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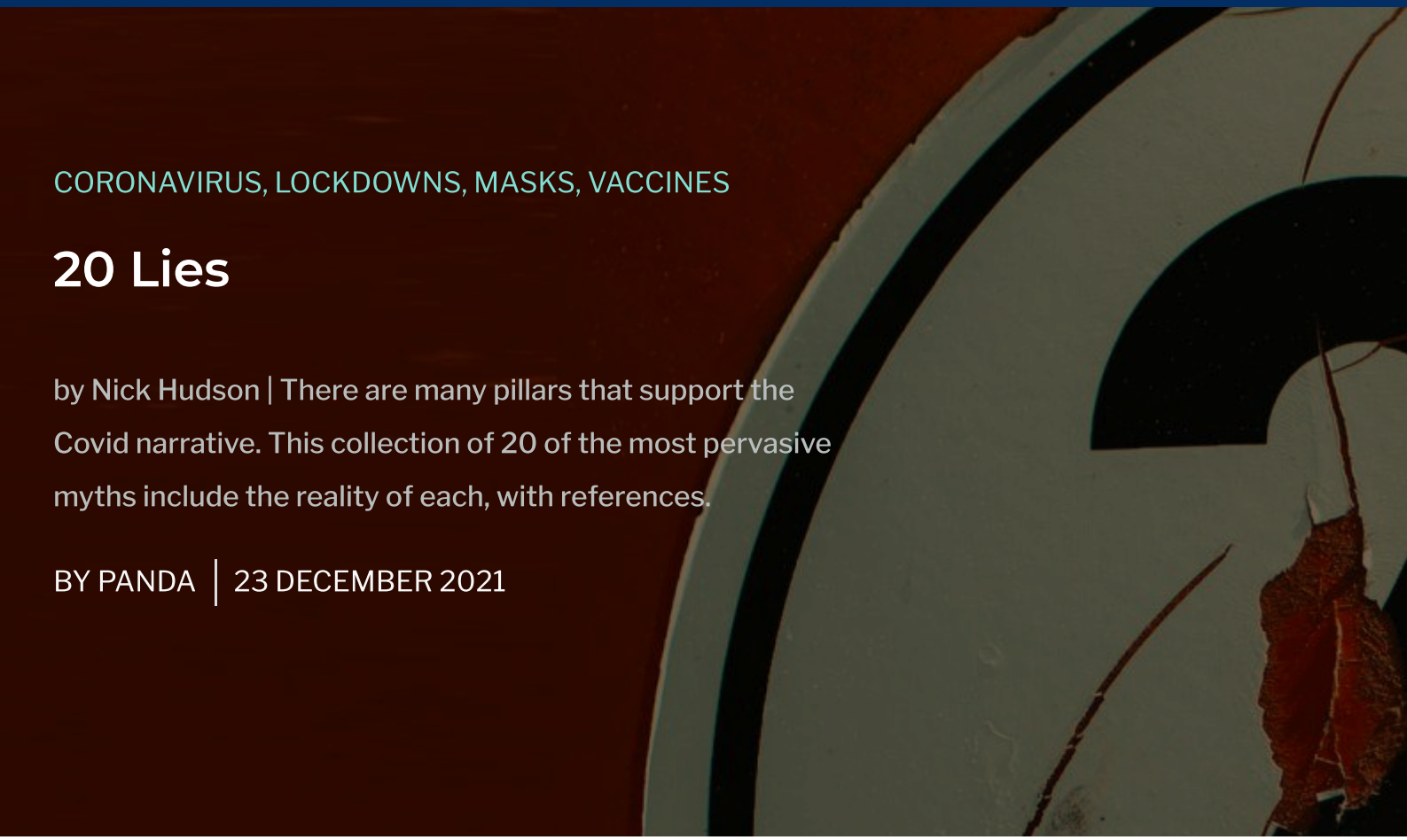

CORONAVIRUS, LOCKDOWNS, MASKS, VACCINES

20 Lies

by Nick Hudson | There are many pillars that support the Covid narrative. This collection of 20 of the most pervasive myths include the reality of each, with references.

BY PANDA | 23 DECEMBER 2021

by Nick Hudson

Myth #1:
The virus is new.

Reality: The virus is closely related to widely circulating betacoronaviruses, sharing 65-70% common genetic material.

Myth #2:
Everyone is susceptible (immunologically naive).

Reality: Pre-existing or cross-immunity is widespread, and moreover children almost universally enjoy robust innate immunity.

of the population the IFR is less than 0.01%, meaning that for most people risk is negligible.

Myth #4:
Lockdowns are effective at reducing deaths.

Reality: More than 50 studies have shown that lockdowns have no material beneficial effect on Covid mortality, and that they worsen overall mortality outcomes when non-Covid collateral harms are factored in. Lockdown had no place in prior public health or pandemic respiratory virus guidelines, existing as a fringe idea among people who advocated militarized approaches to pandemics that completely contradicted public health and epidemiological practice and theory.

Myth #5:
Cloth mask mandates are effective.

Reality: The most comprehensive study to date, by the European CDC, demonstrated that almost all papers supporting cloth mask use were of low evidentiary value, and most exhibited signs of bias. The WHO admitted that its reversal on mask efficacy was politically motivated. There is no sign in the international epidemic data of mask efficacy. Behavioural science teams have been revealed to have deployed masks as a tool of psychological warfare (to increase compliance with public health measures). Masking as source control is inconsistent with aerosol transmission.

Myth #6:
Transmission is by droplets and fomites, so masks, sanitizing, stickers, social distancing and perspex screens are effective.

Reality: The most comprehensive study to date, by the Oxford Centre for Evidence-Based Medicine, found no evidence supporting droplet and fomite transmission. Airborne aerosol transmission has the most evidentiary support, as for other respiratory viruses. Almost all the countermeasures deployed at great cost have no basis in science.

Myth #7:
Asymptomatic transmission is a driver of the epidemic.

Reality: Primary evidence suggests the opposite is the case—that asymptomatic infected people share small innocula, acting beneficially to spread and boost immune recognition.

death.

Reality: PCR testing is not competent for diagnosis of COVID, or detection of "cases", infections or infectedness. In particular, when deployed at high "cycle thresholds", it is prone to generating epidemiological false positives, with severe economic consequences.

Myth #9:
COVID is untreatable. Nothing can be done until a patient arrives at hospital, at which point they should be ventilated and put on Remdesivir.

Reality: Early intervention in the 6-8 day window when the disease enters its inflammatory phase has been shown to be remarkably effective, drastically reducing deaths. Remdesivir and early ventilation have killed many. Off-label drugs have shown efficacy in many studies, yet are the targets of obvious propaganda by pharmaceutical companies and captured media.

Myth #10:
The vaccines materially prevent transmission.

Reality: By their very mechanism of action, injectable vaccines cannot and do not materially prevent transmission. This is not even a claim made by their manufacturers, but by politicians and conflicted scientists. There is no evidence for transmission reduction in the international epidemic data. The "greater good" argument is wrong.

Myth #11:
The vaccines are about 95% effective.

Reality: Manipulation of the trials to hide pronounced initial negative efficacy owing to immunosuppression has been ubiquitous. Actual efficacy is lower than indicated, and apparently also negative after 20 weeks or so. "Real world studies" double up this error by treating the recently vaccinated as unvaccinated, a move that represents nothing less than a gross scientific fraud.

Myth #12:
The vaccines are so safe that nobody should hesitate to take

difficult to tell how big this group is.

Myth #13:
Everybody will benefit from vaccination.

Reality: The current vaccines may pass the hurdle for net benefit for the vulnerable, non-recovered minority. The majority of the population, including the young and the recovered, suffer net harms from vaccination.

Myth #14:
Natural immunity is less broad, durable and strong than synthetic immunity.

Reality: By its very mechanisms of action, synthetic immunity is much narrower than natural. Natural immunity confers medium-term sterilizing immunity, while synthetic immunity cannot. By invoking a greater range of immune response, natural immunity can be assumed to provide more durable and flexible (against variants) protection than synthetic.

Myth #15:
Science is an institution and its authorities' perspectives are infallible and final.

Reality: Science is a process that only proceeds by robust conjecture and criticism.

Myth #16:
Long COVID is an unusual and dangerous component of the epidemic.

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Reality: Sequelae appear to be no more common for COVID than for other respiratory viruses. Where Long COVID clinics have been established, they have quietly been closed, unutilized.

"Pandemicity". Pandemics are going to occur more often because there is more contact between humans and animals and because humans are more connected.

Reality: Urbanisation and commercial farming practices have reduced human-animal contact. Interconnectedness of humans means that many mild viruses are distributed worldwide, ensuring that immune systems recognize more deadly variants that may emerge. Contrast this with the fate of the indigenous peoples of South America when they were first exposed to European diseases.

Myth #19:
Reducing spread reduces deaths.

Reality: Reducing spread by restricting the mobility of the non-vulnerable shifts disease burden onto the vulnerable, causing more of them to be struck down before endemicity is attained.

Myth #20:
Escalation of perceived threat is in the interests of public health.

Reality: Perceived threat drives hysteria, leading to pronounced and deadly nocebo effects (effects of negative expectations on outcomes, the opposite of placebo effects).

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