or ignore**. *The former honours the principles of science.* **The latter betrays them**.

In either case, history will remember not only what we discovered—*but how quickly we dared to look*.

8 - Vaccine-Induced Thrombotic Thrombocytopaenia (VITT): A New Iatrogenic Disease

Among the most serious and paradigm-altering iatrogenic conditions to emerge during the global COVID-19 vaccination campaign is *V*accine-*I*nduced *T*hrombotic *T*hrombocytopaenia (VITT)—a rare but often life-threatening disorder (*iatrogenic disease*) **marked by the seemingly contradictory combination of thrombotic events (*clotting*) and thrombocytopaenia (*low platelet count*). Identified in early 2021**, *VITT was rapidly associated with adenoviral vector vaccines, including AstraZeneca's ChAdOx1 nCoV-19 and Johnson & Johnson's Ad26.COV2.S*, and was **characterised by aggressive** and **often fatal clotting in unusual anatomical sites**, such as the *cerebral venous sinuses* and *splanchnic* (abdominal) *veins*. **In numerous cases, the condition resulted in stroke, multi-organ damage, and death—often in young, otherwise healthy recipients**.

The underlying pathology of VITT **closely mimics autoimmune heparin-induced thrombocytopaenia (HIT), despite occurring in individuals with no prior exposure to heparin**. Studies published in *The New England Journal of Medicine*, *Blood*, and *The Lancet Haematology* **confirmed the presence of autoantibodies targeting platelet factor 4 (PF4), which induce widespread platelet activation, immune-mediated inflammation, and disseminated thrombus formation**. This immune reaction

constitutes a novel vaccine-related disorder (***iatrogenic***), *entirely separate from classical clotting syndromes and* ***unaccounted for in traditional vaccine safety modelling***.

While regulatory bodies such as the UK MHRA, European Medicines Agency (EMA), and U.S. Centers for Disease Control and Prevention (CDC) have publicly acknowledged the existence of VITT, **estimates of its incidence remain unreliable**. Official figures suggest rates between 1 in 50,000 and 1 in 100,000 doses, but real-world incidence may be substantially higher due to:

- **Systemic underreporting through passive surveillance systems like VAERS, CARM, and EudraVigilance**
- **Dismissal of early case reports as anecdotal or "coincidental"**
- **Misclassification of VITT as standard thrombotic stroke, DIC, or autoimmune disease in clinical settings**

By mid-2021, multiple nations—including USA, Denmark, Germany, Norway, and Canada—**had suspended or restricted use of adenoviral vector vaccines,** ***particularly in younger age groups***. However, despite mounting clinical concerns, **similar thrombo-inflammatory syndromes reported following mRNA vaccine administration have received *little attentio*n**. These include **microvascular clotting**, **myocarditis-linked thromboembolic events**, and **vasculitic phenomena**—suggesting that ***the phenomenon of vaccine-induced clotting may not be confined to adenovirus platforms***.

VITT represents more than a rare complication. It is a **watershed moment in pharmacovigilance**, compelling a wholesale reassessment of how vaccine safety is evaluated, reported, and acted upon. **Crucially, the** *early warnings about VITT came not from pharmaceutical companies or regulatory agencie*s, but from **frontline clinicians**, **coroners**, and **independent researchers**—many of whom were **ridiculed**, **censored**, or **threatened with professional sanction**.

For affected families, VITT has become not just a medical term, but **a symbol of regulatory failure**—***a stark reminder that speed, secrecy, and political orthodoxy can override both science and ethics***. *Many victims were young, healthy individuals who participated in good faith, trusting that appropriate safety oversight existed*. **That trust was misplaced**.

This syndrome must also be seen in the broader context of the experimental mass deployment of gene-based biologics under Emergency Use Authorisation (EUA). Framed as "vaccines," these agents were released into the population:

- **Without long-term safety data**
- **With incomplete toxicology studies**
- **In the absence of thorough biodistribution profiles**
- **Under the narrative that COVID-19 was the greatest existential health threat in modern history**
- **With blanket dismissal of existing therapeutics—*a claim now widely discredited*. It simply was not**.

The consequence of this posture—one that combined narrative enforcement with institutional silencing—was **a global campaign that actively excluded alternative voices, suppressed early treatment options, and ignored red flags** that would, **under normal scientific standards, *trigger immediate re-evaluation.***

Conclusion: A Reckoning Deferred

VITT is not merely a rare side effect. It is the **canary in the coal mine—a clinically manifest warning of what happens when urgency eclipses evidence**, *and when medical interventions are rolled out faster than the science that must validate them.*

The global rise in excess mortality, unexplained cardiovascular events, long-term immune dysfunction, and iatrogenic injury must be viewed in this light—**not as isolated data points**, but as part of a **systemic failure to safeguard public health from the very policies implemented in its name**.

The question now is not whether mistakes were made.

They were.

The question is: *Will they be acknowledged—and will they be corrected—before more lives are lost?*

Anything less would not be medicine.

It would be malpractice—on a global scale.

9 - The Ivermectin Discourse: Legal and Scientific Perspectives

Ivermectin, traditionally used as an anti-parasitic agent, gained attention during the pandemic as a potential treatment for COVID-19. Early *in vitro* studies suggested antiviral properties, leading to widespread interest. **Subsequent meta-analyses based on 18 randomized controlled treatment trials indicated *significant reductions in mortality***, time to clinical recovery, and time to viral clearance. Furthermore, r**esults from numerous controlled prophylaxis trials reported significantly reduced risks of contracting COVID-19 with the regular use of Ivermectin.**

In response to **public demand** and **emerging studies**, several U.S. states have *enacted legislation to make Ivermectin more accessible*. For instance, **Idaho** and **Arkansas** have *passed laws allowing the sale of Ivermectin for human use without a prescription*. These legislative actions *reflect a shift towards recognizing alternative treatments and granting individuals greater autonomy in their healthcare choices*.

In **India**, Ivermectin was incorporated into COVID-19 treatment protocols in several states. The state of **Uttar Pradesh**, for example, **adopted Ivermectin for both prophylactic and therapeutic use, *reporting beneficial effects in reducing infection rates and mortality*.**

A matched case-control study conducted among healthcare workers in Bhubaneswar, India, found that two-dose Ivermectin prophylaxis at a dose of 300 μg/kg with a gap of 72 hours was associated with a 73% reduction in SARS-CoV-2 infection among healthcare workers for the following month. However, it's important to note that subsequent evaluations by Indian health authorities led to the removal of Ivermectin from national treatment guidelines in January 2023, citing insufficient evidence of efficacy. **This is widely understood to a political response due to increasing pressure from world authorities including the WHO.**

Major health organizations, including the U.S. Food and Drug Administration (FDA), have stated that there is insufficient evidence to support the use of Ivermectin for COVID-19 treatment. The FDA has not authorized or approved Ivermectin for use in preventing or treating COVID-19 in humans or animals. **The U.S. Food and Drug Administration concluded that the available clinical trial data did not demonstrate Ivermectin's efficacy in treating COVID-19 in humans.** ***Why?***

However, *this position appears to have been adopted in the absence of a comprehensive evaluation of real-world evidence and emerging international studies*. The consistency and timing of such regulatory statements suggest that *institutional bias—potentially influenced by* ***commercial alignments*** *and* ***patent-driven incentives****—may have* ***played a decisive role****. This raises serious concerns about whether public health guidance was shaped*

more by economic and political considerations than by an impartial assessment of therapeutic potential.

Conclusion

The global narrative surrounding COVID-19 vaccination has undergone a profound transformation — from **early optimism and mass mobilization** to **rising scrutiny, scientific reassessment, and legislative backlash**. While initial policy responses were driven by urgency and the promise of novel biomedical technologies, hindsight has introduced new dimensions of complexity: ethical tensions, legal challenges, and **continually accumulating evidence of harm**.

Emerging scientific analyses, such as those led by physicist and epidemiologist **Dr. Denis Rancourt, estimate that the global death toll from vaccine-related adverse events may now approach 30 million people** — *a figure derived from analyses of* ***excess mortality temporally aligned with vaccination rollouts, independent of COVID-19 infection rates.*** Such findings challenge the prevailing public health narrative and demand rigorous investigation. This figure, though controversial and not widely accepted by mainstream bodies, is grounded in excess mortality analysis and deserves independent scientific review. *The scale of these claims, if further substantiated, would represent one of the* ***most significant public health misadventures in history.***

Simultaneously, alternative therapies once ridiculed or censored — such as Ivermectin — are being reconsidered in both clinical and policy circles. **Success stories from states like Uttar Pradesh**

in India, where Ivermectin was integrated into early intervention protocols with notable reductions in hospitalizations and deaths, *stand in stark contrast to the centralised suppression of treatment options observed elsewhere.* The recent legalisation of over-the-counter Ivermectin sales in parts of the United States marks **a tectonic shift in regulatory tone and underscores the growing emphasis on therapeutic pluralism and patient sovereignt**y.

What began as a **Legislative changes in numerous U.S. states — banning vaccine mandates for workers and students, and even restricting the deployment of mRNA technology itself — reflect a broader cultural reckoning with the coercive public health strategies of the past three years. Many nations are now openly debating the role of global health institutions, the erosion of informed consent, and the economic and psychological toll of prolonged crisis management.**

What began as a collective effort to contain a novel virus has evolved into a historic test of biomedical ethics, government transparency, and scientific integrity. The continued rise in non-COVID excess mortality, the prevalence of white fibrous clots observed in clinical and postmortem settings, and the emergence of aggressive post-vaccine cancers ("turbo cancer") suggest that **the precautionary principle — once neglected — *must now be reclaimed as a guiding standard*.**

In this shifting landscape, truth-seeking demands not only robust data, but humility, redress, and reform. The voices of those

harmed must be heard. The **scientific questions must remain open**. And the **policymaking processes must move from *command-and-control* to *evidence-informed pluralism*.** Pluralism is the idea that diversity of beliefs, values, groups, and perspectives in a society is not only inevitable—but desirable. It's the opposite of trying to enforce a single way of thinking or being.

Only through such a reckoning can public trust be restored — and the profound lessons of this global episode be translated into a more humane, balanced, and resilient future.

In order to fully understand the gravity of the importance of Ivermectin in the treatment of viruses, a brief summary of the latest scientific mechanisms is presented in the Appendix. **What is clearly apparent is that there is an institutional bias towards denying any alternative treatment of biochemical mechanism that may endanger the predicate that there was "*no alternative treatment*"** (a lie) thus **making the way clear for a ruling of Emergency Use Protocol for the COVID-19 experimental gene therapy approaches, masquerading as vaccines in order to facilitate greater public acceptance.**

The next section will provide a short summary of the potential role of Ivermectin acting as a zinc ionophore, and the importance of this biochemical / physiological mechanism in the fight against COVID-19.

10 - Short Summary: Ivermectin as a Zinc Ionophore

Ivermectin, long recognized as a safe and effective anti-parasitic, has recently attracted scientific and clinical interest for its potential antiviral properties—particularly in the context of SARS-CoV-2, the virus responsible for COVID-19. One of the more intriguing hypotheses under investigation is that **Ivermectin may act as a zinc ionophore—a compound capable of assisting zinc ions in crossing the otherwise impermeable lipid membranes of cells**.

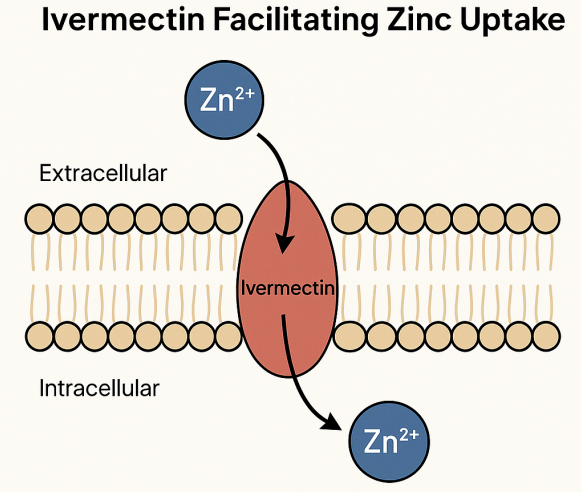
Zinc itself is well-known in virology for its ability to inhibit viral replication. Specifically, **it has been shown to interfere with the activity of RNA-dependent RNA polymerase (RdRp), a critical enzyme used by RNA viruses to reproduce their genetic material.** However, **zinc cannot easily enter cells on its own due to the hydrophobic nature of lipid membranes.** ***This is where ionophores become important.***

An ionophore is a type of molecule that facilitates the movement of ions—like zinc (Zn^{2+})—through the cell membrane, either by forming a complex and physically carrying the ion across (carrier-type) or by creating a hydrophilic channel (channel-forming type). *Without such a transport mechanism, zinc tends to remain extracellular, limiting its potential antiviral action within the cell.*

While not traditionally classified as an ionophore, *Ivermectin has been proposed to exhibit ionophoric behavior in the presence of zinc.* If this is correct, *it could enhance zinc uptake into cells and elevate intracellular zinc levels—thereby amplifying zinc's natural antiviral action against RdRp.* This could *effectively reduce viral replication in the early stages of infection.*

In addition to this proposed ionophoric role, *Ivermectin also displays broad-spectrum antiviral properties, including interference with nuclear import proteins* (e.g., importin α/β1), and *exhibits anti-inflammatory effects that may be beneficial in mitigating the cytokine storm associated with severe COVID-19.* These combined actions provide a biologically plausible rationale for continued exploration of Ivermectin, particularly as an early intervention agent or as part of a multi-drug protocol.

While more high-quality clinical data is needed to confirm these mechanisms and their practical relevance in treating COVID-19, the **concept of repurposing existing drugs like Ivermectin for their ionophoric and synergistic potential remains a promising area of research.**



11 - Grounds for Public Inquiry into Therapeutic Suppression - Evidence of Coordinated Obstruction

Given the well-documented biochemical and physiological mechanisms by which Ivermectin may exert antiviral effects—particularly through its role as a zinc ionophore, alongside its anti-inflammatory, immunomodulatory, and nuclear transport inhibition properties—**the level of institutional resistance to its evaluation and use demands serious scrutiny**.

From early 2020, a mounting body of preclinical and clinical data suggested that **Ivermectin, an off-patent medicine with an extensive safety record, could play a meaningful role in early intervention against SARS-CoV-2 infection**. **Meta-analyses of dozens of studies—compiled by independent researchers and international collaborations—demonstrated promising results in both prophylaxis and treatment.** Its low cost, widespread availability, and known pharmacodynamics made it a logical candidate for repurposing in a global emergency. **Yet instead of encouraging scientific exploration, the response from public health institutions was marked by systematic dismissal, reputational attacks, and regulatory obstruction.**

Medical journals declined to publish supportive studies. Research funding was withheld. **Social media platforms censored discussion**. In some jurisdictions, including **New Zealand**, *doctors faced investigation, suspension, or deregistration*

for prescribing Ivermectin or even publicly advocating for its study. The stated justification—**lack of robust evidence**—was **deployed selectively**, often **while simultaneously blocking the very research needed to produce that evidence**, or **allowing only trials designed to fail**, such as *late-stage administration* or s*ub-therapeutic dosing*.

This pattern did not occur in isolation. It occurred in **parallel across multiple jurisdictions**, **synchronised in timing and messaging**. Regulatory bodies including the FDA, EMA, TGA, and Medsafe adopted near-identical stances. **Professional medical colleges issued uniform statements discouraging off-label use.** Media narratives **evolved rapidly from cautious scepticism** to **outright vilification of any deviation from the vaccine-only strategy**.

The result was **a coordinated narrowing of therapeutic discourse—one that eclipsed evidence-based medicine in favour of policy orthodoxy**. This alignment of government agencies, professional institutions, and corporate stakeholders raises serious questions about the influence of commercial interests, particularly those connected to patented pharmaceutical products, vaccine procurement contracts, and global funding frameworks. **The convergence of this institutional bias with commercial alignment shaped not only public perception, but also clinical options, regulatory priorities, and ultimately, patient outcomes.**

In **New Zealand**, the government not only followed this international pattern but embedded it in formal policy. The

exclusion of early treatment options, the centralisation of health messaging, and the delegitimisation of medical dissent represent a profound departure from the principles of transparency, open scientific inquiry, and patient-centred care. By actively suppressing viable therapeutic alternatives, **New Zealand** *authorities aligned themselves with a global strategy that prioritised uniformity over adaptability, and compliance over* ***critical evaluation***.

This is not a minor deviation. It is a **systemic failure of public health governance—a failure that obstructed informed consent, distorted the risk-benefit calculus, and *may have cost lives unnecessarily*. If even one effective early treatment was withheld due to institutional interference, the ethical breach is profound. If dozens were ignored or actively suppressed, the breach becomes a matter of international significance.**

The precedent is not without comparison. **History offers examples**—from the **suppression of early AIDS treatments in the 1980s** to the **delayed recognition of thalidomide toxicity**—of how ***institutional inertia and commercial interests can derail scientific integrity***. But what distinguishes this case is the global scale, the **speed of synchronisation**, and the **deliberate erosion of therapeutic plurality** during a declared state of emergency.

The time has come for a full and independent public inquiry into the suppression of early treatment protocols, including:

- **The rationale behind Ivermectin's exclusion from national pandemic strategies**

- **The funding sources and policy influences shaping institutional positions**
- **The communications between public agencies and pharmaceutical corporations**
- **The decision-making processes within regulatory bodies that delayed or obstructed alternative treatment trials**

This is not an attack on science—*it is a defence of it.* Because science that cannot tolerate questioning is not science at all. It is ***dogma in a lab coat***.

New Zealand, as a participant in this coordinated suppression, must confront its role honestly and transparently. Nothing less than the integrity of future public health responses depends on it.

Conclusion: Truth Denied Is Trust Destroyed

The coordinated suppression of early therapeutic options—particularly Ivermectin—was not simply a failure of policy. It was a ***global exercise in narrative control*, enforced at the expense of scientific objectivity, clinical independence, and *human life*. What might have been an open and pluralistic response to a novel pathogen became, instead, a closed-loop system of ideological enforcement, in which dissent was not debated but *silenced*.**

This was not the natural product of scientific consensus. It was a **manufactured alignment of institutions, regulators, media platforms,** and **corporate interests,** all *converging on a single outcome*: **the exclusion of repurposed therapeutics to preserve**

the dominance of a vaccine-only strategy. The cost of that alignment has been profound—measured not only in missed opportunities, but in lives lost, trust broken, and freedoms curtailed.

New Zealand, like many nations, must now reckon with its part in this global suppression. To pretend this was simply "**following the science**" is to **misrepresent what science is: a process of contest, refinement, and constant challenge—*not an edict from the top*.**

If governments can sideline therapeutic options without scrutiny, silence physicians without recourse, and shape public health policy in concert with commercial interest—then what we face is not a temporary lapse, but a *systemic vulnerability that will repeat itself in future crises unless meaningfully addressed*.

The only remedy is sunlight: full transparency, independent investigation, and a public accounting of the decisions made, the data suppressed, and the voices ignored.

Because in the end, it is not merely a question of what treatments were withheld. It is a question of **what kind of society we wish to live in**—*one that defends the right to question*, or ***one that punishes the impulse to ask***.

We must choose now.

And we must do so while there is still time to repair what has been broken.

12 - Excess Mortality and Temporal Associations

Beyond debates around transmission, mechanism of action, and regulatory oversight lies one of the starkest and least adequately explained phenomena of the pandemic era: **the global rise in excess mortality, beginning in 2021 and persisting well into 2025.** These patterns of increased deaths—defined as the number of deaths above the expected historical baseline—have been observed across dozens of countries, irrespective of lockdown stringency, healthcare capacity, or case fatality rate. They demand scrutiny.

In New Zealand, **where COVID-19 deaths were minimal in 2020 and much of 2021, the total mortality rate began climbing significantly only after the commencement of mass mRNA vaccination.** According to data from Stats NZ and corroborated by actuarial reviews, **2022 witnessed one of the highest annual death counts in recent history**—*despite an ostensibly well-managed pandemic and high compliance with pharmaceutical interventions.* **Similar patterns were observed in Germany, the USA, UK, Australia, Canada, and many other countries.**

Importantly, this surge in excess deaths did not coincide with major COVID-19 outbreaks, nor could it be attributed to viral variants alone. In fact, **the temporal alignment between booster campaigns and subsequent waves of non-COVID excess mortality—including cardiac events, strokes, neurological**

syndromes, and sudden deaths among the working-age population—*has led many researchers to re-examine causality*.

A report by former Blackrock analyst **Edward Dowd**, drawing on U.S. insurance and disability claims data, **indicated a sharp rise in all-cause mortality and long-term disability filings among younger, working-age adults beginning in the third quarter 2021. This demographic had previously shown the lowest COVID-19 mortality risk, yet now reflected the highest post-vaccine excess death signal**. Likewise, **peer-reviewed studies** from countries such as **Germany** and the **Netherlands found statistically significant correlations between vaccine uptake and non-COVID mortality trends**.

While causation cannot be inferred from correlation alone, **the absence of transparent investigation into these patterns is conspicuous**. **Regulators have largely failed to disaggregate excess deaths by vaccination status, comorbidities, or post-injection interval**—data that could clarify whether these trends are biologically plausible or simply coincidental. **This lack of inquiry stands in sharp contrast to the urgency and scrutiny applied to COVID-19 case counts in 2020.**

To date, **no national agency has presented a thorough breakdown of cause-specific excess mortality with respect to vaccine exposure.** This omission, whether bureaucratic or intentional, *contributes to declining public trust and violates the principles of post-market surveillance and pharmacovigilance*.

Conclusion: The Statistic That Cannot Be Buried

Excess mortality is not a theory. It is a number—a cold, immutable figure that tells the part of the story too often ignored. When more people are dying than historical baselines predict, and no adequate explanation is offered, **it is not merely a public health mystery—*it is a moral emergency*.**

The consistent temporal alignment between vaccine rollout, particularly booster campaigns, and rising non-COVID deaths across multiple nations—among demographics least at risk from the virus itself—**demands urgent, transparent, and independent investigation**. *That such inquiry has not yet been undertaken is not a reflection of uncertainty*. It is a **symptom of institutional paralysis**, or worse, ***deliberate evasion***.

No responsible public health authority can claim to operate in the interest of the population while refusing to disaggregate mortality data by vaccination status, co-morbid risk, and temporal proximity to pharmaceutical exposure.

The failure to publish such analyses undermines the core tenets of pharmacovigilance, post-market surveillance, and public accountability.

If such patterns were observed following the introduction of any other medical product—let alone one administered to billions under emergency authorisation—they would trigger immediate suspension, investigation, and systemic review. **That no such measures have occurred in the case of mRNA vaccines speaks**

volumes—not about the safety of the products, but about the **frag*ility of the institutions tasked with protecting us*.**

Public trust, once fractured, is not easily restored.

It cannot be rebuilt with reassurances, slogans, or silence.

It must be earned back with evidence—delivered not when it is convenient, *but when it is hardest to provide*.

The longer this excess mortality remains unexamined, the more it begins to resemble something worse than negligence.

It begins to look like complicity.

It is time to ask the hard questions—and demand the data that answers them.

Because in the arithmetic of public health, every unexplained death is not just a statistic.

It is a story that someone failed to tell.

13 - Informed Consent and the Ethical Void in Public Health Messaging

At the heart of all ethical medical practice lies a fundamental principle: *informed consent.* This is not a procedural formality, but a *legal and moral cornerstone requiring that individuals be provided with accurate, balanced, and complete information about the risks, benefits, uncertainties, and alternatives before making a health decision.*

During the global COVID-19 vaccine rollout, this principle was not merely compromised—it was *systemically replaced with a model of coercive compliance masquerading as public health communication.*

Patients were routinely told that the **vaccines were "safe and effective,"** *a phrase repeated across official channels, advertising campaigns, and media outlets with religious uniformity.* Yet this statement, at best, referred to short-term, trial-based relative risk reductions, not absolute outcomes or long-term safety profiles. **Few recipients were told that:**

- **The mRNA products were *still in Phase III trials* at the time of rollout, with *estimated completion dates stretching into 2023 and beyond.***
- ***The vaccines did not prevent transmission*, a fact confirmed later by public admissions from Pfizer representatives during EU hearings. ·**

- ✦ **Adverse events, including myocarditis, pericarditis, and thrombosis, were actively under investigation but had not yet been fully characterized.**

Furthermore, **the legal requirement that informed consent be "*free of coercion*"** was ***systematically violated***. **Governments, including New Zealand's, used mandates, employment threats, travel restrictions, and access denial to essential services to pressure 29 of 42 individuals into receiving a medical product. Informed choice was nullified not by medical necessity, *but by administrative decree*.**

Ethical bodies such as the Nuremberg Code and UNESCO's Declaration on Bioethics and Human Rights stipulate that *individuals must not be subjected to medical interventions without free and informed consent, particularly when the intervention is experimental*.

Despite this, public health authorities encouraged, and in some cases compelled, uptake through a combination of fear, incentive, and censorship.

Clinicians who sought to disclose emerging risks, or to advise patients based on personal medical history, were investigated, suspended, or *deregistered*.

The failure to uphold informed consent has created a *crisis of legitimacy*.

In *place of trust*, there is now *growing scepticism*. In place of *autonomy*, a sense of *betrayal*.

Restoring ethical medicine requires not only public accountability, but *a reassertion of the foundational truth that consent is a process, not a checkbox.*

Conclusion: Consent Without Truth Is No Consent at All

The erosion of informed consent during the COVID-19 vaccine rollout represents not just a failure of communication, but a collapse of the most sacred principle in medical ethics: *the right of individuals to make autonomous decisions about their own bodies, free from coercion and armed with the truth.*

What took its place was not public health—*it was policy by persuasion, enforcement by omission, and compliance by design.* The phrase "safe and effective" became a shield against inquiry, a substitute for evidence, and a weapon against dissent. Informed dialogue was replaced by slogans. *Individual medical judgment was overridden by political expediency.*

The result is a wound that reaches beyond the clinical and into the moral. It is a wound borne by patients who were misled, by doctors who were silenced, and by democratic societies that watched the cornerstone of ethical medicine reduced to a checkbox on a form, *ticked under duress.*

International codes—from the **Nuremberg Code** to **UNESCO's Declaration on Bioethics and Human Rights**—do not describe informed consent as optional, conditional, or situational. They **describe it as *INVIOLABLE***. *A non-negotiable precondition for any*

medical intervention, especially one conducted at scale and under experimental authorisation.

That this principle was discarded at the very moment it was most needed is not an accident of crisis—*it is a consequence of design*. And it must be accounted for with the same urgency that once accompanied the rollout itself.

Public trust is not restored by repeating assurances. It is restored by admitting when consent was never truly sought—and by ensuring it can never again be so easily taken.

For where consent is abandoned, medicine ceases to be a practice of healing.

IT BECOMES A SYSTEM OF CONTROL.

And that, history has shown, is the beginning of something far darker than disease.

It is the death of freedom disguised as care.

The weaponisation of medicine.

A system where obedience is health, and dissent is pathology.

Disease touches the body, but coercion poisons the soul.
Where the needle becomes a command,
healing dies at the end of it.

14 - Global Health Governance and Pandemic Power Structures

While scientific evidence and public health ethics provide the foundations for pandemic policy, **the final implementation of global vaccination strategies was equally shaped by political economy**—namely, *the complex interplay of pharmaceutical influence, multilateral power blocs, indemnity contracts, and public-private partnerships.* **Understanding these forces is essential not only to contextualise past decisions but to forecast future risks should the current model remain unchallenged.**

At the centre of this global response architecture stood entities such as the World Health Organization (WHO), Gavi, the Vaccine Alliance, CEPI (Coalition for Epidemic Preparedness Innovations), and the Bill & Melinda Gates Foundation—all of which collaborated to initiate the Access to COVID-19 Tools Accelerator (ACT-A) and COVAX Facility.

While these organizations promoted equitable vaccine access, **their decision-making was neither transparent nor democratically accountable**. In many cases, **national governments ceded sovereignty over procurement, distribution, and even messaging**, *aligning their domestic responses with global coordination plans forged by private or semi-private institutions.*

This governance model was further complicated by contractual indemnity agreements between pharmaceutical companies and national governments. In order to secure early access to vaccines, countries—including New Zealand—**were required to sign confidential contracts that granted manufacturers legal immunity from liability for adverse events. Pfizer's agreement with the European Commission, for example, included clauses that exempted the company from post-market damages unless gross negligence could be proven—a near-impossible bar under current pharmacovigilance standards. Similar contracts were signed globally, *many of which remain redacted and shielded from public scrutiny*.**

These indemnity frameworks created a perverse incentive structure: *rapid mass deployment was prioritised over safety monitoring, while governments were discouraged from acknowledging or compensating for vaccine injuries that could be construed as admissions of liability.*

The WHO's own Emergency Use Listing process, expedited under pandemic conditions, allowed for global rollout before full trial data were available. *This approach may have been justified in the acute crisis phase, but was then retained long past the point where more rigorous review was warranted.*

Compounding the problem, major vaccine stakeholders—including **Pfizer and Moderna—reported record-breaking profits**, *while simultaneously maintaining control over the intellectual property (IP) rights and distribution channels of what were*

described as "**public health goods**". **Pfizer's 2021 revenue** from its COVID-19 vaccine **exceeded $36 billion USD**, making it *the single most lucrative medical product in history*. Despite this, efforts to waive patent protections for low-income countries were largely blocked at the World Trade Organization (WTO), with support from the same entities championing global vaccine equity.

This global governance structure—characterised by consolidated authority, limited accountability, and commercial entanglement—now serves as the *de facto* blueprint for future emergency responses. Proposals for a WHO global pandemic treaty, currently under negotiation, would formalise this model, granting expanded powers to declare health emergencies, recommend counter-measures, and coordinate supply chains, potentially overriding national constitutional protections in the process. If left unexamined, these evolving power structures pose a profound risk to medical ethics, national sovereignty, and civil liberties. *A more transparent, pluralistic, and locally accountable model of global health is urgently needed—not only to restore public trust, but to prevent future crises from becoming vehicles for unilateral control in the name of emergency response.*

Conclusion: Power Without Accountability Is a Prescription for Harm

What emerged during the COVID-19 pandemic was not merely a global health response—it was a reconfiguration of public authority, in which private interest, opaque governance, and

supranational influence replaced democratic oversight and national autonomy. *The institutions that shaped the pandemic narrative and directed its countermeasures operated beyond the reach of electoral scrutiny, legal liability, or transparent review.*

Under the guise of emergency response, sovereign governments entered into secret contracts, *shielded corporate entities from accountability*, and *implemented public health mandates directed more by centralised coordination than by local clinical judgment or population-specific needs*.

The architecture of global health governance—anchored in partnerships between the WHO, multilateral funding bodies, and private philanthropies—became a mechanism of compliance, *not collaboration*.

That such arrangements were sustained even after the acute phase of the crisis had passed reveals not a failure of foresight, *but a deliberate institutional drift toward unaccountable control*. Proposals to formalise this model through instruments like the WHO pandemic treaty risk codifying this drift into law, embedding emergency powers as permanent fixtures of global governance, insulated from the democratic checks that define free societies.

If the response to the next declared emergency is to be more ethical, more accountable, and more respectful of individual rights, then the current pandemic power structure must be interrogated—not enshrined. Public health cannot be used as a

backdoor for geopolitical leverage or corporate consolidation. It must return to its roots: local, transparent, and accountable to those it claims to serve.

Global coordination is not inherently harmful—but when it **operates without consent**, **without redress**, and **without restraint**, ***it becomes indistinguishable from authoritarianism***.

The people of every nation have the right to know who governs their health—and under what authority.

That clarity does not exist today. And until it does, no global health agenda should be allowed to override the constitutional protections and ethical foundations that have guided medicine for generations.

This is not a rejection of preparedness.

It is a demand for proportionality, sovereignty, and truth.

Epilogue

In science, as in society, moments arise when our frameworks must be revised—not because they were maliciously wrong, but because new knowledge demands it. This report does not claim finality; *it claims fidelity—to the evidence, to the process of inquiry, and to the lives impacted along the way*.

The events examined here do not reside solely in the past. They continue to shape present realities: in the quiet persistence of excess deaths, in the emergence of unexplained medical phenomena, in the stories of people left behind by the systems they once trusted. If there is discomfort in this accounting, it is because we are still living its consequences.

History will one day place the COVID-19 response in context. But before that can happen, we must be willing to see clearly—through the fog of slogans, beyond the shield of emergency declarations, past the **bureaucratic obfuscation that has too often replaced scientific transparency**.

The questions raised here—about classification, consent, safety, governance—are not academic abstractions. They are questions of duty. Of accountability. Of care.

No public health policy can justify the suppression of honest discourse. No emergency can excuse the erosion of ethical foundations. ***And no institution should be allowed to declare an end to a conversation still unfolding in hospital rooms, courtrooms, and kitchen tables around the world.***

This submission is not offered in judgment, but in service—to the record, to future inquiry, and to the principle that science must always remain open to revision, and society open to redress.

Let this be a contribution to that work…

Bruce

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Appendix

Ivermectin and COVID-19: Mechanisms of Action and the Role of Zinc Ionophores

The global response to COVID-19 has placed intense scrutiny on both novel and repurposed therapeutic agents. Among the most controversial is Ivermectin, a well-established anti-parasitic drug that has been the subject of significant debate regarding its potential efficacy in treating SARS-CoV-2, the virus responsible for COVID-19. While regulatory agencies such as the U.S. Food and Drug Administration (FDA) have stated that current clinical trial data do not demonstrate sufficient efficacy, emerging research has continued to explore plausible biochemical mechanisms that may justify further investigation.

One of the most compelling hypotheses involves Ivermectin's ionophoric properties, particularly its potential to facilitate intracellular transport of zinc ions, which are known to interfere with viral replication.

1. What Is a Zinc Ionophore?

An ionophore is a molecule that facilitates the transport of specific ions across lipid membranes—structures that are typically impermeable to charged particles like metal ions. In the context of human cells, **zinc ionophores help shuttle zinc ions (Zn^{2+}) from the extracellular space into the cytoplasm**, where they can exert various biochemical effects.

Zinc is a vital trace element with multiple roles in immunity, inflammation, and cellular signaling, and has been shown to **inhibit coronavirus replication via RNA polymerase suppression** *(te Velthuis et al., 2010*). It also has antiviral properties, particularly by inhibiting RNA-dependent RNA polymerase (RdRp)—an *enzyme critical to the replication of many RNA viruses*, including SARS-CoV-2.

However, simply increasing dietary zinc intake does not necessarily raise intracellular zinc levels due to poor cellular uptake. Therefore, zinc ionophores are crucial in "flooding" the intracellular environment with zinc where it can exert antiviral effects.

2. Zinc's Role in Inhibiting SARS-CoV-2

Zinc has long been recognized for its antiviral properties. *In vitro* studies, including those from the early 2000s during the SARS-CoV-1 outbreak, demonstrated that elevated intracellular zinc concentrations can inhibit viral polymerase activity, effectively shutting down the virus's ability to replicate its RNA genome.

In the case of SARS-CoV-2, it is believed that similar mechanisms apply. **Zinc may interfere with:**

- RNA synthesis via inhibition of RdRp
- Viral protease activity
- Membrane fusion and entry

- Modulation of the host immune response, including reducing the severity of cytokine-mediated inflammation

Thus, **increasing intracellular zinc has been proposed as a broad-spectrum antiviral strategy**.

3. Ivermectin as a Zinc Ionophore

While compounds such as quercetin and epigallocatechin gallate (EGCG) are well-documented natural zinc ionophores *(Xue et al., 2014*), there is growing interest in I*vermectin's potential to act in a similar manner* (Huffman et al., 2021).

Preclinical data have shown that Ivermectin (*Caly et al., 2020*):

- **Disrupts importin α/β1-mediated nuclear transport, a pathway hijacked by many viruses to suppress host antiviral responses.**
- **May alter membrane potential and facilitate increased permeability to metal ions.**
- **Exhibits synergistic effects when co-administered with zinc, implying a functional role in intracellular zinc delivery or potentiation.**

Although direct evidence confirming Ivermectin's ionophoric action is still emerging, its molecular structure and pharmacodynamics support this possibility. It possesses lipophilic properties and functional groups capable of chelating metal ions—hallmarks of ionophoric behavior.

Further, clinical outcomes in observational studies and early trials show **greater effectiveness when Ivermectin is administered alongside zinc and other supportive micronutrients** (Soto-

Becerra et al., 2020; Bryant et al., 2021), reinforcing the hypothesis of complementary or facilitating roles.

4. Broader Mechanisms of Ivermectin Against SARS-CoV-2

In addition to its possible ionophoric function, Ivermectin has demonstrated several other mechanisms that may be relevant to viral inhibition:

- **Inhibition of viral entry by binding to spike protein or ACE2 receptor interface.**
- **Suppression of NF-ϰB and STAT3 pathways, both involved in cytokine storm and hyper-inflammation (DiNicolantonio et al., 2020).**
- **Immunomodulation, including downregulation of pro-inflammatory cytokines (IL-6, TNF-α).**
- **Antiviral activity against a range of RNA viruses, including dengue, Zika, and influenza, suggesting a non-specific antiviral mechanism.**

These properties make Ivermectin a candidate for further exploration, particularly in early-stage infection or as part of combination therapy.

5. Controversy and Current Status

Despite a strong mechanistic basis and positive signals from several small clinical trials (*Bryant et al., 2021*), Ivermectin remains controversial. Critics argue that the evidence is inconsistent or of low quality, and that enthusiasm outpaced regulatory caution.

Defenders counter that:

- **Many of the largest trials had confounding variables or were conducted in later-stage disease, where antiviral agents are typically less effective.**
- **Suppression of early treatment options delayed investigation into low-cost repurposed therapies.**
- **Zinc was not included in many negative studies, possibly masking the ionophore-dependent efficacy.**

As of 2025, the tide may be shifting. New molecular studies, including those examining spike protein behavior and zinc flux modulation, are renewing interest in Ivermectin's biochemical potential.

6. Conclusion

Ivermectin's potential as a COVID-19 treatment rests on a *constellation of plausible mechanisms*. Among the most significant is its role as a zinc ionophore—**a property that may enhance intracellular zinc concentrations and disrupt viral replication.** Combined with its anti-inflammatory, antiviral, and immune-modulating properties, Ivermectin warrants renewed scientific scrutiny, **not as a silver bullet, but as a component of a broader, evidence-based treatment paradigm**.

In the pursuit of pandemic truth, ideological inertia must give way to biochemical evidence. **Only by interrogating such compounds thoroughly—and without institutional prejudice—can we arrive at treatments that are not only effective, but accessible to all** (Lawrie, 2021).

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Prepared for review by Public Health Oversight Bodies, Legal Commissions, and Parliamentary Investigative Panels. Prepared in the public interest by a concerned independent analyst and citizen contributor, 1 April 2025.

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