Voice for Science and Solidarity

Answers by G. Vanden Bossche to questions asked by the parliamentary commission following the hearing on 'compulsory vaccination' of 26.01.2022

Given that many of the questions asked reveal a misinterpretation of my warning and the scientific evidence - and this despite the many writings and interviews in which I repeatedly explained it - I found it useful to clarify two things beforehand in order to save a lot of time in answering the questions asked....

i) Regarding my opinion on the pernicious effects of current mass vaccination
Again: My enormous concern is for the

1. **large-scale vaccination** of the different strata of the population
2. **during a pandemic**
3. of **more infectious SARS-CoV-2 (SC-2) variants**
4. with C-19 **vaccines that are unable to prevent virus transmission**.

These four conditions are perfectly fulfilled by the current vaccination campaigns and promote the spread (not the emergence!!) of more infectious mutants/variants. Since these thereby begin to dominate (and displace less infectious variants), the infection pressure in the population increases. This leads to more (cases of) disease (cfr. Omicron). Just like overpopulation (overcrowding), a wave of a highly infectious virus will cause the infection rate to rise sharply and, due to the resulting high morbidity rate, exert high immune pressure on the virus (via naturally acquired antibodies that are, however, unable to suppress the virus at high infection rates!) Reducing this infection pressure is possible via (one-time) antiviral chemoprophylaxis. On the contrary, continued vaccination will increase the immune pressure and ensure that the vicious circle of increased infectivity is maintained.

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ii) Regarding the scientific substantiation of my arguments:

It would be nice if, as with Influenza, there were also ready-made studies for SARS-CoV-2 describing how innate and naturally acquired types of immunity to SC-2 complement each other and how vaccine-mediated immunity simply bypasses the effector cells of the innate immune system with recognized efficacy against SC-2. It has been described in the Influenza infection, for example, how the action of innate and naturally acquired antibodies succeed each other and only in this way do these antibodies have a synergistic effect (https://pubmed.ncbi.nlm.nih.gov/11043776/; https://pubmed.ncbi.nlm.nih.gov/15633017/); it is also generally known that the effector function of vaccines is based on cells of the *acquired* and not of the innate immune system.

It would also be nice if studies existed describing exactly how effector cells of the innate immune system (e.g. B1a and NK cells) could be trained through epigenetic changes in the course of an SC-2 pandemic. It is a well known and published fact that innate immunity can indeed be trained by epigenetic changes.

It would be nice to know the molecular biophysical mechanisms of how *acquired* S(pike)-specific antibodies can outcompete *congenital*, polyspecific IgM antibodies, which recognize self-like motifs on the surface of corona viruses, based on a much higher affinity for the antigen. However, this has been described more generally for antigen (Ag)-specific and innate antibodies.

Finally, it would also be nice to have an exact description of how innate antibodies can neutralize SC-2 variants and all corona viruses. This has been described for several Influenza virus variants (with similar self-like N-glycan patterns on the surface).

Literature sources that support the above arguments and put them in a logical context are mentioned mainly in my next contribution (also published on TrialSiteNews; https://trialsitenews.com/):

https://www.voiceforscienceandsolidarity.org/scientific-blog/the-alleged-case-for-experimental-c-19-vaccination-of-children-is-merely-based-on-silo-mentality-and-immunological-ignorance

As with an invention, the trick is to fit these pieces of the puzzle together precisely, relying on publications which - as far as the specific SC-2 case is concerned - are, of course, always behind the facts. When the pieces of the puzzle fit, the hypothesis is tested against reality to see if it can explain the evolution of the pandemic - despite human intervention - where conventional epidemiologists and virologists fail to do so despite all possible models. The strength of the hypothesis therefore lies not in the separately published pieces of the puzzle but in the reliability of the entire puzzle with respect to the predicted evolutionary behaviour of the pandemic. I have always said that mass vaccination would lead to a succession of dominantly circulating, more infectious SC-2 variants. That prediction has come true. I also predicted that this would eventually lead to resistance from the virus to neutralizing anti-S antibodies. That prediction has also come true. Finally, I also predicted that further mass vaccination (i.e. now shortly with anti-Omicron vaccines) would lead to an even greater increase in infection, illness, and mortality in the vaccinated population. I hope that this prediction does not come true, but it is what I infer from my scientific understanding of how mass vaccination affects the evolution of the virus and the adaptive response of the immune system.

Am I a doomsayer? Anything but; however, I am often mindful of a maxim of Sherlock Holmes:

'How often have I said to you that when you have eliminated the impossible, whatever remains, however improbable, must be the truth?'

Kathleen Depoorter *(N-VA):*

I will have some general questions for both speakers later, but for now I turn to Mr. Vanden Bossche. You began by saying that you have no conflict of interest. Then, you made a certain clarification. I would have liked to come back on this. I read in the press that you are developing a vaccine yourself, based on T-cells. Is that correct? Is your statement that there would be no conflict of interest still correct in that case? Also, since you are a consultant, I find it hard to imagine that you are completely unaffiliated. A clarification of this would be an important annotation in my opinion.

As you probably know, the official press only gossips about me. First of all, my concept is not about T cells but about N(atural) K(iller) cells. Despite frantic attempts by fact checkers, there is no patent on this concept and I have no infrastructure or any contract with possible financial sponsors or companies that could possibly help with the further development of this, in my opinion, promising concept. Several major players in the vaccine industry are aware of my concept and the data generated *in vitro*. In the meantime, this research has also been completely halted since the beginning of the Corona crisis. Moreover, the question must also be asked which vaccine producer would be interested at all in a universal vaccine that could offer protection against numerous different pathogenic agents with a single administration. Perhaps just a little more thorough homework is needed to examine how there could even be a hint of a conflict of interest in such a context. In fact, I have already publicly stated on several occasions that, in the unlikely event that there is an interest in developing a vaccine based on this concept, I will make available all my knowledge about this vaccine approach without the intention of earning a single euro cent or dollar from royalties or the commercialization of possible intellectual property rights. We apparently live in times where true philanthropy and integrity only seem 'suspect'. Given that the tax collector in this country apparently intends, at all costs, to impose vaccination on the population, it would perhaps be more useful to conduct an investigation into the possible conflicts of interest of a number of promoters of this mass vaccination who are paid for precisely with these taxpayer dollars. It is also clear that a not insignificant part of the income that some of these institutes pocket from C-19-related collaborations with industry flows back into their own pockets.

You state that a natural pandemic extinguishes after one year. However, the literature often talks about periods of four years. Which scientific publications do you use for your statement? Can you share them with us?

I think you have consulted the wrong literature. It's not about the literature from the two world wars, but it is about the literature about pandemics. See here just a small sample of the available literature sources:

https://www.britannica.com/story/how-long-did-the-flu-pandemic-of-1918-last

https://www.ccohs.ca/oshanswers/diseases/pandemic_flu.html

https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC7252012/

https://sfamjournals.onlinelibrary.wiley.com/doi/full/10.1111/1751-7915.13889

The documented duration of pandemics varies between 10 and 20 months. The Russian flu (possibly not even caused by Influenza but by Corona virus), which lasted from spring 1889 to spring 1890 did have a brief flare-up two years later (from January to May) with 2017 cases, 66 of which were fatal: https://www.um.edu.mt/library/oar/bitstream/123456789/651/1/2005.Vol17.Issue3.A2.pdf

You also said that vaccines should have a sterilizing effect. Every year the government supports a seasonal flu vaccination, with a range of 60-70%, which has been known for years. Different strains are used for this. And so, are you saying that this vaccination campaign is also inadequate or unnecessary? Scientifically, we assume that the influenza vaccination has an effect and that it ensures that fewer people end up in hospital and die of influenza. To this day, the literature also indicates that after covid vaccination, there are fewer severe covid forms and fewer patient fatalities. Do you completely contradict this? And what literature are you basing this on?

See above: **Seasonal flu vaccination does not involve mass vaccination or vaccination during a pandemic or epidemic.** The vaccination season does precede the flu season and only a small part of the population (i.e. older and vulnerable people) are vaccinated. If we were to vaccinate en masse with conventional vaccines (which includes flu vaccines) during a flu pandemic, as we are doing now during the SC-2 pandemic, I would indeed raise the same cry for help as I am doing now.

What I find difficult in your reasoning about the competitive advantage of vaccination and natural immunity is that you state that one must start vaccinating before a pandemic breaks out. However, there are many examples from the past with ebola, cholera, and so on where vaccination started in the middle of the epidemic. And so, is your contention that you would have thought it appropriate to start vaccinating after the crisis?

First of all, let's not compare apples with pears here. **I am not aware of any examples of vaccinations against viral diseases with non-replicating vaccines that took place during a pandemic**. The Ebola vaccine, too, was a replicating vaccine (VSV-EBOV) the efficacy of which was shamefully falsified by the WHO in clinical studies, as shown by my analysis at the time as an employee of GAVI: https://uploads-ssl.webflow.com/616004c52e87ed08692f5692/61f65c43db047c9050ffe014_Critical_analysis_Ebola_vaccine_trial_GVB.pdf

You also say that, by vaccinating, the virus will begin to develop more and more because it competes with immunity, so the virus has to strengthen each time. Actually, you are going down the bacterial route with this statement. After all, you are comparing this to a bacterium becoming resistant to an antibiotic. To date, I have found no literature to support this statement. Can you provide me with accepted scientific publications on this?

The fact that mass vaccination as described above does raise very serious questions, to say the least, with regard to promoting the spread of more infectious variants is evident from various publications. I would like to share only a small selection with you:

https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0250780 :

'*Hence, the evolutionary rate ..... may underestimate the evolutionary potential of the virus to evade nAbs deployed as active immunity (vaccines) or passive immunity (nAb prophylactics).'*

'When nAbs are broadly present in the population, population-level selection for antibody-evading, infection-competent viral mutants may result in a rapid resurgence of SARS-CoV-2 infections.'

'Although these mutants are at a fitness disadvantage compared to the wild-type virus before nAbs are broadly present in the population, they are constantly generated through de novo mutation which allows them to exist at nonzero frequencies. However, once nAbs are common in the population, these mutants will have a selective advantage.'

https://pubs.acs.org/doi/10.1021/acs.jpclett.1c03380:

'*Recent studies confirm that natural selection is the dominating mechanism of SARS-CoV-2 evolution, which favors mutations that strengthen viral infectivity. Here, we demonstrate that vaccine-breakthrough or antibody-resistant mutations provide a new mechanism of viral evolution*.'

'*We anticipate that as a complementary transmission pathway, vaccine-breakthrough or antibody-resistant mutations, like those in Omicron, will become a dominating mechanism of SARS-CoV-2 evolution when most of the world's population is either vaccinated or infected*.'

https://journals.plos.org/plosbiology/article?id=10.1371/journal.pbio.1002198 :

'*Our data show that anti-disease vaccines that do not prevent transmission can create conditions that promote the emergence of pathogen strains that cause more severe disease in unvaccinated hosts*.'
(Note: prophylactic vaccination of chickens [lifespan: 6-8 weeks] toward highly infectious Marek's disease, however, does not exert pressure on the infectivity of the virus - unlike mass vaccination with C-19 vaccines - but does exert pressure on its virulence)

https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC8672435/pdf/jz1c03380.pdf:

'.....the binding between the S and antibodies could be transmitted among vaccinated people, especially in countries with high vaccination rates.'

'*.... vaccine-resistant mutations will gradually become one of the main evolution driving forces of SARS-CoV-2, especially in those areas with high vaccination rates.'*

'By tracking the evolutionary trajectories of vaccine-resistant mutations in more than 2.2 million SARS-CoV-2 genomes, we reveal that the occurrence and frequency of vaccine-resistant mutations correlate strongly with the vaccination rates in Europe and America.'

'*The early stage of SARS-CoV-2 evolution was entirely dominated by infectivity-strengthening mutations. However, since late March 2021, once vaccines had provided protection to highly vaccinated populations, several vaccine-resistant mutations such as Y449S and Y449H have been observed relatively frequently.'*

https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(21)00036-0/fulltext:

'*If substantial immune evasion occurs, current vaccines are likely to still offer some benefit to individuals. At the population level, however, they could induce viral selection and escape, making the prospect of achieving herd immunity increasingly remote*.'

'*We scientists working against COVID-19 must have the courage to address those in power, who bear ultimate responsibility for the policies chosen and their consequences. If this responsibility is shirked or delayed, the inevitable day of reckoning might be terrible*.'

https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC7941658/:

'*The emergence and rapid rise in prevalence of three independent SARS-CoV-2 "501Y lineages", B.1.1.7, B.1.351 and P.1, in the last three months of 2020 prompted renewed concerns about the evolutionary capacity of SARS-CoV-2 to adapt to both rising population immunity, and public health interventions such as vaccines and social distancing. As a consequence, all have gained epidemiological and immunological properties that will likely complicate the control of COVID-19*.'

'*Immune pressure is at present likely impacting the ongoing evolution of SC-2 variants.'*

'*Besides favoring ACE2 in competitions with neutralizing antibodies for spike protein binding sites, increased ACE2 binding affinities might shorten the time needed for viruses to enter cells and, therefore, shrink the window of their vulnerability to antibodies.'*

https://pubmed.ncbi.nlm.nih.gov/34873910/:

'*By tracking the evolutionary trajectories of vaccine-resistant mutations in more than 2.2 million SARS-CoV-2 genomes, we reveal that the occurrence and frequency of vaccine-resistant mutations correlate strongly with the vaccination rates in Europe and America*.'

(Edit Febr 22) https://pubs.acs.org/doi/10.1021/acsinfecdis.1c00557:

"The odd for these 100 most observed mutations to be there accidentally is smaller than one chance in 1.2 nonillions (2100 ≈ 1.2× 1030)"

"There is no doubt that natural selection via viral infectivity, rather than any other competing theories, is the dominating mechanism for SARS-CoV-2 transmission and evolution. This mechanistic discovery lays the foundation for forecasting future emerging SARS-CoV-2 variants"

More clarification and especially literature on this can be found in a contribution published in TrialSiteNews:

https://www.voiceforscienceandsolidarity.org/scientific-blog/why-the-ongoing-mass-vaccination-experiment-drives-a-rapid-evolutionary-response-of-sars-cov-2

Scientists like me don't just 'go for a spin'. **Anyone with even the slightest understanding of evolutionary biology will not be able to deny that any micro-organism that is pressured in a way that hinders its propagation and spread will appeal to natural selection to eventually adapt to its altered, 'hostile' environment**. The fact that viruses, unlike bacteria, rely on living host cells for propagation does not change the applicability of Darwin's theory of evolution that variants that gain a competitive 'fitness' advantage over their peers eventually displace and dominate the latter. Moreover, this explains why mass vaccination is unable to subdue SC-2 infection:

https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC8481107/

https://thepulse.one/2021/11/17/a-100-vaccinated-nation-sees-exponential-rise-in-covid-cases-cautions-citenry/

https://theconservativetreehouse.com/blog/2021/11/16/geert-vanden-bossche-was-right-the-worlds-most-vaccinated-country-cancels-christmas-due-to-massive-rise-in-covid-19-infections/

You say that 'the software cannot be erased.' We know that immunity works with a kind of memory, but so does natural immunity. And so, what do you think is the difference between the natural immunity that will work in the long run and the vaccines? The vaccines also affect the T cells. I do have literature on that, but you contradict this. Are you also in possession of scientific publications that contradict this? In that case I would have liked to receive them from you.

In contrast to immunity induced by C-19 vaccines, in natural SC-2 infection effector cells of the innate immune system are stimulated (e.g. B1a cells and NK cells). These alone may be sufficient to eliminate the virus and consequently make the infection symptomless or at most mild.

https://pubmed.ncbi.nlm.nih.gov/33391280/ : 'Different Innate and Adaptive Immune Responses to SARS-CoV-2 Infection of Asymptomatic, Mild, and Severe Cases'

https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC7202830/ : 'The immune system of children: the key to understanding SARS-CoV-2 susceptibility?'

B1a cells produce polyreactive IgM that play a key role in containing the virus in the early stages of infection. This has been demonstrated in several publications -see literature in the link above: https://www.voiceforscienceandsolidarity.org/scientific-blog/why-the-ongoing-mass-vaccination-experiment-drives-a-rapid-evolutionary-response-of-sars-cov-2 as well as: https://pubmed.ncbi.nlm.nih.gov/15633017/ : 'Inherent specificities in natural antibodies: a key to immune defense against pathogen invasion') for, among others, another enveloped and glycosylated respiratory virus (i.e. Influenza) that, like SC-2, causes an acute infection that comes to a standstill itself ('acute, self-limiting'). The pathogen exposure-induced training and adaptation of these IgM-producing cells to more antigen-specific IgM memory B cells has so far not been investigated very much: (https://www.frontiersin.org/articles/10.3389/fimmu.2020.595535/full : 'Immunoglobulin M in Health and Diseases: How Far Have We Come and What Next?'). However, it is likely that, just as has been demonstrated for NK cells and for other mediators of the innate immune system, innate B1a cells also undergo such reprogramming and fine-tuning (i.e., 'training'): '*The cellular basis of trained immunity and heterologous protection against secondary infections resides in the functional reprogramming of innate immune cells, which were first observed in invertebrates.'* In: Trained Innate Immunity, Epigenetics, and Covid-19; https://www.nejm.org/doi/full/10.1056/NEJMcibr2011679. **And so, the advantage of natural SC-2 infection lies mainly in the training and acquisition of a kind of memory by the innate immune system that is thereby able to control and eliminate SC-2 variants (!) with ever-increasing efficiency in the future.** Vaccine antibodies have a much higher affinity for SC-2 than innate polyreactive antibodies (the difference in binding mechanism is also described under: https://www.voiceforscienceandsolidarity.org/scientific-blog/why-the-ongoing-mass-vaccination-experiment-drives-a-rapid-evolutionary-response-of-sars-cov-2). Based on their high affinity, antigen (Ag)-specific vaccine antibodies therefore offer an advantage when the virus to be controlled can be recognized clearly by those antibodies. However, this is not the case with current C-19 vaccines because they are directed against an S(pike) protein that is increasingly different from that of the circulating variants. As a result, these antibodies are barely functional, while innate antibodies, which, because of their multispecific nature, could recognize and eliminate these variants (in synergy with NK cells), are sidelined.
Apart from the advantage of training the innate immune system, natural infection - in contrast to vaccination - avoids immune escape because the peak of the virus load is already eliminated before antibodies are generated (thanks to the innate immune system). In this way, the antibodies do not put the virus under immune pressure whereas this is the case when people are vaccinated in the middle of a pandemic and build up antibodies while they are under full siege by the virus

(https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0250780; https://pubmed.ncbi.nlm.nih.gov/15633017/).

The effect of natural SC-2 infection is therefore - even independent of the better quality and diversity of the antibodies generated - clearly more efficient and stable than that of vaccine-induced immunity (i.e. because of sterilizing immunity, training of innate cellular immunity and low risk of immune escape). This may also explain why natural immunity achieves a more sustained and stronger protection against SC-2 than vaccine-induced immunity (see links below), even after administration of a booster (and even after a third dose, protection against severe C-19 disease seems only short-lived). Even CDC has since conceded the superiority of natural immunity (see top of next links):

https://childrenshealthdefense.org/defender/cdc-natural-immunity-trumps-vaccine-immunity/

https://twitter.com/martinkulldorff/status/1430660291579105284?s=21

https://thepulse.one/2021/11/23/130-research-studies-affirming-the-power-of-natural-immunity-to-covid/

https://brownstone.org/articles/79-research-studies-affirm-naturally-acquired-immunity-to-covid-19-documented-linked-and-quoted/

https://www.nature.com/articles/d41586-021-01557-z

https://www.sciencedirect.com/science/article/pii/S2352396421002036

Meanwhile, it has also been shown that there is sufficient reason to believe that even after mild natural infection, robust, long-term protection against SC-2 can be induced, and this even at very low serum concentrations of acquired, antigen (S)-specific antibodies. And so, again, this study points to the 'hidden' protective power of natural SC-2 infection:

https://www.nature.com/articles/s41586-021-03647-4.pdf

There is a risk of immunological side effects according to you. We can indeed subscribe to that statement. Indeed, any vaccine can have side effects, and these should be anticipated. You indicate that you would contain the pandemic in a different way, but you don't get very specific, apart from what you say about the puzzle, which is common today, because it is no longer based only on vaccination, but also on the other scientific insights, such as prophylaxis and so on, wearing a mouth mask, hand hygiene, and keeping your distance. What specifically is the step that you would suggest?

I have repeatedly made clear in writings and interviews, all extensively documented on my web site, that it is crucial firstly to **stop mass vaccination completely, to bring down the infection pressure via a one-time mass antiviral chemoprophylaxis for about six weeks and to organize campaigns to sensitize the population to the crucial importance of healthy food** (incl. vitamin D during the winter) **and lifestyle** (e.g. exercise, not being overweight, getting enough rest, etc.) because there is a strong, scientifically proven link between good health and optimal functionality of the innate immune system (https://pubmed.ncbi.nlm.nih.gov/33013904/). Furthermore, **the vulnerable population (e.g. the elderly and people with underlying diseases) should be protected via infection prevention measures as long as the pandemic is not under control and they should be treated in a timely manner with appropriate medication** ('early, multi-drug treatment': see below;i.e. as soon as C-19 symptoms appear).

You talk about natural immunity. Had you then - however you endorse this scientifically - from the beginning of the pandemic not taken steps towards vaccination or towards immunization and on what do you base your assertion that the pandemic could then have been over after a year?

At the beginning of the pandemic, no C-19 vaccines existed. If they had existed, it might have been justifiable to vaccinate only the vulnerable with an appropriate C-19 vaccine (i.e. whose spike protein matches that of the circulating variant), although I personally am not a proponent of vaccinating even a limited group of the population with 'leaky' vaccines *during a pandemic*. It would have made much more sense to treat vulnerable people immediately with the drugs that were already available at the time (monoclonal antibodies, antiviral drugs, anti-inflammatory drugs, corticoids, antihistamines, anticoagulants, etc.), if necessary preventively in the case of a positive test, in order to avoid hospitalization and to allow these patients to contribute more quickly to group immunity through a speedier recovery. The efficacy of such therapy has been clearly demonstrated, even in peer-reviewed journals:

1. https://www.ijirms.in/index.php/ijirms/article/view/1100, https://www.ijirms.in/index.php/ijirms/article/view/1100#downloadTab
2. https://www.preprints.org/manuscript/202007.0025/v1

You speak of the innate immune system. To my knowledge, a child goes through a lot of infections when he or she goes to nursery school and kindergarten, and therefore builds up a certain basic immunity. Of course, all the molecules and links to build the immunity are present in that child, but it is the contact with the different viruses that must ensure that the immunity is built up.

And how do you think the child builds up that basic immunity you speak of instead of succumbing to the infection? How can a child who is immunologically naive resist these infections? It is the innate immunity that initially absorbs the infection and thereby prevents severe disease or tissue damage before the slower developing adaptive immune response kicks in. The immunity that is built up against various pathogens of which you speak is only possible if the innate immune system (e.g. due to innate antibodies) takes on the majority of the infectious load (https://pubmed.ncbi.nlm.nih.gov/15633017/: 'Inherent specificities in natural antibodies: a key to immune defense against pathogen invasion').

You state that innate immunity would have been sufficient to contain the corona virus, but I would have liked a scientific explanation for that because we all know that with age - you referred to that - the immune system will react a little less alertly. The experts who guided the government in the pandemic made it very clear at the beginning of the crisis that there was not yet a naturally built-up immunity in the population to the corona virus because it was a totally new virus and so it was not actually possible that we, as individuals, had already built up an immunity.

The problem is that our experts apparently do not know about the existence of innate cellular immunity and they are the prisoners of dogmas that are infatuated with acquired antibodies while the generation of those antibodies doesn't occur until after the bulk of the SC-2 virus has already been removed by the innate immune system. It is therefore the innate immunity together with the activation of CD8+ T cells (without memory) that are responsible for sterilizing immunity (via elimination of virus-infected cells) and the recovery from disease (see also presentation Covid-19 symposium: Geert Vanden Bossche speaks at Covid-19 Health Symposium | Voice for Science and Solidarity). Precisely because of this, these viral infections are called 'acute, self-limiting' and this is also the reason why the 'naturally' acquired antibodies do not correlate to protection. Innate immunity did exist at the start of the pandemic and explains why the vast majority of the healthy population - despite lacking naturally acquired antibodies - was at least protected against severe C-19 disease.

So how do you refute that assertion? Was it possible, then, that an individual or a senior, healthy citizen had sufficient immunity to deal with the virus after all, and what do you base that on?

Even healthy older people can still have a functional innate immunity e.g. when it has been sufficiently trained, such as, for instance, by other viral infections (e.g. Influenza, RSV etc.). It is also true that many healthy older people, even if not vaccinated, appear to be protected against flu (and this is also true obviously for healthy older people who have been vaccinated with a flu vaccine that is not even effective because of the mismatch with the circulating flu strain). Surely it is also clear that numerous older, healthy people did not succumb to Covid 19 (C-19) at the start of the pandemic, and have still not succumbed to it, despite not being vaccinated. To say that all of them were not infected is very difficult.

So how would you proceed with patients who have an immunodeficient system? How would you protect them?

They must be specially protected by infection prevention measures (as long as there is no group immunity) and must have access to early treatment, especially since it has been proven to be extremely effective (see above).

Where do you situate acquired immunity through vaccination in the combination of innate immunity and acquired immunity? Is that not an issue for you at all or is it?

Immunity acquired by vaccination with the current C-19 vaccines has no a place in the fight against a CoV pandemic in my opinion. These antibodies do not induce sterilizing immunity, so they are not capable of eliminating the virus and when induced en masse (mass vaccination) they promote the expansion of more infectious *immune escape* variants. Moreover, the binding of vaccine antibodies that do not adequately recognize the S antigen on the circulating variant may give rise to inadequate neutralization of the virus which poses a potential danger for the emergence of ADE (antibody-dependent enhancement) (https://www.journalofinfection.com/article/S0163-4453(21)00392-3/fulltext). The protection against severe disease, the only claim that now stands for the C-19 vaccines, relies on the activation of polyfunctional, non-cytolytic T cells, as I clarified earlier (all contributions also published on TrialSiteNews; https://trialsitenews.com/):

When anti-S(pike) antibodies against Omicron can no longer sustain the narrative, why not resort to T cells?
https://www.voiceforscienceandsolidarity.org/scientific-blog/when-anti-s-pike-antibodies-against-omicron-can-no-longer-sustain-the-narrative-why-not-resort-to-t-cells

Do cross-reactive T cells explain mild course of Omicron infection?
https://www.voiceforscienceandsolidarity.org/scientific-blog/q-a-09-do-cross-reactive-t-cells-explain-mild-course-of-omicron-infection

To all those who continue to attribute abrogation of SARS-CoV-2 infection to pre-existing cross-reactive T cells rather than to innate immunity. The devil is in the detail of peer-reviewed publications.
https://www.voiceforscienceandsolidarity.org/scientific-blog/to-those-who-continue-attribute-abrogation-sars-cov-2-infection-pre-existing-cross-reactive-t-cells-rather-innate-immunity-the-devil-is-the-detail

Cross-reactive memory T cells are associated with (but not responsible for) protection against SARS-CoV-2 infection in COVID-19 contacts.
https://www.voiceforscienceandsolidarity.org/scientific-blog/cross-reactive-memory-t-cells-are-associated-with-but-not-responsible-for-protection-against-sars-cov-2-infection-in-covid-19-contacts

'Killer' immune cells still recognize Omicron variant.... oh really?
https://www.voiceforscienceandsolidarity.org/scientific-blog/killer-immune-cells-still-recognize-omicron-variant-oh-really

The induction of such T cells is also not without danger. Indeed, as a vaccinologist, I know all too well that any autoimmune disease or immune-inflammatory pathology due to natural disease or vaccination is always linked to strong activation of T cells, mostly CD4+ T cells.

You indicate that in vaccination, antibodies are generated while there is high contact with the virus. You cite indirect publications. What do you mean by indirect? Is that really scientifically based? Can you clarify that?

This is based on one simple fact: When people are vaccinated during a pandemic i.e. during a period of increased risk of infection, part of the population will still be building up antibodies even though they have already been exposed to the virus. These antibodies are by definition 'immature' (e.g. during build-up or after the first of two injections) and therefore insufficiently functional. When they are also directed against an antigen (spike) of a variant different from the Wuhan strain, this also has a negative influence on the antigen affinity and therefore functionality (i.e. virus-neutralizing capacity) of these antibodies. Hence, mass vaccination during a pandemic of variants with vaccines that do not induce sterilizing immunity is doomed to fuel the spread of more infectious immune escape variants (see above)

You also indicate that the variants arose before mass vaccination. On what are you basing this? After all, that's the first time I've heard that. I haven't read that anywhere either. I would like some clarification on that.

Then you should indeed review the literature. Some of your colleagues are apparently aware of this. There is no question that the variants, even the famously named VoCs (variants of concern) existed before mass vaccination was initiated. Even the most ruthless fact checkers will agree with that.

You state that mass vaccination against omikron is not necessary. What is your proposal for the next variants? After all, when we do the exercise today, it is not just about omikron. For omikron, it is already too late. On that we are in agreement. Is it not then necessary to examine what should be done effectively with subsequent variants?

I'm not just arguing that it's not necessary, I'm arguing that it's actually very likely to be harmful. As I said before, we should be committed to (trained) innate immunity, not to vaccination with vaccines that put more and more pressure on the virus without allowing them to control it. The Omicron family can expand to include new members as long as they meet the condition of a receptor-binding domain (RBD) that is resistant to virus-neutralizing antibodies (brought about by 15 mutations in RBD that are common among the known members of the Omicron family so far). The innate immunity of a new, highly differentiated variant such as Omicron may need some training, but it is expected that because of its polyvalent character it will be able to resist new members of the Omicron family within a short period of time. Before that training is completed, we may experience a peak of mild to moderate disease due to the very high infection pressure. However, the resistance to anti-S antibodies allows the innate antibodies to interact maximally with the virus, and that in my opinion is the main reason for the - at least initially - generally quite mild course of Omicron. **As long as the population does not build up mass antibodies against Omicron** (e.g. as a result of increasing immune pressure on the virus caused by increasing anti-S seroprevalence**) there is no reason to believe that more dangerous variants will develop**. However, as people become more frequently exposed to Omicron they will develop more and more inferior antibodies due to '*antigenic sin*' (in those vaccinated with current C-19 vaccines or those recovering from C-19 disease) or, in the case of the unvaccinated, due to asymptomatic/ mild infection. Because **of the high infectivity of Omicron, this will undoubtedly lead to more and more disease and therefore higher anti-S (Omicron) seroprevalence in the population. The next variant may become resistant in this way to anti-Omicron antibodies.** Of course, in view of the frequent circulating variants, the chance of SC-2 variants recombining among themselves in the same host and giving rise to new variants

with totally unpredictable properties does increase. But even in that case, they will only be able to thrive if their infectious properties allow them to resist the anti-Omicron antibodies. **Such natural selection will only be accelerated by a massive anti-Omicron vaccination of the population** because this too has been shown to reawaken the 'old' anti-Wuhan anti-S antibodies in the first place (https://www.biorxiv.org/content/10.1101/2022.02.03.479037v1.full.pdf). The infectious nature of *subsequent* variants will therefore, in my view, depend on the immune pressure exerted by the population as a result of the higher morbidity rate that Omicron itself (due to *natural* boost of the seropositive population and/or the high infectiosity of the virus) or the anti-Omicron vaccine (due to *vaccine-mediated* boost of the seropositive population) will bring about.

You also state that non-vaccinated people have the same reaction to omikron as vaccinated people. In my contacts with physicians in the ICU, the situation is quite different. The patients who are seriously ill, who develop COVID-19, and who really need hospitalization and help are mainly and almost exclusively non-vaccinated patients. How do you refute this fact?

Maybe that's the data you have. In any case, meanwhile, according to Sciensano, the daily average of new C-19 hospitalizations is higher among the vaccinated (including those who have already received a boost after full vaccination) than among the unvaccinated (https://covid-19.sciensano.be/nl/covid-19-epidemiologische-situatie: p. 28). In particular, your claim is also unsupported by data from other countries:

https://theconservativetreehouse.com/blog/2021/09/28/truth-being-ignored-victoria-australia-records-867-new-covid-cases-375-in-hospital-and-95-of-those-hospitalized-are-vaccinated/

https://www.lifesitenews.com/news/death-rate-from-variant-covid-virus-six-times-higher-for-vaccinated-than-unvaccinated-uk-health-data-show/

https://dailyexpose.uk/2021/07/03/fully-vaccinated-people-have-a-885-higher-chance-of-death-due-to-covid-19-than-people-who-are-unvaccinated-according-to-official-data/

By the way, there was a recent publication indicating that vaccinated people are more susceptible to infection with Omicron and therefore get sick more easily (https://www.medrxiv.org/content/10.1101/2022.01.28.22270044v1). However, vaccinated persons in that study were found to excrete less virus. Hundreds of reports, publications and such like have already been published, and the data often appears to contradict itself. The degree of susceptibility to infection as well as of viral shedding depends on many factors, such as viral load, type of SC-2 variant, degree and type of immunity (of which vaccine-induced immunity is only a part), age of tested individual and possible presence of underlying diseases, time of testing, environmental factors, etc. Since both dominant viral variants and the immunity (training!) of the population evolve during the pandemic and similar criteria are often investigated by different investigators using different parameters or methods, it is not surprising that the data on susceptibility to infection and excretion also evolve during the pandemic and differ depending on the research institution.

However, I still maintain that it is perfectly possible and, in my opinion, even probable that vaccinated persons will become increasingly sensitive to C-19 disease and will find it increasingly difficult to control the virus, whereas I expect just the opposite in non-vaccinated persons (mainly due to the adaptive capacity and reprogramming of lymphocytes responsible for the production of innate antibodies that are effective against all variants). And so, let's feel free to follow up on the figures of hospitalizations 'as a result of' (and not 'with') Covid, neatly stratified by vaccination status, age group and underlying diseases. And let's revisit those figures between now and next month. **Figures from Public Health Scotland show that the risk of serious illness and hospitalization among double-vaccinated people is already considerably higher than among unvaccinated people** (https://palexander.substack.com/p/devastating-negative-efficacy-public). However, instead of focusing on 'snapshots' and asking the wrong questions, I think it is high time that scientists and experts finally address i) **how we can contain the pandemic via (real!) group immunity and let it move into an endemic phase** and ii) **which immunity people should choose in the meantime**. These are, in my

opinion, the only two questions that are of critical importance from the point of view of both public and individual health.

I had one more question, which I may come to later.

To the general questions for both speakers, I would like to add a few more questions.

If we were to make vaccination compulsory, which vaccine should be made compulsory? Do we leave the patient with a choice? There are protein vaccines and mRNA vaccines. Is it important that there is a choice or an option for the patient or for the physician, for example?

There are obviously differences with respect to safety between genetic vaccines and conventional vaccines. **However, since it is my belief that if vaccines are used for mass vaccination, they will all lead to failure from both the individual and public health standpoints, I cannot recommend that anyone be vaccinated with any of these vaccines. It is safer and more efficient to ensure protection of the vulnerable from serious disease through preventive measures and especially early treatment.**

If we were to make the vaccines compulsory, how many doses would be needed? How does one work that out? What is your view on seasonal influenza vaccination? If this virus becomes endemic and eventually acts like a flu, should we make flu vaccination compulsory as well?

Given my answer above, this question is irrelevant to me. If we continue to follow the same course, SC-2 will become anything but endemic. Moreover, I can only warn that if governments get it into their heads to implement mass vaccination now with conventional vaccines for seasonal flu as well, we are in danger of being confronted with waves of more and more infectious Influenza variants in no time at all.

There are a number of other vaccines in development, such as peroral vaccines and sprays. Do we need to take these into account today and can they have a different impact on the immunity obtained?

No, these vaccines do induce mucosal antibodies, but this doesn't mean that their administration during a pandemic will prevent the expansion of more and more infectious variants. The problem of *immune escape from* the highly specific antibodies also induced by these (mucosal) vaccines remains identical. And even when such vaccines are administered prophylactically (i.e. outside a pandemic), it is known that they must be topped up regularly (every three to six months) so that the mucosal antibodies remain present in sufficient concentration. One may also wonder why there is no mucosal vaccine on the market to date that targets viral infections and is based on a non-replicating antigen.

In terms of long-term effects, and one of the speakers mentioned this, we are convinced that any vaccine should be followed up anyway. Pharmacovigilance is an obvious necessity. To what extent will long-term effects determine the impact a vaccine can have on future therapies that patients have to undergo? We have the PEG lipids, which are mildly immunogenic and on which research is in progress at Ghent University. Have you taken that into account in your assertion today?

Not sure if that question was meant for me. In any case, as a vaccinologist, I can inform you that I am stunned by the side effects reported so far (e.g. VAERS, EudraVigilance, DoD), especially in association

with the genetic C-19 vaccines. To what extent the immunogenic or non-immunogenic nature of PEG contributes to this is, in my opinion, unknown but, like many other factors, needs to be thoroughly investigated before these vaccines are administered en masse to all sections of the population on a purely experimental basis.

Sofie Merckx *(PVDA-PTB):*

I come to the questions for Mr Vanden Bossche.

These hearings are taking place in the context of whether or not vaccination should be compulsory. I note that we have now entered a debate about the utility of vaccination, at least in this pandemic.

I think it is important to address this issue as well. You have stated that a pandemic spontaneously stops after one year. Can you give examples of that from history, because apparently we have not read the same history books?

I do not read history books but I do read scientific publications. I am happy to share with you the same remark that I made earlier to Ms Depoorter. It is clear that the duration of the current pandemic has already doubled in comparison to that of a natural pandemic, even though there are now suddenly voices that would like the population to believe that the infection is now endemic. **The infection rate has never been so high and there is anything but group immunity. Consequently, the end of this pandemic is nowhere in sight**.

You are clearly in favour of collective immunity, if I understand correctly. On November 26, Sciensano published a study stating that 30,000 hospitalizations had been prevented by vaccination. Do you question that study and on what basis? Do you favour the Brazilian model? In Brazil, those in power have clearly chosen the option of collective immunity. Do you think the situation there is better from a sanitary and an immunological point of view?

This analysis demonstrates the 'short-term thinking' that prevents us from controlling this pandemic. The number of hospitalizations by itself is a flawed measure of the success of human intervention in a pandemic. **The success of intervention in a pandemic can only be reliably assessed by its impact on viral transmission**. Reducing the number of hospitalizations is the result of a 'symptomatic' intervention that only results in more competitive i.e. more infectious variants becoming increasingly lush until they become completely resistant to vaccine antibodies. At that point the even higher degree of infectivity (e.g. Omicron) leads to more cases of disease. It cannot be excluded that the resulting increase in immune pressure on the virus will lead to a natural selection of a variant capable of even higher infectivity because, for example, the antibodies generated can still bind to the virus but can no longer neutralize it. In this way, such a variant can cause ADE. This can only be accelerated by additionally vaccinating against Omicron. Triggering ADE would only really cause a storm of hospitalizations. **Hence, my primary plea is for an immediate halt to mass vaccination and general antiviral chemoprophylaxis in countries with high vaccination and infection rates** (e.g. Belgium).

For comparison, the number of prevented hospitalizations should also be calculated over the duration of a natural pandemic. As indicated above, we have already doubled the number of hospitalizations. Hospitalizations should be avoided by early treatment (whose effectiveness is undisputed as evidenced by several peer-reviewed publications (https://www.ijirms.in/index.php/ijirms/article/view/1100, https://www.preprints.org/manuscript/202007.0025/v1) and not by vaccines that only promote the spread of more infectious *immune escape* variants. **This is tantamount to mopping up with the tap *wide* open....**

Brazil still has a relatively low mortality rate despite a very high infection rate, and there are significant regional differences. Just as antiviral drugs and early therapy can greatly reduce the hospitalization of patients, it is to be expected that general antiviral chemoprophylaxis can greatly reduce the infection

pressure and therefore the number of patients. This is especially true in places where the infection pressure can rise very rapidly due to overcrowding and poor hygiene. And so, just as with individual treatment, the idea is to allow natural immunity to take place in a controlled way at the population level as well. That is diametrically opposed to the claim that I would advocate letting the pandemic run its course, even in areas of very high infection pressure! **In any case, I expect that the already declining wave of infections in Brazil will lead to the emergence of group immunity while I don't see that group immunity occurring any time soon in European countries that continue to vaccinate their citizens en masse (soon with anti-Omicron vaccines)**.

You say that high vaccination rates lead to the emergence of variants. Can you demonstrate that for the corona vaccine relative to the variants which we see emerging? We had the British variant before we vaccinated and all the other variants that have emerged in countries with low vaccination rates.

See above: Obviously, variants existed before mass vaccinations started. And so, that is not my point at all in raising the issue of mass vaccination.

You also say that you are completely against vaccinating in a pandemic like now and that we should let natural immunity do the talking. Even if we don't make vaccination compulsory, a lot of people who have been vaccinated anyway would have been vaccinated once the vaccines came on the market, because a lot of doctors recommend it to their patients and the government organizes it. Are you then advocating banning vaccination? Do you think that would be better?

Everything has to do with open scientific debate and truthful communication to the population. **I find it hard to imagine that if a lot of doctors had the right to speak without censorship and if the population were properly informed about i) the significant side effects of some of these vaccines and ii) the increasingly apparent negative efficacy (especially with regard to cases of mild and moderate illness), iii) the hopeless prospect of ever achieving group immunity via this vaccination, and iv) the high efficacy of 'early, multi-drug treatment' in vulnerable groups, many people would still find themselves prepared 'anyway' to have one booster after another injected into their bodies and those of their children**.

You also say that vaccinated and non-vaccinated people are in the same boat. However, in Belgium we have figures showing that the risk of hospitalization is greater for an unvaccinated person and that the vaccines protect against worse forms of covid. Among other things, there is a study by Sciensano that I am sure you are familiar with. Because time is short here, I have not been able to look them up for a while. Can you show with studies that the vaccinated have the same hospitalization rate as the unvaccinated?

See above: There are indeed several sources that contradict this. But as I pointed out above, as well as in my talk, one is not served by 'snapshots', but rather by a view of the end goal. **Further pushing mass vaccination based on the ratio of hospitalized vaccinated versus unvaccinated cannot possibly lead to the desired end goal of group immunity.** Unless one rewrites virology and immunology, such a strategy threatens only to promote the natural selection of a new variant against which only those whose innate immune defenses against CoV were not compromised by vaccination remain.

Catherine Fonck *(cdH):*

Mr. Vanden Bossche, you have made a presentation that deeply questions the contribution of vaccination. I am a scientist, I have been reading the scientific literature about SARS-CoV-2 since the beginning of the

pandemic. So let me ask you to bring to this committee today, on the basis of evidence and rigorous scientific publications, details on the four points that you wanted to put forward.

You talked about the danger of vaccinating during the pandemic because vaccination would induce variants. What is the scientific evidence for this?

See above: again: I have never said that mass vaccination generates variants, but rather that it promotes the spread of more infectious variants

It is well known that the process of variant occurrence occurs just as much during induced immunity following infection. In fact, in this SARS-CoV-2 pandemic, variants appeared spontaneously, following the accumulation of mutations, well before vaccination against covid-19.

I have never claimed otherwise. People should listen carefully to my words. I have already explained above the difference between immunity induced by natural infection versus vaccine.

The second assumption you make is that immunity is lost if children are vaccinated, because of competition between the antibodies in the vaccines and the innate antibodies. The scientific evidence is very clear for immunity which is, on the contrary, stimulated and completed by vaccination. On what scientific basis do you make this assumption of loss of immunity? For me, it clearly has no scientific proof.

See also above.

You talk about a phenomenon of antibody-mediated facilitation of infection. What is the scientific basis for this, since it has not been documented for SARS-CoV-2? But there have been billions of people around the world who have either been infected or vaccinated.

I did not even mention this in my talk. However, no scientist would deny that antibodies that bind to the virus without neutralizing the virus pose a risk of inducing ADE. It is suspected that such a phenomenon also explains why incompletely vaccinated people (e.g. after one dose) exposed to SC-2 may develop a severe form of C-19 disease If you would like to listen to a professor explain his views on this, please click on the following link: https://www.youtube.com/watch?v=wBm1BKL4zlg

There is no doubt that ADE is a highly feared complication, not only in infections with CoV but the phenomenon is not only well known but also feared in this type of virus. **Given the fact that variants are being less and less efficiently neutralized by vaccine-induced immunity, the main issue is to prove that the probability of this phenomenon** (i.e. ADE) **occurring can be virtually excluded**. The occurrence of side effects and disease in vaccinated persons with weakly neutralizing antibodies (due to incomplete vaccination or vaccination with C-19 vaccines in which the target antigen is very different from the antigen presented on the dominant variant) **should first be investigated much more thoroughly to enable us to give a definite answer**.

Finally, you said that non-vaccinated people are more protected than vaccinated people. On what do you base this assumption, which, for me, does not hold water at all? Since on the one hand, for SARS-CoV-2, covid-19, the risk of death and hospitalization, and hospitalization with severe pathologies, there is very clear evidence that this risk is greatly reduced, extremely, strongly reduced for vaccinated people.

See my comments above. Perhaps you should also realize for a moment that the hospitalized are only a small fraction of the population and that it is more relevant to control the pandemic to compare the number of cases of infection (e.g. between vaccinated and unvaccinated) in the vast majority of the population that is not hospitalized. **As shown by Public Health Scotland (PHS) and UK Health Security Agency statistics, in that part of the population the number of SC-V positive cases is significantly lower among the unvaccinated than among the vaccinated, and that has been leading to negative vaccine efficacy for some time:**

https://andrewmadry.substack.com/p/vaccine-effectiveness-time-to-recalibrate

https://paretos.substack.com/p/vaccine-failure-across-the-board?utm_source=substack&utm_campaign=post_embed&utm_medium=web

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1041593/Vaccine-surveillance-report-week-50.pdf

https://dailysceptic.org/2022/02/04/evidence-of-increased-infection-risk-following-third-dose-exacerbated-by-vaccination-drive-during-omicron-wave-ukhsa-data-show/

https://palexander.substack.com/p/devastating-negative-efficacy-public

https://uploads-ssl.webflow.com/616004c52e87ed08692f5692/61fea931da6b2fad72873ea4_Appendix_11_negative_vaccine_efficacy.pdf

(Edit Febr 22) https://www.voiceforscienceandsolidarity.org/videos-and-interviews/revised-frightening-update-uk-data

(Edit Febr 22) https://www.voiceforscienceandsolidarity.org/videos-and-interviews/the-data-noose-uk-data-update-is-it-time-for-those-responsible-to-pay

(Edit Febr 22) https://www.voiceforscienceandsolidarity.org/videos-and-interviews/uk-data-noose-on-the-masses-vaccine-stakeholders-what-have-you-done

What is worrying, however, is that due to mass vaccination across all age groups of the population, **it is no longer possible in** practice **to compare vaccinated and non-vaccinated people, not in the short term, but also not in the longer term**. In view of the above results it is difficult to shake off the impression that health authorities apparently feel increasingly uncomfortable with such comparisons.

Moreover, in the context of other vaccinations, in the context of other epidemics, other vaccinations have been carried out during epidemics, and this has never led to an increase in deaths.

Perhaps you should first inquire whether a non-replicating vaccine has ever been used to contain an epidemic of a virus that causes an acute, self-limiting viral infection/ disease. To my knowledge, even for live attenuated vaccines, there are no writings documenting their use for mass vaccination in the midst of a pandemic/epidemic of a highly mutable virus (not to mention in the presence of already circulating viral 'variants'). If your documentation contradicts this, I would love to hear about it.

I would really like, Mr. Chairman, that in a debate where a thesis is presented, which is clearly an anti-vaccination thesis, that scientific evidence be provided; evidence in serious scientific literature reviews.

If you pride yourself on your scientific training, it would be best if you first studied the literature rather than hurling a number of uneducated, but arrogant allegations at a thoroughly experienced and passionate vaccinologist. Your arguments don't make sense. This is a waste of time. You should be deeply ashamed as a politician.

Mr. Chairman, this concludes my remarks and I thank you.

Barbara Creemers *(Ecolo-Groen): I thank the two speakers in advance.*

Mr. Vanden Bossche, actually my question was for Dr. Herry to respond scientifically to some of your arguments. I have seen him frown from time to time. I can imagine that he has other insights. I hope he will have the space to communicate them later on.

You said at the beginning of your speech that we rely far too much on snapshots. How many deaths are there today, how many hospitalizations are there today? We don't focus enough on the end goal, according to you. Do you have studies, predictions, or statistics on how many additional deaths, on top of the 28,800 we count today, we would have had if we had gone for group immunity? Are there any predictions of that? Sciensano says that if we didn't have that high vaccination rate today, we would have 30,000 additional hospitalizations. I heard regularly that our health care system was breaking down. We would not be able to handle those 30,000 additional admissions. How many additional deaths would that have resulted in?

See my comments above regarding ''short'' versus 'long'' term vision and the fact that public health agencies appear to be unaware of the high efficiency rate of 'early treatment.''

As has been pointed out repeatedly in the past, the **combination of 'early (multi-drug) treatment' together with a reduction in the viral infection pressure** by means of infection prevention measures or, more effectively, antiviral prophylaxis, seems to me to be the more scientifically and ethically sound approach to achieving group immunity, even in the current 'highly infectious' stage of the C-19 pandemic. We are entering the third year mark of the pandemic and the infection rate has never been higher. Does no one realize that symptomatic mass vaccination only leads to a higher degree of infection, thereby causing more disease and eventually (if mass vaccination continues long enough) severe disease?

You say that, when it comes to the effectiveness of the vaccine, you have a number of questions. After all, we rely on clinical studies. Surely Sciensano is not relying solely on clinical studies to assert that 30,000 additional hospitalizations have been avoided because of the vaccinations?

Indeed, the results of the clinical studies would not even allow such a calculation. However, I doubt whether this calculation takes account of the entire population because, in the vast majority of the population, the number of registered infectious cases is significantly lower among the non-vaccinated than among the vaccinated, as you can see for yourself in the reports from the UK Health Security Agency and Public Health Scotland. As mentioned above, this also leads to a clear negative vaccine efficiency. Less chance of illness in the non-vaccinated population means less chance of serious illness and therefore less chance of hospitalisation. **Analyses and conclusions based on comparisons between hospitalised patients therefore give a distorted picture of the degree of protection against hospitalisation for the entire vaccinated population compared with the non-vaccinated population due to confounding factors ('confounder')**.

I hear you in your last slide calling for independent scientists. And so, do you not consider Sciensano to be independent? That is the government agency we rely on, isn't it?

When the tax collector (i.e. the government) tries to make vaccination compulsory, it is hard to assume that those who are paid with this tax money can easily afford to hold a different (scientific?) opinion. But our physicians are apparently also under serious pressure. This is shown, for example, by the comparison

between different countries of the number of side effects reported (source: EudraVigilance; status: end of January 2021). If we compare these only for the Moderna vaccine, we come to the conclusion that the Netherlands is head and shoulders above other countries (including Belgium!):

Netherlands 17.4 million inhabitants
Germany 83.2 million inhabitants
That's 4.78 times more than in the Netherlands and yet fewer reports

Netherlands 17.4 million inhabitants
France 67.4 million inhabitants
That's 3.9 times more than in the Netherlands and yet fewer reports

Netherlands 17.4 million inhabitants
Belgium 11.4 million inhabitants
That's only about 1.5 times less than in the Netherlands but that's offset by about 12 times less reporting!

Number of individual cases	
Netherlands	34,306
Germany	31,163
France	20,763
Italy	14,991
Spain	10,803
Austria	6,744
Denmark	6,509
Norway	4,727
Sweden	3,573
Belgium	2,816
Portugal	2,724
Ireland	1,351
Czech Republic	1,227
Finland	1,181
Iceland	675
Croatia	673
Greece	614
Lithuania	603
Romania	534
Latvia	505
Estonia	482
Bulgaria	393
Northern Ireland (UK)	362
Poland	347
Cyprus	260
Hungary	248
Luxembourg	174
Slovakia	93
Slovenia	66
Malta	39
Liechtenstein	29
Total	**148,975**

More generally, the reports and data provided by Sciensano are anything but transparent:
https://legalhearts.org/wp-content/uploads/2022/02/Persbericht-Wanneer-ook-de-waakhond-een-

slaappil-krijgt.pdf . A general lack of transparency and the concealment of important clinical data and information by health authorities and regulators has already been firmly addressed by the publishers of one of the most prestigious peer-reviewed journals, the British Medical Journal:

https://uploads-ssl.webflow.com/616004c52e87ed08692f5692/61fea9310d82c58b6cd89454_Appendix_09_lack_of_transparency_of_data.pdf

and also:

https://www.researchgate.net/publication/357778435_Official_mortality_data_for_England_suggest_systematic_miscategorisation_of_vaccine_status_and_uncertain_effectiveness_of_Covid-19_vaccination:

'A recent investigation conducted by world-class experts qualified the data published by UKHSA as unreliable and misleading, especially in regard of their reporting on Covid deaths. A preprint of their findings has been published ("Official mortality data for England suggest systematic miscategorisation of vaccine status and uncertain effectiveness of Covid-19 vaccination their findings").'

You literally said that it is not necessary to vaccinate children. I heard Ann De Guchtenaere on the radio this morning. We will hear her here this afternoon as well, but I would like to submit to you a quotation from her.

She says on the radio this morning that one in three thousand young people over the age of 12 develop MIS-C, a serious complication, after infection Jessica). After a vaccination, that chance drops by more than 90%. How does that square with your statement that we should not vaccinate children and adolescents?

If Ms De Guchtenaere already has extensive statistical material at her disposal that demonstrates the widespread occurrence of this disorder in a sufficiently representative population, I would like to consult that database. **I would be interested to know which children this concerns exactly and whether there are any underlying diseases in these children. Has Ms De Guchtenaere also tested her enthusiasm against the frequency of side effects that occur in this age group as documented in detail in VAERS?** Dr. Jessica Rose on Sars-CoV-19 vaccines for Children? | Voice for Science and Solidarity; https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC8483988/[2]. VAERS does sound an alarm bell regarding a greatly increased number of serious side effects, such as (but far from limited to) myocarditis. Even though the causal connection can never be proven beyond doubt, it is **the task of the health authorities to rule this out rather than to allow an experiment in which the increased frequency of serious side effects would first have to be proven.**

You say that infection leads to illness and in the vast majority of cases to recovery and permanently acquired immunity. How do you respond to the many repeat infections of which we are aware?

A solid and permanently acquired natural immunity in no way means that a person can no longer contract a mild disease, much less that he/she is protected from infection. It does mean that in good health the innate immune system after recovery has been sufficiently trained to prevent the breaking of that first line of defense from leading to serious C-19 disease now or in the future and it also means that after repeat infection the virus is eliminated. Indeed, one should not forget that the evolution to Omicron results from a kind of 'evolutionary burst' in which an antigen 'shift' poses a greater challenge even to the antibody-producing B1a cells of the innate immune system than if the SC-2 virus had gone through only an antigen 'drift'. It is therefore not surprising that even in the case of a prior natural

[1] This publication was unexpectedly and without any scientific reason withdrawn by the publisher Elsevier, coincidentally (?) just a few days before FDA was due to decide on infant vaccination authorisation....
[2] This publication was unexpectedly and without any scientific reason withdrawn by the publisher Elsevier, coincidentally (?) just a few days before FDA was due to decide on infant vaccination authorisation....

infection the immune system will have to work in two steps to control the infection fully. However, this does not detract from the indispensable task of the innate immune system to 'clean up' the bulk of the CoV load as a first line of defense and thereby reprogramme innate IgM-producing immune cells to recognize formations of N-glycans on SC-2 CoV with higher affinity in the future ('training effect').

How do you respond to Sciensano's study published in December on the long-term effects of covid? Sciensano surveyed people between late April and late June who became infected during that period. Often those people had not yet been vaccinated. I was one of them. Of the participants in the study, 47% always had at least two symptoms after three months that fit into the pathology of lung covid. How does that fit with your contention that infection leads to illness and in the vast majority of cases to recovery and long-term acquired immunity? How do you deal with long-term covid, a reality for about half of the participants in the Sciensano study?

Again: One must consider the health status and medical history of these people. A lot of viral diseases, described as acute, self-limiting infections, can lead to immune pathology or some form of chronic disease when the contribution of the innate immune system is weakened. This is certainly not an exclusive feature of Corona virus infection. Hence the importance in this assessment of whether underlying diseases or other predisposing factors were present in the affected patients. And there were. The report states that individuals with a history of chronic disease are significantly more likely to have *lung covid*, as are overweight and obese individuals. **But please also take a look at the possible side effects of the vaccine and then judge for yourself whether their regularity and quality does not seem excessive, given that the vaccination only protects against serious illness at most**. A selection of these numerous and, to say the least, disturbing officially reported side effects can be found in recognized sources as listed in the following links:

https://uploads-ssl.webflow.com/616004c52e87ed08692f5692/61fea9310d82c5d9b1d89455_Appendix_10_adverse_events.pdf

https://thepulse.one/2021/11/08/50-of-serious-vaccine-injuries-reported-in-last-30-years-are-from-covid-shots/

https://thepulse.one/2021/11/25/pfizer-was-aware-of-over-50k-serious-covid-vaccine-reactions-with-months-of-distribution/

https://rumble.com/vqx3kb-the-pfizer-inoculations-do-more-harm-than-good.html

Appendix 03 Cumulative Analysis of Post-authorization Adverse Event Reports.pdf (webflow.com)

https://www.aier.org/article/all-cause-mortality-in-the-united-states-during-2021/

https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC8483988/

https://uploadsssl.webflow.com/616004c52e87ed08692f5692/61fea931a30e6edce164f876_Appendix_06_Eudravigilance_tem_Jan_29_2022.pdf

https://www.nejm.org/doi/full/10.1056/NEJMoa2113017

https://www.nejm.org/doi/suppl/10.1056/NEJMoa2113017/suppl_file/nejmoa2113017_appendix.pdf

(Edit Febr 22)
https://www.researchgate.net/publication/357403474_Daten_die_nahelegen_dass_die_betrachtliche_Anzahl_der_schweren_Nebenwirkungen_und_Todesfalle_nach_Gabe_der_neuen_COVID-19_Impfstoffe_einen_kausalen_Bezug_zur_Impfung_hat

(Edit Febr 22) 1000 Peer Reviewed Studies Questioning Covid-19 Vaccine Safety (informedchoiceaustralia.com)

https://www.jessicasuniverse.com

https://uploadsssl.webflow.com/616004c52e87ed08692f5692/61fea9327b175b0d58023139_Appendix_08_Dr_Jessica_Rose_Analysis_of_Supplementary_Appendix.pdf

https://uploadsssl.webflow.com/616004c52e87ed08692f5692/61fea932e132248c62d1fffd_Appendix_05_Dr_Jessica_Rose_Symposium_CHONG.pdf

Also, the figures that recently became known from DoD (US department of defense) via whistleblowers illustrate that vaccine-related side effects are anything but negligible:

https://www.ronjohnson.senate.gov/2022/2/sen-johnson-to-secretary-austin-has-dod-seen-an-increase-in-medical-diagnoses-among-military-personnel

You say that a pandemic requires a global approach. If I understood you correctly, you say about that global approach that vaccination is not the way to go, but group immunity is. To what extent does that global approach fit into your research on a universal vaccine, focusing on natural killer cells, your own research project that you are working on professionally as a consultant? Does that fit in, do you want to steer us in that direction? I'm not a scientist, but I have some experience with communication. It fits in nicely communicatively, I think.

First of all, any immune intervention that contributes to group immunity will enhance the containment of a pandemic. In any case, I cannot be convinced that this can be done with a vaccine that does not achieve sterilizing immunity. Secondly, a vaccine that does not do this acts like mould on a damp wall when deployed en masse during a pandemic of variants.

Communication is one thing, being properly informed is another. I have already explained my research into the use of NK cells as a target for vaccines above. The spectrum of this research is very broad and does not focus specifically on Corona viruses. As an added bonus, I owe my deep insights into this pandemic and how our immune system is able to fight the SC-2 virus effectively to my study of how cells from our immune system are able to recognize the fine line between 'self' and 'self-like'. That study automatically introduces a scientist to the fascinating world of NK (Natural Killer) cells. I wonder if I should be surprised that politicians of all people are suspicious of people who in all conscience work for a higher cause...Since when does integrity make one 'suspicious'?

Laurence Zanchetta *(PS): Thank you Mr. Herry for your intervention. As for Mr. Vanden Bossche, I sincerely regret the lack of references to your speech.*

I hope that the various sources of literature I cite in my answers will ensure that you are no longer dissatisfied.

Steven Creyelman *(VB): I thank both speakers for their presentations. Most of my questions are for both of you, but if I have specific questions for one of you, I will say so.*

Everyone on this committee has been invited because of a certain expertise and has a clear position for or against compulsory vaccination. That has become very clear today. A number of propositions have been brought forward. What I did not hear in either presentation, honourable speakers, is on the basis of which specific studies you came to your position and why those arguments are more valuable to you than those of the other side. I am genuinely interested in those studies and would like to read them so that I can then get a better grasp of your world. If you could share those studies with us, I would certainly appreciate it.

I think the literature sources I mentioned above are a good start to understanding how complex and evolutionary a pandemic is. As soon as you acquire this insight, you will be able to conclude for yourself how simplistic it is to vaccinate an entire population en masse with this type of vaccine during a pandemic and thereby to put the virus under considerable evolutionary pressure when it cannot be contained at all. Add a touch of Darwin and you immediately understand the consequences of this large-scale experiment.

I'm an economist by training, so I'll talk about marginal surplus revenue. What do you both think is the marginal surplus revenue from making vaccination compulsory? 93% of Flemings are double vaccinated and a significant portion are already boostered. Being aware of that, what do you think is the better course, the most sensible one? Is it to focus on reaching those who are not yet vaccinated in the hope of achieving a higher vaccination rate, or is it rather to focus on the people who are already vaccinated and convince them to get their booster shot in order to protect them even more effectively, or is it rather a combination of the two? How do you see that yourself?

My opinion on this can be gleaned from prior responses

Following on from that, the question of one million, in your opinion, can we vaccinate ourselves out of this pandemic? Mr Vanden Bossche, if I understood correctly, you are saying that the current vaccines put pressure on the virus, cause it to mutate, and create variants. Do I understand that correctly? On what do you base your statement?

Again, vaccines do not cause the virus to mutate, but promote the spread of pre-existing, more infectious viral variants/mutants.

I read that a virus has no interest in killing its host and so variants are not necessarily a bad thing because a virus, in its survival instinct, is trying to become more infectious and less lethal or pathogenic. And so, it's just trying to survive. What is your position on that?

A virus can only replicate or mutate or hide (e.g. in the host genome but the latter is not applicable for CoV- it is for latent viruses). The virus cannot reason and has no strategy. **If the virus becomes less pathogenic or lethal, this is purely due to the growing immunity of the population**. However, certain viruses can continue to survive even then because some people act as asymptomatic carriers/excretors and also certain animal populations can harbour the virus (so-called 'reservoirs'). Both modalities are known and documented in case of SC-2.

Isn't vaccination a good thing in that sense? As you yourself pointed out, at least that's how I understood it, that way the virus is put under pressure and mutates into a softer form that becomes less problematic for us. I would like to hear your opinion on this.

Even though the dominance of Omicron is, in my opinion, due to the ever-increasing immune pressure of the population on the infectivity of the virus (antibodies are directed towards spike protein responsible for infectivity of the virus), one cannot consider Omicron as a 'softer' SC-2 version than the original Wuhan virus. Even if Omicron does not make people severely sick, it causes a huge infection pressure that will undoubtedly lead to more cases of disease. A sudden increase in the number of disease cases causes a sudden increase in immune pressure in the population without being able to stop the spread of the virus. This pressure - and thereby the probability that an Omicron-resistant variant will be selected this time - will only increase if mass vaccination (with anti-Omicron vaccines) is continued. **Once again, this shows that continuing the current vaccination campaigns is not a good thing from any point of view.**

As for the timeliness of compulsory vaccination, the WHO predicts in its crystal ball the end of the pandemic in Europe. I wonder if compulsory vaccination would then still make sense at all. In your opinion, is this still timely as a potential measure, taking into account, among other things, the variants that are now dominant, the medication against COVID-19 that is being developed, and the vaccination coverage?

As I indicated in my presentation, compulsory vaccination for C-19 in any form whatsoever cannot be scientifically justified.

Suppose Parliament decides to move to compulsory vaccination, we will be able to start roughly around the Easter period. I assume that at that time, in April and May, there will be less virus circulation. How should we deal with compulsory vaccination then? Does compulsory vaccination at that time make sense, given that by the winter period we will potentially have to inject a booster anyway? In other words, if a decision is made to have compulsory vaccination, when should we schedule it? What do you both think is the most suitable time?

As I indicated in my presentation, compulsory vaccination for C-19 in any form whatsoever cannot be scientifically justified.

Regarding viral inhibitors, what role do you both see for viral inhibitors, such as those produced by Merck and Pfizer in combating the pandemic? Can they be an alternative to compulsory vaccination or do you see it more as a complement?

Virus inhibitors may have a useful place in the early stage of C-19 treatment. They are then particularly useful in vulnerable individuals (immunosuppressed, elderly, those with underlying diseases) to inhibit viral replication. However, *general* antiviral propylaxis can also be useful, especially in the early stages of an infection wave, to curb the infection pressure and the resulting immune pressure of the population on the virus. It never makes sense to use antivirals for a long period of time and at a late stage of infection because it greatly increases the likelihood of resistance.

Yesterday, at the committee meeting, Mr Vandenbroucke said that vaccination for children and adolescents is actually essential in the defense against the virus. He also strongly recommends it. What is your position on vaccination for children up to the age of eleven and adolescents up to the age of seventeen? What is your position on the compulsory vaccination of these young people? What are for you the main advantages and disadvantages to be weighed?

According to the Office of National Statistics (UK), in 23 months (counting up to and including the end of December 2021), three children under the age of 18 died from Covid-19 (on a total population in the UK of approx. 67 million)**. This clearly illustrates that SC-2 is not a serious childhood disease**, even though children are infected and can get sick. Only very rarely do they become severely ill. Even in children, vaccines cannot control the infection. Even if the literature were to show unanimously that vaccination significantly suppresses viral elimination in children, that would not be a reason to vaccinate children. On the contrary, the more you put pressure on the virus with vaccines that cannot prevent it from spreading, the more pressure you put on the infectivity of the virus and the more quickly infectious 'immune escape' variants, which are selected as a result, will spread. Furthermore, children enjoy strong protection against SC-2 due to relevant (i.e. broadly effective against CoV) innate antibodies capable of recognizing all SC-2 variants. However, if the binding of these antibodies is dominated by vaccine antibodies that bind strongly to the virus without achieving significant neutralization, this is not a good thing in terms of individual protection against SC-2 variants. This may even suppress the recognition of other respiratory viruses equipped with a similar glycosylated envelope (e.g. Influenza or RSV) and the capacity of these innate antibodies to recognize and remove certain excess *self-antigens*, such as those originating from degenerated cells, may be limited (https://pubmed.ncbi.nlm.nih.gov/15633017/; https://pubmed.ncbi.nlm.nih.gov/33193450/). This raises questions regarding a possible risk of

developing autoimmune diseases. If one also takes into account the statistics of the possible side effects in children (Dr. Jessica Rose on Sars-CoV-19 vaccines for Children? | Voice for Science and Solidarity; https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC8483988/[3]) then **the vaccination of children against SC-2 is completely irresponsible**. **Finally, from the point of view of group immunity, mass vaccination of children is a bad thing**. This opinion is supported by several experts:

Feature: The scientific case for an immediate halt to covid 'vaccination' of children | Alliance For Natural Health (webflow.com)

Microsoft Word - Verkerk_paper_NL.docx (webflow.com)

https://www.thehumanside.be/post/de-olifant-en-de-mug-deel-2

https://covidrationnel.be/2022/01/03/revision-04-01-2022-la-vaccination-anti-covid-19-des-enfants-nest-pas-obligatoire-elle-nest-surtout-pas-necessaire/

https://americasvoice.news/video/17LSdDeqVc40GgZ/

Solid natural immunity (i.e. innate natural ±acquired immunity), as naturally present in healthy children, results in virus elimination and strong reduction of virus transmission (without exerting selection pressure on the virus!). **And so,** especially after training their innate IgM-secreting B1 cells, **healthy children make an important contribution to the emergence of group immunity**. Mass vaccination of children only contributes to the dominant circulation of more infectious to even vaccine-resistant variants which only further increases the infection pressure and the chance of group immunity melts away like snow in the sun.

Professor Ann De Guchtenaere said today on the radio programme De Ochtend that 70% of children had already had corona. What is the best thing to do with my child?

See above for my comments regarding Ms De Guchtenaere's conclusions.

By the way, what about the difference in immunity acquired by infection and by vaccination? Which protects best?

I have described the difference above. There is indeed a big difference.

Is that similar or is it different in young people from in adults?

Possibly, the innate immune cells of adults have a greater adaptive capacity resulting in a higher affinity of relevant innate antibodies while the innate B1a cells of children are more numerous but produce IgMs with relatively low affinity (i.e. more antigen-naive). This could at least explain why in older unvaccinated age groups the rate of infection is lower (in both vaccinated and unvaccinated people) and this trend even increases with increasing exposure (i.e. depending on the time) as shown in the graphs below (source: UKPHA):

[3] This publication was unexpectedly and without any scientific reason withdrawn by the publisher Elsevier, coincidentally (?) just a few days before FDA was to decide on infant vaccination authorisation....

Figure 2. Rates (per 100,000) by vaccination status from week 33 to week 36 2021

(a) COVID-19 cases

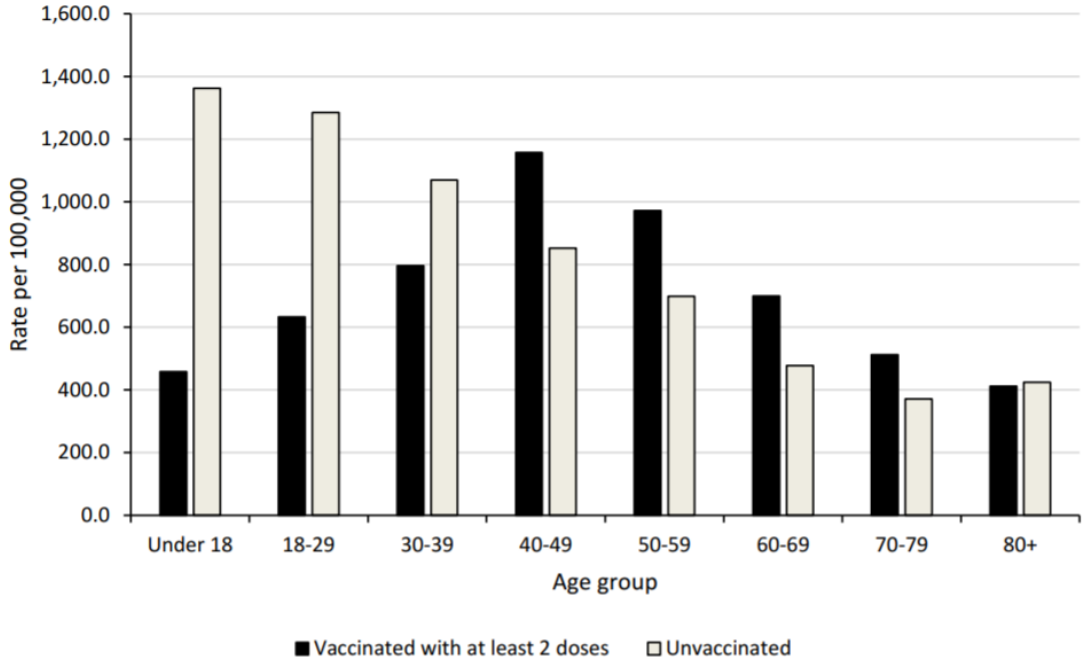
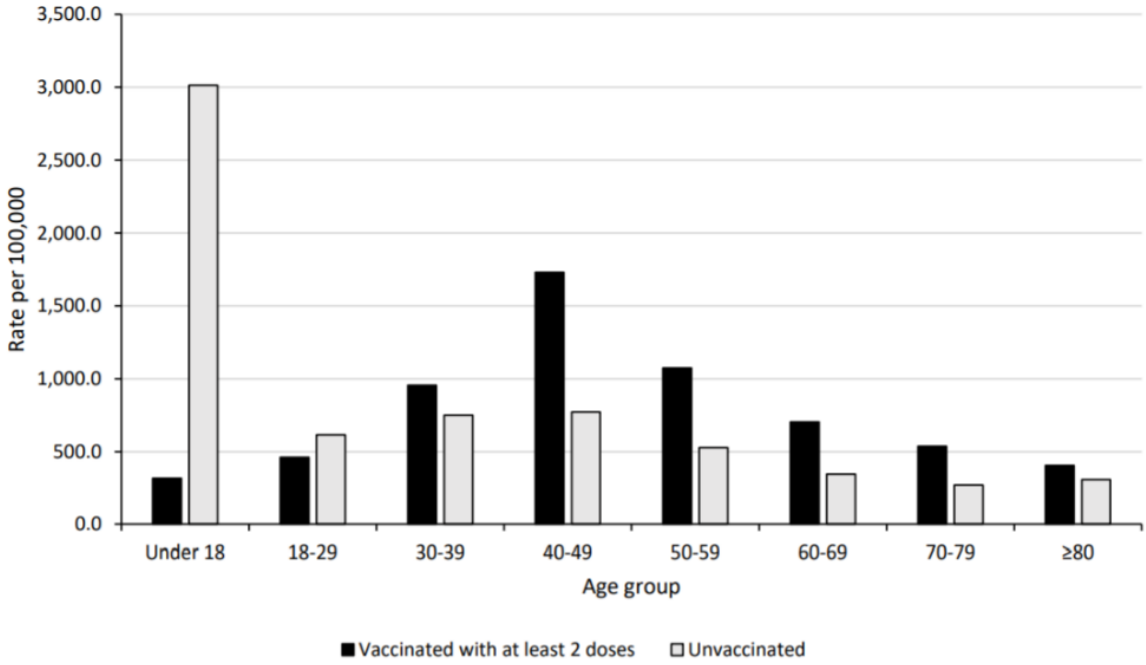


Figure 2. Rates (per 100,000) by vaccination status from week 38 to week 41 2021

(a) COVID-19 cases



Is there added value in vaccinating healthy people who have already had an infection? Is there a scientific consensus on that?

As noted above, there are numerous studies that show that people who have experienced symptomatic infection, and therefore acquired antibodies naturally, enjoy firm and lasting protection. And so, why expose oneself to a risk of side effects by getting vaccinated? Personally, I also believe that further increasing the concentration of S-specific antibodies will only ensure that the antiviral effect of relevant, polyspecific innate antibodies and other mediators of the innate immune system (https://www.researchgate.net/publication/357994624_Innate_Immune_Suppression_by_SARS-CoV-2_mRNA_Vaccinations_The_role_of_G-quadruplexes_exosomes_and_microRNAs) will be suppressed for an extended period of time. This possibly explains the higher incidence in the vaccinated population of other diseases, both infectious and non-infectious (including cancer), which are now increasingly being reported in the medical community. Even if the evidence is not officially accepted, the concern about this is scientifically serious enough to warrant more specific research rather than continuing such - incidentally very unusual - vaccination practices on an experimental basis.

Finally, what is the end goal?

Is it the eradication of the virus? Is it learning to live with the virus as a kind of seasonal virus? To fight the virus, we also need to know where we are going. What path should we take to get to where?

The end goal for a CoV is reached when an equilibrium is established between the virus and the host's immunity. That equilibrium can be achieved either by group immunity[4] or by selecting, through large-scale, non-sterilizing immune pressure, an SC-2 virus that can still be contained only by those who possess sufficient functional innate antibodies. In my opinion, this amounts to selecting that part of the population whose innate immunity is not compromised by e.g. S-specific vaccine antibodies that still bind to the virus, however without being able to neutralize it.

As described above, mass vaccination should be abolished and efforts should be made to provide one-time but large-scale antiviral chemoprophylaxis (to reduce infection pressure) **and to promote individual health** (to stimulate innate immunity). Only in this way can group immunity be created. This will automatically also provide better protection for vulnerable individuals. The latter must also be **given access** (e.g. through the family doctor) **to early treatment** consisting of various off-label medications that are safe, inexpensive, and widely available (e.g. anti-inflammatory drugs, antihistamines, cortisone, anticoagulants, etc.).

Daniel Bacquelaine (MR): *Mr. Chairman, I would like to thank Dr. Herry for reaffirming the benefit of vaccination because I think it is interesting and necessary that there be no doubt about the added value of vaccination. The debate we are having today is to determine the best way to increase the vaccination coverage of the population. What are the most appropriate instruments and strategies to achieve this goal? The purpose of Parliament is not to debate the value of vaccination. Dr. Herry has been very clear on this point. Vaccination is an effective and necessary tool. I would also like to thank him for reminding us of the involvement of general practitioners and hospital doctors in the fight - that is the right word - against this pandemic for the benefit of the entire population.*

I would like to ask a few questions. When we talk about the best way to increase vaccination coverage, in theory we immediately think of compulsory vaccination or the vaccination pass, which is a kind of obligation that is somewhat disguised but which ultimately allows the person to give full informed consent, since he or she can refuse the vaccination, even if it means not participating in social activities - and this can be his or her deliberate choice. My question is about proportionality. Clearly, when we impose an obligation, we must

[4] As already mentioned, it cannot possibly be achieved if mass vaccination continues because vaccination with the C-19 vaccines does not allow sterilizing immunity

always question its legitimacy and proportionality. These are the two criteria used by the Council of State to judge the relevance of an obligation, of a constraint with respect to the population.

As far as legitimacy is concerned, I think there is no difficulty. We are pursuing a public health objective, which is legitimate. There is no doubt about it. On the other hand, it is necessary to determine whether the way to achieve this public health objective is proportional and respects a certain proportionality in the extent of the constraint. This is the second criterion and it is the one that, in my opinion, is extremely important when we talk about mandatory vaccination.

The first question is therefore how to organize a mandatory vaccination system in practice. If we were to opt for mandatory vaccination, how would we organize it? Because there is no obligation without a sanction. An obligation without sanction is fallacious. We must therefore ask ourselves how to organize an obligation to vaccinate that would meet the objective of not having to control or test everyone to see if he or she is in compliance with the rules, because if he or she does not comply with this obligation to vaccinate, he or she is in the situation of being controlled or tested again. The obligation does not exempt from control, otherwise it would mean that there is no sanction. This obligation would then become pointless and ineffective.

With respect to health care personnel, Dr. Herry mentioned the term discrimination. Again, I don't think there is discrimination. Again, it's an issue of proportionality. Discrimination occurs when people in the same situation are treated differently. But that is not what we are talking about here. The caregivers and the cared for are not in the same situation. Therefore, there is no discrimination. The objectives of the obligation are based on the person to whom it applies and who is in a different situation. The public health objective imposes a vaccination obligation all the more so if it is aimed at health care personnel. That seems pretty clear to me. It seems that the decision has been made, according to what some people on the government bench have said, but it should be followed up.

Still in the principle of proportionality, there is proportionality in the scope of the obligation and the temporality of the obligation. These are two notions that we must take into consideration. In the scope of the measure, there are the caregivers that I mentioned and another point that was not really addressed. What about a possible obligation for children or minors? In Dr. Herry's mind, does the vaccination obligation also cover children, from what age? Does the vaccination obligation also cover patients who have just taken the covid?

What is the number of months that could be taken into consideration to make this obligation effective after a covid infection? I think that the interest of the vaccination pass in France is to take this notion into consideration. In the vaccination pass, there is not only the need for vaccination but also the fact of having been infected by covid in the five months preceding. What is Dr. Herry's position on this?

Then there is proportionality in terms of temporality. What about future vaccines? Today, we are at a particular moment. As much as we can debate the definition of an effective tool to fight a pandemic on a theoretical and absolute level - I think that the debate on mandatory vaccination has its place - it is necessary, in order to judge the proportionality of the measure at the time it is taken, to consider the time in which we are. Today, we have an omicron variant that produces far fewer severe forms and that infects a very large part of the population, far more than the figures that are quoted. I would point out that many people have been infected with omicron without knowing it or have not done a PCR test.

What about the arrival of new vaccines in terms of timing? If new, more effective vaccines become available tomorrow, will a fourth, fifth or even sixth dose be required as part of a vaccination obligation? Does the stage of the epidemic we have reached really make mandatory vaccination necessary, even if it is considered useful in a more general sense in the face of a pandemic?

Mr. Chair, I don't have a question for Mr. Vanden Bossche because he's outside the realm of knowledge.

And so, I do not need to answer this.

***Nathalie Muylle** (CD&V):*

Then I come to the general vaccination requirement. I have the same questions about that as quite a few colleagues. How do you see the vaccination schedule? Who should receive what at what time? How do you see the transitional periods, because there will always be a period in which everyone gets a booster or a fourth jab? Which authority should decide on this? A lot has already been said about this. On the basis of which study material should which body decide on this?

I also agree with temporality. The question then is when does a pandemic become endemic, when do we need to stop it and who should decide.

Also important is the age. You have not said anything about this. Other European countries do it from the age of 50 or 60, others from 18. Sometimes people ask if it should not be from 6 years of age. Which age do you propose?

You spoke very rightly about the impact today on care and care organization. If this committee were to decide within two to three weeks to go to a general obligation to vaccinate, how do you see the evolution in primary care and in secondary care? What will be the impact on the organization of care in primary and secondary care? How quickly will this change? How quickly will the pressure ease and will there be room for deferred care?

Mr. Vanden Bossche, I thank you for your presentation, but I must say that I also am still not satisfied. I saw your reaction to the article in Knack, in which you said, among other things, that you are not getting enough forum here. I am open to debate, but am actually waiting for studies, especially peer review studies. I understand that you say that Flanders or Belgium is a bit small, but we can also look at it internationally. What you bring today, how strongly does that resonate? How can you substantiate your presentation? We are open to debate and would like to look at those studies. I think this is true for a lot of colleagues. At the moment I am not familiar with those studies, but maybe that also has to do with the fact that we are biased and only see certain things.

It is always easier to look back at the facts post hoc. As I indicated above, it is a lot more difficult to look into the future with a complex evolutionary event that is strongly influenced by human intervention. Nevertheless, it is indispensable to estimate as reliably as possible the final destination of the various pandemic trains that are on track worldwide. Is this final destination the one we are aiming for with numerous human interventions and is it possibly identical? Publications from the various sub-fields concerned with the pandemic provide valuable information like pieces of a puzzle that must be fitted together before they can contribute effectively to a better understanding of the dynamic interaction between the changing virus populations (variants) on the one hand and the host population's adaptive immune defenses on the other. I have already mentioned above the publications that describe how a virus evolves under the immune pressure of the population. On the other hand, I have also mentioned above the publications that illustrate the importance of innate polyspecific antibodies as crucial components of the first line of defense against CoV and especially document how cells of the innate immune system adapt by exposure to CoV to fight the virus more efficiently. **In doing so, they indeed demonstrate the *bias* in the interpretation of many experts, and this is in the sense that due to lack of understanding of the above interaction, they have immensely underestimated not only the evolutionary capacity of the virus but also the natural adaptive capacity of the host immune system. The credibility of my insights should therefore not be tested against publications that do not *de facto* exist on this subject but rather against my predictions**: Inducing population immunity (via mass vaccination) that only protects against (serious) disease will, in my opinion, ultimately lead to only the unvaccinated portion of the population remaining protected against (serious) disease.

I am not trained in health care and therefore lack some basic knowledge, but I am left with a question to which colleagues have also referred. Mr Herry explained that nine million vaccinated people avoided disaster during the fourth and fifth waves. That does mean something. A total of 28,000 people died in our country from covid in the first year. Vaccinations started in February and March 2021, but the pandemic broke out a year earlier. About 20,000 people died from covid in 2020, about 8,000 in 2021, depending on who and what

ages are included in that calculation. If we had followed you, does that mean that - there were no vaccines at all back then - we would not have had 20,000 deaths? Would mass group immunity have solved that and could we have avoided that number of deaths by 2020?

I think I have already answered a similar question higher up. 'Short term' versus 'long term' vision. Tunnel vision versus holistic vision.

I would like to touch on one more element that you mentioned very briefly, but did not elaborate on. We understand your vaccine logic. You say it is treatable today. There are a lot of clinical studies and drug trials going on right now, some of which act on the virus itself and some of which act on our immune system. We are currently still in the clinical trials phase. Some studies have been published off-label, and that means that they are available on the market, albeit for different indication. What is that solution, what does the treatability mean that you are referring to? Why is it that we are still here debating off-label and clinical studies, often at very high cost? I would have liked more explanation on that.

Why this is still being debated without any decision-making process is also beyond me in any case. The above-mentioned peer-reviewed studies describe in great detail how drugs that are off-label, therefore cheap, and moreover widely available and known to be very safe, lead to an 85% reduction in hospitalization if they are used in the early stages of disease (i.e. within a week of the appearance of the first symptoms). One must ask why such treatments are not being used. Given the multiple studies proving the efficacy of these drugs in combating C-19 disease, this is totally irresponsible from a scientific-ethical standpoint.

Robby De Caluwé *(Open Vld): Mr. Chairman, Dr. Herry, Mr. Vanden Bossche, thank you for your explanations. I will try not to repeat myself but I still have quite a few questions for clarification.*

What advice do you give to parents who have been vaccinated themselves but do not yet know whether they will have their children vaccinated? Do you also notice that parents are reluctant to have basic vaccinations against polio and such like? Indeed, I feel that suspicion has increased against other vaccines as well, and that the classic anti-vax movements, as I call them, are running rampant. Do you both see these effects as well?

How often does it need to be repeated that these vaccination campaigns cannot be compared with the classical childhood vaccinations that are being discussed? Corona viruses, including SC-2, are ubiquitous and different animal species form a reservoir for the virus that is also highly variable. Moreover, the C-19 vaccines are non-replicating vaccines. The combination of these facts is not applicable to any of the vaccines in question or childhood diseases. Lack of understanding at the top leads to confusion among the population and, unfortunately, to suspicion regarding vaccination in general. Labelling doubters as 'anti-vaxxers' only adds to the suspicion of the basic vaccinations. The use of the label 'anti-vaxxer' is unfortunately also increasingly used by individuals or groups who have absolutely no knowledge of this matter.

I come to the long-term consequences. In your practices, do you often notice people who are still experiencing effects months later after a covid infection? Conversely, are there also cases of vaccine injury? After all, one reads about that regularly on social media. Mr Vanden Bossche referred to Vaccine Adverse Event Reporting (VAERS), where reports of vaccine damage or possible adverse reactions can be made. However, he described these reports as effectively linked to the vaccination, when in fact they are merely reports and nothing more. This is just lumped together.

Lack of knowledge is one thing but to express it with such conviction is quite another. Perhaps you should first inform yourself about the definition of a vaccine-related adverse reaction. And perhaps you should

also inform yourself about the various parameters that need to be met in order to consider a causal connection probable or unlikely. And then also to what extent the analysis of those parameters, e.g. as far as VAERS is concerned (see links below), led to a downright cry of alarm from people such as Jessica Rose, a lady with a background in computational biology, biostatistics and life sciences to boot (https://www.jessicasuniverse.com/cv-1):

https://www.jessicasuniverse.com

https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC8483988/

https://uploads-ssl.webflow.com/616004c52e87ed08692f5692/61fea9327b175b0d58023139_Appendix_08_Dr_Jessica_Rose_Analysis_of_Supplementary_Appendix.pdf

https://uploads-ssl.webflow.com/616004c52e87ed08692f5692/61fea932e132248c62d1fffd_Appendix_05_Dr_Jessica_Rose_Symposium_CHONG.pdf

Lumping data and analyses together or plainly ignore them, to me, that is incomprehensible and irresponsible behaviour.

Mr Vanden Bossche, most of the committee members here do not have a medical background. I am therefore reassured that some colleagues have the same questions as I do. But it is important that we get accurate information. Your plea was not so much about compulsory vaccination - your position on that is now clear - but mainly a plea against vaccination in brief, I noticed that in your presentation you added references here and there. They were not legible from here. Can you share with us the sources to which you referred?

Most certainly. You will find these and many others in my answers above.

Since I do not have a medical background myself, these expert explanations are very important to me. We hear contradictory views here, and that is good, but I do tend to rely on scientific theses on which there is a certain consensus. I really try to open myself up to your views, Mr Vanden Bossche, and I have also spent a great deal of time examining why you and some others postulate certain things. I am trying to understand why you claim certain things. I still lack a certain amount of substantiation, and that is a pity, especially since you are given a public forum here after all.

It would be utopian to assume that my insights in a short paper such as this would be sufficient to convince you. As I have already said, this is a particularly complex matter involving many different disciplines and correlations between them. **That is why I have from the beginning pleaded for a public but *scientific* debate within a multidisciplinary framework.** I understand your frustration with regard to the persuasiveness and credibility of my statement. I assure you that my frustration is at least as great.

I certainly want to be open to views to the contrary and wonder if you can help me with that. Can you provide me with some questions that I can put to other experts about the theories that they say are generally accepted by science, and this to prove that you are right and not they? I will give some examples (…).

I thought they were of the opinion that science evolves? Or do they only use this argument when predictions that are supposedly based on generally accepted truths don't come true? Perhaps with their supposedly generally accepted scientific theories they have more success in answering the questions I confronted them with earlier in contributions posted online. You can find them neatly listed on my website (https://www.voiceforscienceandsolidarity.org/blog/critical-unresolved-questions) as well as in some of my writings (e.g. https://www.voiceforscienceandsolidarity.org/scientific-blog/the-alleged-case-

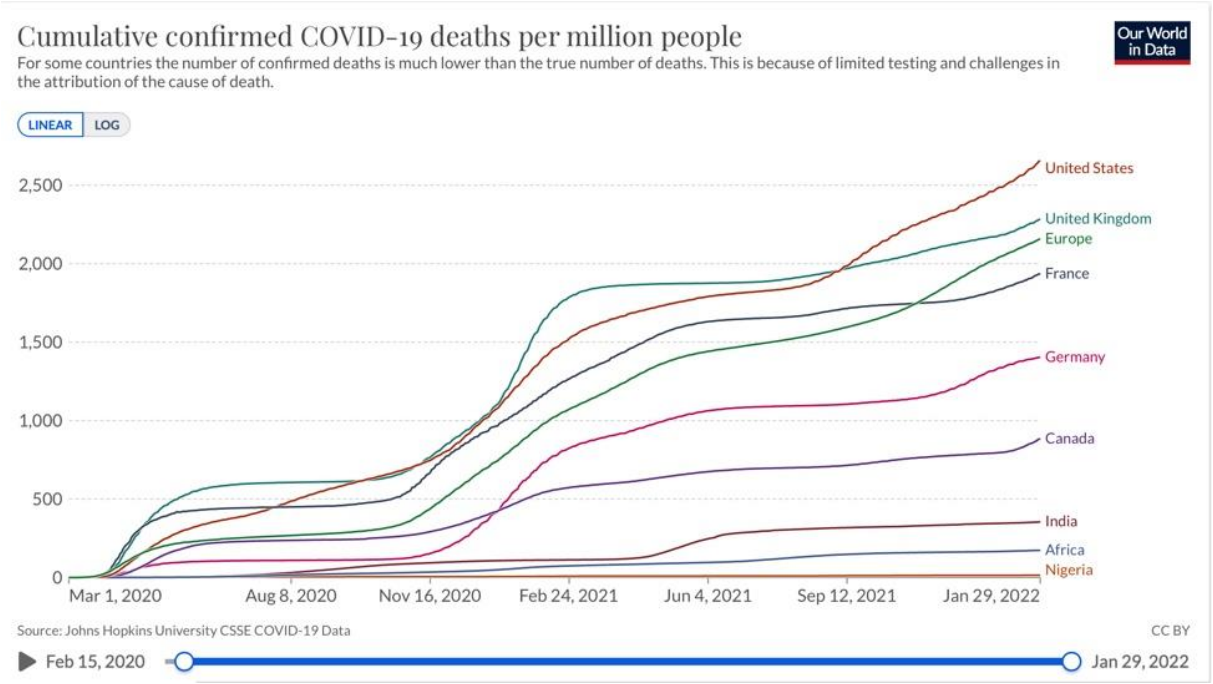
for-experimental-c-19-vaccination-of-children-is-merely-based-on-silo-mentality-and-immunological-ignorance)

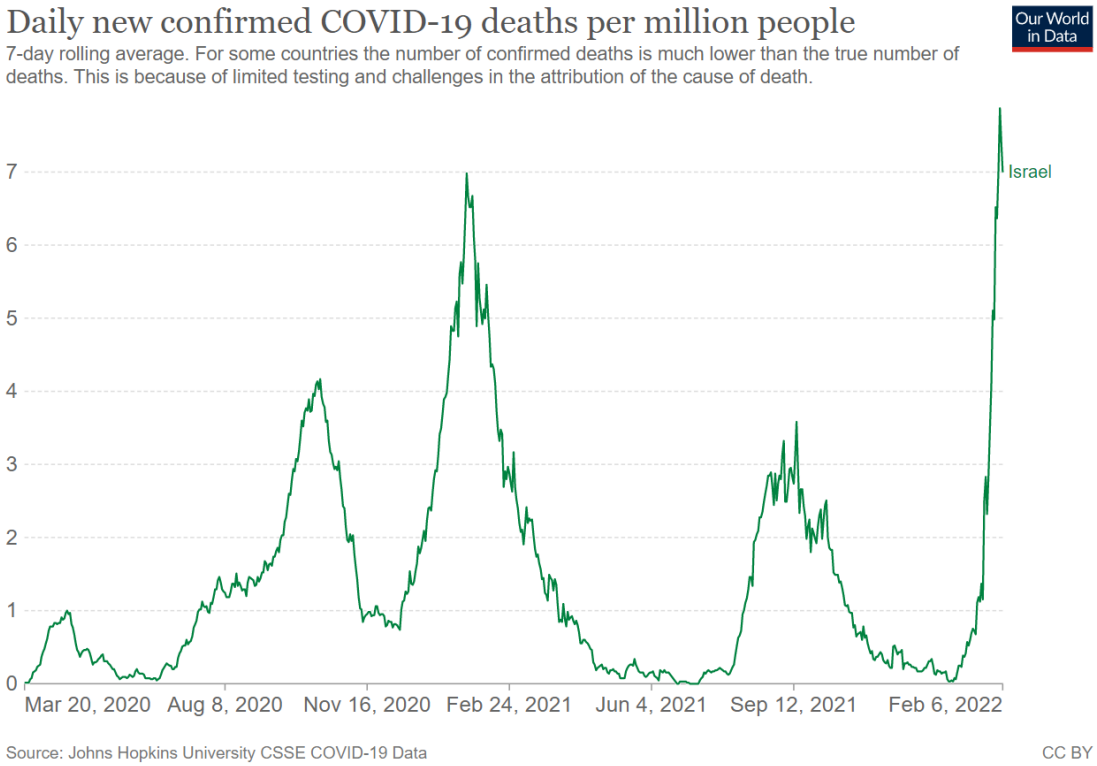
Sciensano's most recent report of January 22 reported that, at that time, 28,780 people had already died as a result of Covid-19, most of them during the first and second waves, when vaccination was not yet available. You predicted then that, with mass vaccination, the death toll would skyrocket even more. In the end, that turned out not to be the case. In your opinion, would it then have been better to pay a few thousand more deaths as a price? I would have liked clarification on that. People with medical backgrounds question that. Do you have any research that confirms that theory?

In a previous reply, I believe I made it abundantly clear that **not vaccinating is not the same as turning a blind eye and that a short-term vision will undoubtedly take a heavy toll in the future.** A toll caused by i) the increasing escape of the virus from the suboptimal immune pressure exerted by the mass vaccinated population, ii) the prolonged duration of the pandemic due to symptomatic mass vaccination and iii) the cases of morbidity and mortality due to vaccine-related side effects. With respect to the latter factor, the significant excess mortality, as determined by insurance companies among others, is particularly noteworthy and very disturbing:

https://www.fox28spokane.com/indiana-life-insurance-ceo-says-deaths-are-up-40-among-people-ages-18-64/

Furthermore, it is also curious that an increasing vaccination rate is apparently accompanied by a significantly increased mortality rate whereby the mortality rate is significantly lower in countries with a relatively low degree of vaccination. In Israel, for example, high vaccination coverage with boosters in quick succession even gives rise to a new, spectacular wave of mortality (see below). There is therefore apparently little evidence of a beneficial effect of mass vaccination on the mortality rate.





There were also your claims about a storm of autoimmune diseases with vaccination and vaccination of children. Could you explain how that differs from other vaccines that children receive - I think that's important too - or is your theory on that the same, which is that it actually makes little sense to vaccinate children against polio, for example? There was something that surprised me enormously, but I think I misunderstood you. I understood you to say that vaccinating children against COVID-19 with the argument that one would avoid MIS-C in this way is actually not done. I do find that strange, because MIS-C is one of the consequences of corona infection, just like other people get sepsis or the common cold. And so, I don't really understand that reasoning.

I have already explained above that a distinction must be made between the various modalities of vaccination and this depending on the pathogen, the occurrence of the disease and the type of vaccine. To make a comparison with vaccination against polio is just about the opposite extreme. As I also mentioned, I want to see the statistics of MIS-C in healthy children; I also wonder how likely it is that a vaccine that at best only protects against severe C-19 disease will be able to prevent MIS-C. Even if one completely ignores my warning about the risk that this mass vaccination will eventually lead to natural selection of a vaccine-resistant *immune escape* variant with more pathogenic character, even then the chance of serious, vaccine-related side effects on the health of completely healthy children must be weighed against a suggested prevention of MIS-C.

You have also been saying for a long time - you repeated it today - that the COVID-19 vaccines are experimental. That is not true. They are conditionally approved. Surely it is correct to make that distinction, so I just wanted to add to that.

'Experimental' does not mean that these vaccines were not tested, however, it means that they were inadequately tested. The preclinical studies were clearly inadequate (e.g. no genotoxicity studies, no biodistribution studies despite the *in vivo* production of the antigen i.e. Moderna, Pfizer and J&J vaccines), the clinical studies of too short a duration to make a relevant assessment of possible side

effects, even in the medium term, and different populations that are now blindly injected were not part of the efficacy study (e.g. children, pregnant women, women of childbearing age, people with underlying diseases, people who had recovered from C-19, the very elderly). **According to scientific criteria, the broad rollout of these vaccines through all walks of life can only be called an 'experiment'**. Even when a perfectly defined product is tested in unfamiliar territory, that product should be considered *experimental* in that capacity. I have too much experience in the vaccine industry to be convinced otherwise.

You also claim that vaccines could have long-term side effects. I notice that that is often an argument for people not to get vaccinated, but in science I read a lot of consensus that that is actually impossible. Can you provide me with some elements that challenge the other scientists and show that they are wrong, because there would still be certain side effects within five years?

I have already listed above the numerous sources that report on the alarming frequency of serious side effects. **There should be an obligation for our regulatory authority to report these side effects proactively, fully, and transparently to the population at very regular intervals (e.g. weekly). However, this is not happening**. The population is supposed to consult the data released by Sciensano on this subject. The problem of objective reporting and especially the probable cause of underreporting have already been mentioned above.

You further claim that natural immunity is better, stronger, and safer than immunity built up through a vaccine. You talk about the indelible immunological memory in that context, but I don't quite understand why that wouldn't kick in when infected. And so, what is the difference?

The difference between natural and vaccine-induced immunity has already been discussed in detail above including the 'memory function' which in natural immunity also relates primarily to the innate immunity ('training').

Do you think it is wise for people to allow themselves to be infected deliberately with the corona virus? After all, contamination parties are organized, some people do even crazier things - at least in my opinion - just to get infected. This is of course motivated by their belief that a natural immunity would be stronger. What is your reaction to this?

All I can say is that such behaviour is inspired and fuelled solely by a number of meaningless prescriptions that discriminate against people but are in no way founded on scientific evidence. Natural infection involves contamination via aerosols or small droplets, never intranasal inoculation to which you may be referring. For young and healthy unvaccinated people I see no reason to avoid contact, quite the contrary. Meetings of very many people in relatively small and poorly ventilated spaces have never been a good idea and this is no different for this respiratory infection.

Finally, I would like to say that the numbers actually contradict what you say about immunity. We really see a difference between people who are vaccinated and unvaccinated in terms of hospitalizations, even in terms of infections and in terms of deaths. If your theory were correct, the people who are vaccinated should end up in the hospital much more. Then the incidence in them should be much higher.

See my previous comments in this connection. Perhaps it's good to look beyond national borders once in a while.... *Vertrauen ist gut, Kontrolle ist besser*' is what they say in Germany. After all, the same pandemic is raging everywhere.

In the last RAG opinion, although based on a small sample, they examined the variant of a number of patients and it showed that of the people in the sample who were infected with the omicron variant, 61 were not vaccinated and only one of the patients was vaccinated. That's a huge difference. To be clear, we are talking about admissions due to corona infection. People who were admitted for other reasons are not included under this figure. I take those figures from the latest RAG opinion last Wednesday.

See above. If one looks at the numbers of people who are not hospitalized, one sees exactly the opposite. Vaccinated people get infected with Omicron more easily than non-vaccinated people (https://www.medrxiv.org/content/10.1101/2022.01.28.22270044v1). You will see that the ratio you indicate can change rapidly as is already the case according to reports from abroad: See my previous answer regarding *negative* vaccine efficacy (e.g. PHS, UKHSA), precisely for what concerns cases of infection! **'Snapshots' are thus not a reliable basis for a sound pandemic policy.**
Instead, the question to be asked is: **How can we end the pandemic and what immunity should we choose in order to protect ourselves as best as possible in the meantime**?

And so, I have a lot of questions about what you are saying. Again, it may be a bit much to answer all of them later on. If it is possible for the chairman, you may also answer many of my questions in writing, but please include the source references, because you may not know them by heart.

Right.

Melissa Depraetere *(Vooruit): Mr Chairman, I thank both speakers for their comments.*

Mr Vanden Bossche, you have said a lot. It was also a long exposition. You gave a lot of variants on the same argument. In my opinion, your reasoning is not entirely consistent.

I would like to make a few comments on that. After all, despite all the scientific evidence and the scientific evidence that currently exists from a great many experts, scientists, independent regulators, and people who are confronted on a daily basis in the field with COVID-19 and the operation of vaccines, you claim that they are all wrong. That's possible, of course. That is a remarkable reservation, to say the least.

I regret to note that you apparently only follow the media that support the narrative. **There are many thousands of scientists who - like me - hold completely different scientific opinions. However, they do not get a forum on the mainstream media despite their deep expertise**. Perhaps in the future you should also pay attention to the alternative media on which these people share their scientific findings. I can also assure you that from various circles of my former employers there is a great deal of support and understanding for my analysis. For reasons that you will be aware of, many of them prefer to remain anonymous. Incidentally, do you not see how the narrative is crumbling precisely because of the many contradictions that are increasingly being exposed thanks to independent scientists and reporters? Do you not notice how more and more countries realize that implementing complex, discriminatory but scientifically unfounded measures is no longer tenable. How they are rolling back those measures and regulations? What **is remarkable is the small world in which many live and the blind faith in media and officials who are paid with tax money collected by a state that is seriously considering introducing compulsory vaccination**. If you emphasize 'independent' regulators, it shows that you are not aware of the criticism that the FDA receives on a daily basis. Two officials resigned from the FDA last year. I happen to know one of them very well. I also happen to know one of the best known vaccinologists on the planet **who, at the beginning of last year, completely agreed with me regarding the consequences of mass vaccination with these vaccines on the evolution of the virus and who also warned me that it would not be worthwhile to oppose this, since I would still encounter incomprehension and would not get a hearing.** Obviously, these coryphets are not free of conflicts of interest. But please continue to think that I am the one who got it all wrong and who mainly wants to profile himself as an anti-vaxxer. That attitude is in any case easier than ensuring that instead of **an obligation to vaccinate, there is an obligation for serious multidisciplinary scientific debate**.

More to the point, the vaccines would also harm immunity because they strengthen the virus. According to you, the vaccines give partial immunity. The virus adapts to it.

I have never claimed that vaccines amplify the virus! I did say that the immune pressure exerted by the population due to mass vaccination with the current C-19 vaccines during a pandemic of SC-2 variants leads to dominance of more infectious escape mutants. And so, this is a consequence of the combination of the aforementioned factors and not of the vaccines themselves.

You have explained at length how you see that, with the escape clause, which is contained somewhere. What is strange about that reasoning is that the same reasoning does not apply to an infection that has occurred. Even with previous infections, we find from research that there is also a time frame attached to that and that after a certain phase, people do not fully see the effect of the infection either. There, too, the protection is incomplete and decreases over time. This has been demonstrated in research.

If I understand your question correctly you are confusing two completely different phenomena. The famously 'immune escape' that I am warning about is a population phenomenon while the fading of the effect of the infection relates to the individual. In other words, *immune escape in* no way precludes the vaccine-induced immune response from being perfectly capable of protecting individuals from (severe) disease. Moreover, it is also wrong to think that when individual antibodies disappear that person would no longer be protected from (severe) disease. **Also, it is a total fallacy to think that natural immunity is not protective because people get reinfected. An SC-2 variant that is highly infectious breaks through the first (innate) line of defense more easily; this does not mean that that line of defense is weakened**; Moreover, one may assume that - as is the case for other effectors of the innate immune system - the innate B1a cells, which protect against CoV via production of relevant polyspecific antibodies, are increasingly well trained and thus reprogrammed to recognize and eliminate CoV (including all SC-2 variants) with higher affinity, and thus more effectively. This therefore implies that the protective function of these innate immune cells does not decrease, but on the contrary increases. **This explains the 'negative' vaccine efficacy that has been clearly demonstrated in the meantime** (see above). **It is therefore a mistake - as long as the pandemic rages - to correlate the titres of antibodies acquired after natural infection with the degree of protection enjoyed by a person who has recovered from natural C-19 disease.** Immunology is thus somewhat more complex than is often assumed by our experts.

It is strange that we would argue that the covid virus would only evolve in light of the naughty vaccines but not based on previous infections or by training the immune system. That is a line of reasoning that I do not follow and find strange.

I have explained before why during natural infection CoV is not put under pressure while during C-19 mass vaccination during a pandemic it is. **This is due to the fact that during natural infection the fight against the virus is conducted in two different phases (innate immunity followed by acquired immunity**) while this is not the case with mass vaccination during a pandemic.

At the same time - this has been said before - all the mutants we know so far, i.e. alpha, beta, delta, gamma and now omikron, arose independently of vaccines. They arose at times when vaccination did not yet play a role in the pandemic or in places where vaccination does not play a significant role. Hence, I do not understand your reasoning very well.

See introduction. I have never claimed that mass vaccination is responsible for the EMERGENCE of viral variants!!

A third problem is a fundamental ethical one, which the committee should also debate. You give an argument that we hear quite often from the self-proclaimed alternative science. It is that the population should be repeatedly infected for the sake of group immunity. However, that is the same as decimating the population in the original sense of the word. That is letting everyone draw a lottery ticket and at the end see who draws the short straw. He or she is then out of luck. That person has then sacrificed for the group immunity. How far does that go? How many people who draw lots are involved?

If you were more or less aware of the literature, you would find that your comparison with the national lottery is not at all valid. **We now know all too well the predisposing risk factors.** We know which underlying diseases greatly increase the likelihood of severe C-19 disease. **We also know how a healthy lifestyle and healthy eating habits greatly reduce the risk. Regular exercise alone greatly reduces the risk of C-19 disease** (https://bjsm.bmj.com/content/55/19/1099). Unfortunately, governments attach too little importance to this and continue to treat SC-2 in the same way as other viral diseases with a totally different pathogenesis, different susceptible target group(s) and caused by viruses with a very different mutation rate and infectivity and which are largely fought with a different type of vaccines (e.g. live attenuated) that are never used for mass vaccination in the middle of a pandemic or epidemic[5]. In addition, early treatment of C-19 symptoms reduces the risk of severe illness and hospitalization by 85%. Whether one likes to hear this or not, as a virologist with extensive experience in immunology, I can assure you that without group immunity, one cannot end this C-19 pandemic without 'sticking it out'.

What you suggest has also been tried. In Brazil it has been more or less tried. However, the situation there is dramatic. Your theory has not worked there. It is therefore not clear to me how you would see it differently in our country. However, the theory has not worked in practice, with all the consequences that entails. Even reduced pressure on hospitals, which is one of your arguments pro, has been absolutely non-existent. Even that benefit is not detectable in Brazil.

Regarding your comparison in Brazil, I refer you to an earlier reply. The reasoning that acquiring group immunity implies that one cannot take any measures at all to prevent hospitalization and mortality is short-sighted. Vulnerable people need to be protected and treated; outbreaks of high infection pressure need to be combated (via targeted infection prevention measures and appropriate housing to avoid *overcrowding*, for example) and more emphasis needs to be placed on healthy diet and lifestyle to significantly reduce the vulnerable fraction of the population. **The chronicity of the pandemic to which our ill-considered policy has led cannot possibly lead to group immunity and will therefore, with the highest probability, ultimately lead to more hospitalizations and deaths than if, as indicated above, measures were used to minimize the damage of a natural pandemic as long as group immunity is not a reality.** However, when these measures - especially early treatment - are ignored, it is not surprising that hospitals are overburdened. **And even if a milder variant such as Omicron takes the pressure off the hospitals, even then people do not seem to realize that this is a last chance to still acquire group immunity at a responsible price[6]**. Instead, our government is ordering anti-Omicron vaccines and will thus prevent group immunity from emerging.

[5] As became (barely) known, by the way, the administration of an Ebola vaccine during the Ebola pandemic in West Africa (2014-2016) was also highly problematic: https://uploads-ssl.webflow.com/616004c52e87ed08692f5692/61f65c43db047c9050ffe014_Critical_analysis_Ebola_vaccine_trial_GVB.pdf

[6] provided that flanking measures such as early drug treatment and, *ideally*, collective antiviral prophylaxis are in place

Mr Vanden Bossche, I do not have any specific questions for you because, with all due respect, I do not expect a scientifically valid answer to my questions from you. My questions were addressed to Mr Herry.

Likewise, with all due respect, bias has never been a good virtue.

Sophie Rohonyi (DéFI): *Mr. Chairman, like my colleagues, I wanted to thank our two speakers for their presentation, although I note that Mr. Herry still had the honesty and decency to support his remarks with scientific studies, unlike Mr. Vanden Bossche, but I will come back to that later.*

We know that other vaccines are also required for a child to be able, for example, to attend a nursery. This is the case for vaccines against diphtheria, whooping cough, measles, mumps or rubella. There are also vaccines that are "strongly recommended", such as those against pneumococcus, meningococcus C or hepatitis B.

I must also come back to the question of contraindications, in relation to your experience with the polio vaccination, but also to confront you with the statements of Mr. Vanden Bossche, who insinuated that contraindications would not be taken into account in the case of compulsory vaccination against covid-19.

However, it is clear that both the Royal Decree of October 26, 1966 and the Health Law of September 1, 1945 expressly provide for medical exemptions; these provisions state that "the existence of a contraindication must be attested by a detailed medical certificate mentioning the probable duration of the contraindication and sent to the health inspector of the area. The latter will inform the mayor of the municipality of the child's residence. Do you consider, in the light of your practice as a general practitioner, that this system is now perfected and that, consequently, it can be transposed to vaccines against covid?

We also observe that in France, medical contraindications have been foreseen in case of allergic reaction to the first doses of the vaccine or in case of myocarditis associated to the covid infection or in case of capillary leakage. These contraindications can be certified by both a general practitioner and a specialist. Except that in France, this list of medical contraindications is much broader than the one existing in Belgium where, for the moment, the only accepted contraindications are allergic reactions to one of the components of this vaccine against covid. Do you advocate for a system similar to the one in France, which has a long list of accepted medical contraindications that can be attested by a medical certificate?

The contraindications mentioned in my argument do not involve factors that could promote side effects of the vaccine but rather modes of administration that could promote either resistance of the pathogen to the vaccine as well as exacerbation of the disease itself upon exposure to the pathogen. Such contraindications are curiously not disclosed for vaccines.

You state your position - namely mandatory vaccination and I will wait for you to specify the age - on the basis of hospitals that should be protected at all costs from new overloads of patients to be treated. But why not target this mandatory vaccination to those most vulnerable to covid, namely the elderly or those with comorbidities?

This is the opinion defended by the infectious diseases specialist Nathan Clumeck, and this is the system in force in Italy and Greece. I would like to know your feelings about this more targeted option.

Do you also think that the vaccination obligation should be temporary, i.e. based on the possible lesser virulence of the virus, for example on the basis of the barometer, or by the disappearance of the virus? As for the geographical area that would be covered in this case.

We also know that the vaccine does not prevent the virus from being carried, but that it drastically reduces both the transmission and the severe forms of the disease. Therefore, can you tell us more about the proportion of patients infected despite their vaccination? Do you confirm that they would have been much worse off if they had not been vaccinated?

The question shows a total lack of understanding of the consequences of symptomatic vaccination on the evolution of the virus. Mass vaccination, or even vaccination of an entire group of vulnerable individuals, when carried out during a pandemic will always lead to natural selection, especially when current C-19 vaccines are used against variants whose spike protein is very different from the spike protein against which the vaccine is targeted.

Do you see a significant improvement in your patients' immunity after this third dose? Do you think that the vaccination obligation should be limited to these three doses or would it be more like several booster doses of the currently licensed vaccines or a booster dose on the eve of winter, similar to what is done for the seasonal flu? In the latter case, could we imagine that the covid vaccine and the flu vaccine could be administered simultaneously, at least for the most fragile people for whom this flu vaccine is necessary??

Such vaccination of a limited group of the population (e.g. the vulnerable) could possibly be considered if these vaccines were used OUTSIDE of a pandemic. However, for the time being, this is not at all the case. The pandemic is still in full swing. Simultaneous administration would, of course, also require extensive clinical studies, not only to demonstrate *non-inferiority* of the immune response to each vaccine but also to generate sufficient safety data.

Still on the subject of the type of vaccine used, do you consider that compulsory vaccination can be done today? Is there a difference between messenger RNA vaccines and others, like Novavax? Or should this mandatory vaccination use the future vaccines that are adapted to omicron and expected in March or April?

Let me briefly turn to the questions I wanted to address to Mr. Vanden Bossche.

Firstly, you say that no vaccination obligation is scientifically justifiable. But the European Court of Human Rights has ruled on this several times and has therefore recognized the legitimacy, the proportionality and therefore the legality of a vaccination obligation for very clear public health reasons. How do you respond to all of these rulings??

My argument is about scientific justification. **As a scientist, it is hard to imagine that immune interventions that are scientifically unjustifiable would find a legal basis**. If this is the case, then there is clearly something wrong with the relevant legislation.

Secondly, you tell us that the current vaccines are not able to control the pandemic. Just to be clear, I think that the responsible parties here have never said that the vaccine is a panacea. On the contrary, we say that it must be seen as one tool among others. This can be seen in the proportion of people vaccinated in intensive care units, which must be analyzed in relation to the proportion of people vaccinated in the general population. It is more or less 10% at present.

Today, we can see from the Sciensano studies that the risk of ending up in intensive care is much lower when people are vaccinated, whether they are in the 18 to 64 age group or in the over 65 age group. Can we therefore consider that you totally question the veracity of these figures given on a weekly basis and even more by Sciensano?

I have already made a statement regarding the statistics in hospitalizations; how they are constantly evolving, absolutely no sound basis for long-term measures and how the 'snapshot' mentality poses a huge risk that symptomatic mass vaccination will eventually lead to variants that are characterized not only by high infectivity but also by increased virulence. I am thinking here of an increased virulence that does not necessarily arise from a change in intrinsic viral properties but, for example, as a result of the binding of non-neutralizing antibodies to the virus, a phenomenon that clearly constitutes a risk for ADE ('antibody-dependent enhancement' of disease). Only when such an evolution of the virus occurs will we

perhaps realize that the short-sighted strategy of avoiding hospitalizations through mass vaccination, regardless of any objective aimed at generating group immunity, was wrong and that it would have been better to have recourse to early multi-drug treatment.

Thirdly, you underlined the lack of hindsight that we have today for all these vaccines concerning the possible side effects. This is an argument that comes up very regularly among those who are reluctant to take the vaccine and who should not be categorized as antivaxers, at least not all of them. Another argument that often comes up is that this vaccine is still in the experimental phase today.

Can we not consider today that the recent nature of these vaccines is compensated by the enormous number of people vaccinated - we are now at 52% of the world's vaccinated population -, by the very low proportion of serious side effects observed and by the transparency that is given to them? This recent character is not compensated by the number of lives saved thanks to the vaccine, by the fact that we have been able to avoid the burn out of doctors or the overloading of hospitals?

The study of safety of a vaccine should be done during the various phases of clinical development, not as an 'experiment' on the population. It seems to me that you are not aware of the severity and extent of the side effects reported. And perhaps also not aware of the underreporting. In Belgium, for example, 15 times fewer side effects are reported than in the Netherlands for a population that is only 1.5 times larger than that of Belgium (see above). I can only hope that the above sources reporting the various C-19 vaccine-related effects will give you pause for thought.

You also said that we were not "honest" enough about the side effects of vaccines. Can you tell us which side effects we have not been honest enough about? As I said, there is a weekly bulletin on this subject that is very clear and that comes from the Federal Drug Agency.

See above. Perhaps it is important to take a moment to look 'beyond the national borders' at the VAERS, EudraVigilance and DoD databases and compare the C-19 vaccine-related side effects reported therein as documented in 2021 with the similar side effects of past Years.

Fourthly, I had to react to your thesis according to which it would be better to move towards a natural immunity which would be acquired by an infection with the virus rather than by vaccination. I think that your argument is extremely dangerous because it encourages voluntary infection. In Germany, for example, advice is circulating on social networks on how to become infected for sure, whereas it is impossible to anticipate - even if you are young and healthy - the severity of the symptoms in case of infection with covid or whether you will suffer from long-lasting covid.

The idea of 'voluntary infection' only came about because of the pressure put on young people by governments either to be vaccinated or to submit either a certificate of recovery from infection. **One should not be surprised that such measures, scientifically unjustifiable, lead to panic and rashness among non-vaccinated people who are increasingly pressured to be vaccinated when they clearly do not want to be**. If you understood this, then perhaps you would not need to accuse me of inciting voluntary infection.

I think your speech is very dangerous, even criminal. I want to say that. By doing so, you encourage people to take the risk of saturating our hospitals, with the consequences that this also implies for non-covid patients who see their treatment and care postponed, sometimes with fatal consequences.

Your arrogant allegation constitutes a direct *ad hominem* attack and is nothing less than an attempt at character assassination. Such statements by people with a political mandate threaten society and quickly give rise to a spiral of degrading discrimination and segregation which a number of countries are already sadly witnessing. And this while your knowledge of the pandemic does not go beyond that of my neighbour's cat. Apparently, you do not even seem to realize that you are thereby stapling your business card inseparably to the first page of the minutes of this hearing.

Finally, still in relation to your theory, I would also like to remind you that there are people who have been infected by the virus several times without ever touching the vaccine. This shows that the immunity acquired by an infection, without being vaccinated, is temporary.

You clearly do not understand that each time in these cases the healthy person in question was protected from disease precisely thanks to natural immunity. The same cannot be said of vaccines. **Why do you set the bar as low as possible with vaccination (protection against severe disease) while setting it as high as possible with natural immunity (protection against infection)?**

In other words, with your strategy, it would be in our interest to keep the virus with us since we would have to be reinfected as soon as the immunity acquired through contamination would no longer be sufficient. I wanted to have your answer to this, especially since, as we have heard, some experts, such as the epidemiologist Pascal Crépey, have reminded us that the greater the circulation of the virus, the more opportunities you give this virus to find solutions to a problem such as vaccination or natural immunity.

Did you really think then that we would eradicate this virus? This would then assume that the vaccines have sterilizing immunity, that there are no asymptomatic carriers in the population, and that there are also no animal populations harbouring the virus. None of these conditions has been met. On the contrary, mass vaccination during the pandemic only gives rise to the dominant circulation of more and more infectious variants with Omicron as the icing on the cake. Exactly that leads to more and more virus circulation and indeed - as P. Crépey claims - increases the chances of natural selection of SC-2 variants capable of overcoming the immense immune pressure exerted by the population. **I argue exactly the opposite i.e. to reduce drastically the infection pressure and risk of transmission via group immunity**. Even though a drastic reduction of the infection pressure leads to the fading away of naturally acquired antibodies, there is something like an 'immunological memory' which enables a previously recovered individual to reactivate the natural immunity very quickly. And so, the population also quickly regains control of the 'outbreak'. Such outbreaks can always occur (e.g. seasonally) during the endemic phase. **However, given the mismanagement of this pandemic, for the time being we can only dream of such an endemic phase....**