VACCINES, VACCINE DEPLOYMENT, AND "NEW VACCINES"

(LSF SPECIAL REPORT ON VACCINATION)

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INTRODUCTION

i. Unbundling an Entangled Subject

The crucial subject of vaccination is actually comprised of three related, but very different issues, viz: Vaccines, their modes of Deployment, and so-called "New Vaccines". The "new vaccines" refer first to various combinations of existing vaccines into one shot; and subsequently to products based on entirely novel principles/formats different from the traditional ones. At the present time, the definition of what constitutes a vaccine has even been revised, such that vaccines are no longer specifically required to prevent infection, and transmission of pathogens. As we show later in this document, any product can now be labelled "vaccine" once it can stimulate an appropriate immune response in the body.

The key issues involved in this subject are largely uncomplicated, and can be discerned by simple common-sense analyses. To simplify our discussion still, however, we must begin by unveiling the major complication in the whole matter - the man Bill Gates. This self-proclaimed "philanthropist-capitalist" is the world's foremost investor in vaccines, and he insists on setting the applicable rules of engagement. Even though he has no training in medicine, medical personnel and institutions worldwide reverently defer to his pronouncements, especially on the subject of vaccination. Recently, Mr Gates announced he would be giving away $200 billion (90% of his entire fortune), over the next 20 years [1]. He, of course, will not be throwing away the money to charity; but rather deploying it to drive values and products he is keen on imprinting on the world. Vaccination happens to be the principal among these.

Bill Gates is very open about his beliefs and convictions. Basically, he is concerned that the world is overpopulated and that this is putting considerable strain on available natural resources, as well as exacerbating global warming. These, he believes, would eventually result in some irreversible planetary catastrophe sometime in the future. Justifying his colossal investments in vaccine development and global deployment, Mr Gates explained at a 2010 Ted Talk, that "New Vaccines" are one of the chief instruments that will help reduce global warming -- by systematically doing away with 1.5 billion people [2].

Though censored out by mainstream media, the speech is widely presented and discussed on the internet. Stating that the global population was heading towards 9 billion, Gates, in what could

be a slip of the tongue, said: "If we do a really great job on New Vaccines, Healthcare, Reproductive Health Services [i.e. abortion], we could lower that by

perhaps 10 or 15 per cent." See video at https://www.ted.com/talks/bill_gates_innovating_to_zero.

A multitude of "Fact Checkers", mostly sponsored by the Bill and Melinda Gates Foundation, have laboured to explain that what Mr Gates actually meant about "New Vaccines" was quite different from the plain meaning of what he said!

At the present time, Mr Gates $200 billion is at work, being disbursed to so-called media Influencers, charged to re-interpret to us what Mr Gates statement was supposed to "actually mean". We should be aware that these Influencers are drawn from our locality, and invariably would include our neighbours, relatives, and church members! This Special Report will be highlighting key clarifications we must demand, when presented with such new narratives. The consequences of our taking wrong actions on vaccination could be very dire, certainly much dire than some projected consequences of "global warming." Among other consequences, it could easily result in the vast reduction of human population which Mr Gates glowingly speaks about.

ii. Summary of our Position

For 10 years, the LivingScience Foundation has endeavoured to educate the public on vaccination, clarifying the important differences between the related concepts of Vaccines, Vaccine Deployment, and "New Vaccines". In our opinion, vaccines on their own, are to be celebrated and embraced as God-given, potentially life-saving products, derived from the labour and ingenuity of hardworking and well-meaning scientists. However, as for any other medical product, marketing vaccines for indiscriminate mass deployment or under dubious scheduling and unending dosing, is fraught with several serious demerits. These potential demerits turn into causes for serious alarm when we see the definition of what constitutes a "vaccine" being changed to incorporate "new vaccines" based on new principles and extremely controversial new technology. In this regard, it is particularly concerning that the "new vaccines," according to alterations made to definitions on the website of the US Centers for Disease Control and Prevention, are no longer required to possess sterilizing immunity (that is, to prevent infection or transmission of diseases – the traditional purpose of vaccines) [3]. The mRNA-based COVID vaccines are a prime example of this new development [4].

iii. Conditions for Justifying a Vaccine Solution

Useful as vaccines could be, their deployment whether in individuals (for example the rabies vaccine for the occupationally-exposed Vet doctor) or in the general population (for example the COVID vaccine) should be based on

carefully-evaluated benefit-to-risk considerations. Factors that would determine the merit or otherwise of a vaccine solution include:

1) Efficacy – how well does it work?
2) Duration of the efficacy - how long after full dosage before the efficacy wanes and "boosters" become necessary?
3) Target biological endpoint and its relevance - What exactly does it "prevent" – new infections? hospitalizations?
4) Safety - are the health risks introduced by the intervention justifiable relative to the benefits?
5) the Logistics involved in its procurement, storage, and delivery (for instance the number of doses required for full dosage: the higher this number, the higher the chances of non-full compliance and consequent failure).
6) The economic Costs of the whole enterprise, and
7) Possible Spin-off benefits for other sectors.

Furthermore, the choice of a vaccine solution should be evaluated against other possible solutions, including primary prevention of the infection in the first place, use of prophylaxis, or prompt therapeutic solution - where effective drugs exist. For infections that are not life- threatening, recovery with prophylaxis and drugs helps the body to acquire a more robust natural immunity than what is obtained from manufactured vaccines. Indeed, vaccines serve as light infections that provoke natural immunity, only that they usually are designed to target specific strains of the disease-causing pathogens. (While this might produce faster result, it is also less robust). Above all, a vaccine solution must be justified not only on its own merit, but also on how well it fits in with other solutions, complementing them rather than competing with, not to talk of jeopardizing, them.

The seminal article by Robert F Kennedy (Jnr) presented incontrovertible historical data establishing that the contribution usually attributed to vaccines in the reduction of childhood mortality is hugely exaggerated [5]. It turns out that in most cases, in the western countries usually cited, mortality had already plummeted before the first vaccines were ever developed.

iv. Criminalizing Rational Hesitancy

The final point of concern to be addressed on the subject of Vaccination is the growing tendency to criminalize acts deemed "vaccine hesitancy". Advocates for indiscriminate mass vaccination try to push some moral burden on the unvaccinated, accusing them of not permitting the attainment of some "herd" immunity that would in theory make possible the "eradication" of some target disease.

The herd immunity theory has however been challenged by several reports of outbreaks of infections even in communities with more than 99% vaccine coverage [6]. Even more striking are data that emerged during the COVID pandemic. For instance, a country like Gibraltar which rushed to attain an official 101% immunization rate, actually ended up becoming the worst- affected COVID nation - within three months of their initially widely acclaimed success.[7]

It will also be recalled that during the same COVID-19 saga, even while no vaccine had yet been developed, Mr Bill Gates came out to authoritatively declare that normalcy to the globally imposed "lockdown, masking, and social distancing" would come, only when literally "every person on earth" is jabbed with one of the experimental COVID vaccines, he was going to sponsor [8]. In the same vein, there was the heinous report in 2012, of rural folks in Malawi being compelled by Gates-funded NGOs, to take the measle vaccine, AT GUN POINT [9].

All these defy plain simple logic. For a vaccine-preventable infection, the only persons who should be in jeopardy of their health are the unvaccinated. For vaccines that are truly effective, the vaccinated should be safe from the infection irrespective of what some other folks do or fail to do.

v. Way Forward:

Every man-made product can always be improved upon. There must be concerted efforts to constantly improve on the safety and efficacy of vaccines. However, this will only happen when they are transparently developed, and administered only in situations where their benefits clearly outweigh the inevitable associated risks; with the contraindicated conditions well noted and respected.

In the next section of this document, we provide brief reviews of some common vaccines/vaccine types, currently being deployed *əò⇒ô ɑẗ ẗ ə*, and largely indiscriminately, in Nigeria. The principal point to note is that most of the vaccines are presented for use in Nigeria in formats that are PROSCRIBED in the developed nations where they are produced. It could also be noted, in passing, that Nigeria's once-thriving capacity for local vaccine production [10], dating back to 1940, was rudely truncated in 1991 during a supposed facility upgrade, promised by players from the advanced countries. This has now turned us into the proverbial beggar that is not entitled to make choices.

SPECIFIC CASES

We now apply the principles and points discussed above, to seven specific special cases – Polio Vaccines, Thimerosal-Containing Vaccines, Combination Vaccines, Malaria Vaccines, Human Papilloma Virus vaccines, Covid Vaccines, and General mRNA-based vaccines. The discussions are concise summaries extracted mostly from our previous articles, which can be consulted for additional, more technical, details and references as might be needed.

i. The Oral Poliomyelitis Vaccine (OPV)

Poliomyelitis, commonly known as polio, is a highly contagious viral disease that primarily affects young children. It can cause paralysis and, in some cases, even death. The disease is caused by the poliovirus, which is transmitted principally in unsanitary conditions through food and water that has been contaminated with faecal matter. Enormous human and financial resources have been deployed towards the utopian goal of totally eradicating polio in the world through the use of vaccines targeting the most prevalent strains of the poliovirus. One cannot but wonder, however, if better health outcomes would not have resulted if only a fraction of such resources had been directed to improve basic sanitation globally. This would not only drastically prevent polio infections to start with, there will also be positive spin-offs for numerous other diseases associated with poor hygiene. These in particular, include diarrheal, which is responsible for the death of 150,000 children in Nigeria, every year [11].

However, the main problem with polio vaccination in Nigeria is that it involves largely the administration of Oral Polio Vaccine – OPV, a vaccine that has been proscribed for use in the western world. The United States for instance, stopped the use of OPV in 2000, and shifted to the Inactivated Polio Vaccine (IPV) [12]. The reason is that the OPV uses weakened but live polio virus to inoculate children and stimulate an immune response. It is however well-established that this weakened virus, shed in the stool of vaccinated children, in course of time regains strength and starts to cause poliomyelitis in the community! [13,14] Since the efficacy of OPV in the vaccinated is less than 100%, both the already vaccinated and unvaccinated stand in jeopardy of being infected by this shed virus. The polio subsequently caused by the vaccine is termed "circulating Vaccine-Derived Poliovirus" (cVDPV), and is deemed by global health authorities as a general, inevitable consequence of vaccination which must be accepted – for developing countries, chiefly Nigeria.

With relentless condemnation of this unconscionable discriminatory practice by respected public health authorities over the years, the World Health Assembly in

May 2012, decided that OPV should be phased out and replaced with IPV globally. Though Nigeria made a symbolic introduction of IPV in 2015 [15], ten years later most of the polio vaccines administered in the country are still OPV. The childhood vaccine schedule from the NPHCDA (Table 1, accessed on 5th August, 2025), stipulates 4 doses of OPV and 2 doses of IPV [16]. The logic of mixing OPV and IPV is not clear. Even one dose of OPV administered to millions of children is guaranteed to generate cVDPV!

Another very troubling dimension to the continued use of OPV is the emerging facts concerning the development of what is referred to as the "post polio syndrome." This has been observed in people who have been exposed to mild polio infection - such as that resulting from receiving the OPV. The syndrome, characterized by "decreasing muscular function or acute weakness with pain and fatigue" in more than 80% of polio infections, takes between 15 to 30 years before manifesting [17]. It is of course, difficult to diagnose and trace it to its source - the polio vaccine administered so many years previously. Conditions contraindicated for OPV are listed on the Medecins Sans Frontieres web page on HPV [18].

ii. Thimerosal Containing-Vaccines (TCV)

Another category of vaccines exclusively shipped to developing nations for their use, but which are proscribed for use in the western nations producing them, are the so-called Thimerosal- Containing Vaccines (TCVs). For this class of vaccines, thimerosal is used as a preservative that allows multiple doses to be put in a single vial. The doses can then be drawn from the vial, with little fear of contamination with repeated access. Thimerosal is, however, a deadly chemical comprised of 49.6% of highly toxic ethyl mercury. Even at minute trace levels, mercury in any form, is known to be a deadly neurotoxicant, affecting brain function and development; as well as causing other health problems including sterility and kidney problems.

The United States, on Tuesday July 22 2025, banned thimerosal, from all U.S. vaccines citing its potential neurotoxicity risks. This is a bold move that the US had been scared to make for two decades, principally on concerns that it might jerk awake, developing countries who are the main recipients of mercury-laced vaccines produced for them by the developed nations. [Watch the announcement of the extensive justification of the US ban at https://www.youtube.com/watch?v=PvzUjHFI9l0&t=4s]

Actually, in the United States, mercury had been proscribed in all vaccines, except the Haemophilia B vaccine, since 2001. For the haemophilia B (Hib, or simply flu) vaccine, a mercury-free version is also made available together with

the mercuric version. For the rest of western nations, all mercury-containing vaccines have been proscribed for more than 30 years. The major concerns are the well-established adverse effects associated with even extremely low level of mercury on brain development in babies.

Nigeria's health authorities are well aware of the deadly nature of mercury, and would not tolerate even the minutest level of this chemical in soaps and cosmetics. The fear is that the chemcial could somehow reach babies in the womb of pregnant women who may use these products [19]. Incredibly however, the very same deadly product is welcome in the vaccines that are injected directly into these same babies. The tacit endorsement given by the World Health Organization to supposed indigent nations, is waved by the Nigerian authority as the licence for perpetuating this heinous atrocity.[19] As at the present time, three major vaccines on the routine childhood immunization schedule in Nigeria contain mercury. These include the Tetanus- Diphtera (or alternatively, the Diphtera-Tetanus-Pertussis) vaccine, the Hepatitis B vaccine, and the Flu (Hib) vaccine. The Hep B vaccine is administered to totally helpless babies at birth! [16]

In announcing the ban of all mercury-containing vaccines in the US, the Secretary to the Department of Health and Human Services, Mr Robert F. Kennedy, made a passionate appeal to the global health authorities sponsoring mercuric vaccines in developing countries, saying:

> *"Now that the US has removed mercury from all vaccines, we urge global health authorities to follow suit for the protection of children around the world. We urge the World Health Organization and GAVI to stop their programs of injecting mercury into more than 100 million black and brown babies in developing countries annually...."* [20]

It is doubtful these global bodies will heed this call which would certainly disrupt a thriving global vaccine industry. It is left for Nigerians to put pressure on the government to free Nigeria's babies from this wicked brain-damaging, destiny-destroying practice.

To read details of the case against Thimerosal-Containing Vaccines, check reference [21]

Iii. Mixed Combination Vaccines

Apart from use of mercury preservative, another class of vaccines prepared almost exclusively for use in the so-called Low and Medium-Income countries like Nigeria is combination vaccines. These new vaccines comprise of several traditional vaccines combined and administered together in one shot. For

instance, the Pentavalent vaccine combines DTP, Hep B, and the Hib traditional vaccines. The DTP vaccine itself is the combination of diphteria, tetanus, and pertussis vaccines, which were developed and trialed as separate entities. The main objective for this combination arrangement is to increase vaccine uptakes, especially in the wake of new vaccines being continually added to the childhood schedules. However, the vaccines were not originally developed for use in this "combination" format, and it should not be surprising the myriads of adverse issues that have been associated with the practice.

A landmark research funded by the Danish government, "examined the introduction of diphtheria-tetanus-pertussis (DTP) and oral polio vaccine (OPV) in an urban community in Guinea-Bissau in the early 1980s". The study reported that unvaccinated children had far better health indices than those vaccinated! According to the paper, "The negative effect was particularly strong for children who had received DTP only and no OPV". It also noted that "All-cause infant mortality after 3 months of age increased after the introduction of these vaccines".[22]

A 2012 paper in the Archives of Disease in Childhood reported that: "Studies from low-income countries have suggested that diphtheria-tetanus-pertussis (DTP) vaccine provided after Bacille Calmette-Guerin (BCG) vaccination may have a negative effect on female survival." The study then went on to confirm that girls who received DTP after BCG had a significantly increased death rate ratio (DRR) of as high as 5.68, compared with unvaccinated girls. [23]. Despite such a finding, the Nigerian vaccine schedule still requires babies to receive BCG at birth, followed by DTP six weeks later [16].

The general explanation indicated by the results of vaccinated subjects having worse health outcomes (including higher "all-cause mortality") than unvaccinated subjects, is that even though a vaccine might be providing relatively positive outcome for the particular disease it was developed for, it invariably could be having overall deleterious effects on the general immunity status of the recipients, thereby making them more susceptible to other diseases. Clearly, therefore, the justification for vaccines to be routinely administered should be evaluated holistically, not just with respect to a particular disease. It is clear that better outcomes will result if vaccines are rationally deployed, with contra-indicated factors carefully considered; rather than blind, mass vaccination of all subjects available using one-size-fits-all protocols.

The performance of these new combination vaccines is perhaps best summarized with the following reports of Adverse Effects Following Immunization (AEFI), taken from "*Extract from report of GACVS meeting of 12-13*

June 2013, published in the WHO Weekly Epidemiological Record on 19 July 2013": [24]

"Four countries that introduced pentavalent vaccines from 3 different manufacturers presented their experience:

- *1) Sri Lanka introduced the pentavalent vaccine from Crucell in January 2008. Within 3 months, 4 reports of deaths and 24 reports of suspected hypotonic-hyporesponsive episodes prompted regulatory attention and precautionary suspension of the initial vaccine lot. A subsequent death that occurred with the next lot in April 2009 led the authorities to suspend pentavalent vaccine use and resume DTwP and hepatitis B vaccination.*
- *2) Bhutan introduced pentavalent vaccine from Panacea in September 2009. The identification of 5 cases with encephalopathy and/or meningoencephalitis shortly after pentavalent vaccination prompted the authorities to suspend vaccination on 23 October 2009. Subsequently, 4 additional serious cases related to vaccine administered prior to suspension were identified and investigated.*
- *3) India introduced pentavalent vaccine from the Serum Institute of India in the states of Tamil Nadu and Kerala in December 2011.... To date, 83 AEFI cases, some of which were associated with mortality, have been reported after vaccine introduction from some states.*
- *4) Vietnam introduced pentavalent vaccine from Crucell in June 2010. Through May 2013, a total of 43 serious AEFI cases were investigated, including 27 with a fatal outcome. Following receipt of reports of 9 deaths following vaccination between December 2012 and March 2013, health authorities suspended use of the vaccine.*

(https://www.who.int/groups/global-advisory-committee-on-vaccine-safety/topics/pentavalent-vaccine)

Despite these established negative outcomes, the vaccine remains in use till today. The Report ascribes this to "actively managed public communication about the observed events and their public health implications." As seen in Table 1, this same pentavalent vaccine still features prominently on the Nigerian childhood immunization schedule at the present time (at weeks 6, 10, and 14).

In closing, we might also mention here another notorious form of this unscrupulous mixing of vaccines - recommended specifically for the "low and medium-income countries" (LMIC). This is the "Mix-and-Match" protocol recommended by the WHO with respect to mRNA COVID vaccines in the heights of the COVID debacle [25]. The protocol encourages people from LMICs

to freely mix their uptake of COVID vaccines by receiving whichever brands were available to them at any particular point in time – as "generously donated" by western countries.

In short, the WHO bold-facedly endorsed that subjects from LMIC could take a first dose with one brand of vaccine, and take subsequent doses with other brands! This is outrageous, as clearly, there have been no clinical trials ascertaining the safety or efficacy of such combinations!

Iv. Malaria Vaccine

We wrote a comprehensive article on the malaria vaccine at its debut in Nigeria in 2023. [24]. Interestingly, the NAFDAC had condemned the RTS,S vaccine endorsed by the Federal Ministry of Health, rather routing for the R21 vaccine which had been ignored by the Ministry. Both vaccines, however, are based essentially on the same principles and materials. Both target the pre-erythrocytic phase of malaria, using the same key antigen - the Circumsporozoite Protein (CSP) - albeit in different concentrations, and with different adjuvants.

In the article, it is shown from hard records that the newly touted malaria vaccines were indeed developed for short-term visitors from the outside world to malaria-endemic zones (specifically military personnel and tourists). A strong market in sub-sahara Africa is however required to make their production economically viable!

Stated efficacy of the vaccine is generally between 30 – 40% with duration of less than 7 months. Particularly concerning were safety issues. It is sad but noteworthy that the World Health Organization was found culpable of hiding adverse effects observed during clinical trials in a clearly desperate effort to promote this vaccine. The adverse effects included "a ten times higher rate of meningitis, a higher chance of cerebral malaria, and a doubling of deaths from all causes in girls who had received the vaccine and not the placebo."[25]. Sadly, these issues are yet to be transparently resolved [26].

Notwithstanding all these serious deficits, we still recognize that these products of decades-long hard work by dedicated scientists might still be literally life-savers for some categories of people. We therefore endorsed the vaccines with the caution that it should be deployed strictly in line with their actual characteristics. We particularly recommended that it be made clear to people (particularly the press!) that at less than 50% efficacy, the vaccines are no silver bullets; and that government should not attempt to incorporate them into the list of essential vaccines to be vigorously recommended for the masses – as the marketers had bluntly demanded! [27] Unfortunately, these counsels have gone

unheeded, and the malaria vaccine is now incorporated into childhood vaccine schedule in several regions of Nigeria [28] A 2013 Report by the Parliament of India, investigating the deaths of several girls in the shoddy clinical trials (dubiously dubbed "observational study") of HPV vaccine in India, noted that once a vaccine got included in the universal immunization programme of a country, the manufacturer(s) are guaranteed "windfall profit, ... by way of automatic sale, year after year, without any promotional or marketing expenses." It further noted that "once introduced into the immunization programme it becomes politically impossible to stop any vaccination".[29]

v. HPV Vaccine

It is generally held that cervical cancer, causing an estimated 8,000 annual deaths in Nigeria, is associated with infection by the human papillomavirus (HPV). However, although the infection by HPV definitely leads to warts which could progress to cervical cancer after about 15 - 20 years, if left untreated; the pathway is not at all straightforward, and the rationale for mass vaccination as the solution for cervical cancer has been vigorously challenged .

In 2006 Gavi announced a $600 million HPV initiative with the goal of vaccinating 86 million girls in low- and middle-income countries by 2025. In the estimation of Gavi, the exercise will somehow avert "over 1.4 million future deaths" . Several assumptions used to arrive at these figures are clearly faulty.

First, HPV is a sexually transmitted infection, with the virus present at some point in time in up to 90% of anyone who has ever had sex. However, the infection is naturally cleared in over 99% of people who get it. Progression to cancer only occurs if this infection persists, is undetected, and consequently left untreated for a period of over a decade. A number of simple laboratory tests, including the pap smear test, regularly taken every three years could however reveal such HPV infection and available effective treatments applied. This looks like the straightforward approach to dealing with cervical cancer, rather than the global mass vaccination solution concocted by the GAVI.

This is especially so, since there have been numerous serious adverse effects associated with the vaccine. The medical literature from across various regions of the world is full of these adverse effects, which can be summarized under two broad categories: premature ovarian failure (leading, of course, to various reproductive issues) ; and serious neurological and autoimmune disorders . Other, rarer adverse effects include veinous blood clots, kidney issues, and even death . In the US, the federal Vaccine Injury Compensation Program has paid out more than $70 million to people making claims regarding for injuries arising from HPV vaccines .

These adverse events are known to be inevitable. Deliberately embracing them in mass vaccination events offering spurious benefits is therefore quite incredible. According to Lyons- Weiler of the Institute for Pure and Applied Knowledge [37]:

> *"In 2009, we were told the Severe Adverse Event [SAE] rate of HPV vaccines was 6.5%. But a study we published in Science, Public Health Policy & The Law showed that the adverse events profile of the HPV vaccine is far worse than has been reported.....Unleashing this vaccine on millions of girls and young women will lead to a mass casualty event these countries do not now have, and do not need. SAE's will occur at the rate of 65,000 per million women vaccinated, and the claimed net benefits of the vaccine are just not there."*

Then again come the very concerning technical issues surrounding the vaccine types itself. First of all, as is becoming the trend, the particular vaccines shipped for use in LMIC are different from those in use in the first-world countries. Actually, they are essentially products that have been tested and discarded (or even proscribed) in the first-world countries, but are expected to be managed by LMICs – supposedly for an interim period - due to economic reasons. There are about 150 strains of HPV, with two of them, strains 16 and 18, responsible for about 70% of warts that could lead to cervical cancer, globally. However, the contribution of the different strains to cervical cancer is not uniform all across the globe, and there are significant regional variations. [In Nigeria, the major strains are 16,18,31,35,51,52, with the first two responsible for about 67% of cancerous warts].

Currently, the only vaccine used in the US is the nonavalent Gardasil-9 which targets 9 strains of HPV, with two or three doses, according to ages of the recipients [38]. In Nigeria however, the recommended vaccine is the Gardasil-4 quadrivalent HPV vaccine targeting only 4 strains [6, 11, 16 and 18]. On roll-out, the vaccine was to be administered in three doses to achieve the nominal efficacy indicated during its development. However, at the present time, the WHO has determined that one dose will suffice [39]. It is troubling that the main reason for this new protocol seems to be a desire to enroll as many participants from the LMICs into the vaccination programme, with little concern for the health outcomes. Indeed, a WHO Press Release hailing the revised protocols, specifically related them with a "goal of having 90 per cent of girls vaccinated by the age of 15 by 2030." [40]

Apart from the safety issues previously mentioned, there is also a big technical question on the long-term efficacy of the vaccine solution for HPV infections

and cervical cancer. This arises from studies indicating that while the vaccine might indeed reduce the prevalence of the target strains of HPV, they could end up increasing the prevalence of other more virulent, previously non-target strains. These also could end up contributing to cervical cancer! This phenomenon is known as HPV-type replacement [41].

It is therefore not at all surprising reports indicating that despite two decades of global mass HPV vaccination campaign, there is no significant reduction in incidences of cervical cancers. Indeed, in some populations, there are reports of increased incidences of cervical cancer in the vaccinated compared with the unvaccinated [42].

An extensive review of mass HPV vaccination written by the US-based Children's Health Defense (CHD) featured some specific comments on the programme in Nigeria. In the report [37], Michael Baum, an attorney representing vaccine-injured plaintiffs in several lawsuits against Merck in the US was quoted:

> *"U.S. data makes it clear that vaccinating millions of Nigerian girls with Gardasil will cause a staggering number of serious adverse events, including death."*

Similarly, Kim Mack Rosenberg, co-author of "The HPV Vaccine on Trial" said:

> *"Having studied the HPV vaccines in depth for several years, I am profoundly concerned about Nigeria's mass vaccination campaign. Instead of vaccinating millions of girls, steps should be taken to reduce risk factors that may contribute to cervical cancer, including early pregnancy and multiple pregnancies, poor nutrition and poor nutritional status, lack of access to clean cooking fuels, and others."*

Sexual intercourse at a young age, multiple sexual partners, and oral contraceptive use are other well-established risk factors associated with cervical cancer. [43, 44, 45]

vi. COVID Vaccine

During the extra-ordinary COVID pandemic, several vaccines were developed and given Emergency Use Authorization. Among these were vaccines based on mRNA technology which were being authorized for human use for the first time ever. With time, the mRNA brands by Pfizer and Moderna have risen to be quite popular, relative to those based on traditional methodology, such as Sinovac and Novavax.

The many serious shortcomings in the novel mRNA-based COVID vaccines are by now thoroughly exposed. An extraordinary virtual library, called the Covid

Index (https://covidindex.science/), provides what has been described as "the world's first and largest searchable directory of excerpted, categorized evidence countering the fallacious 'Covid Narrative.'" One article searched from the Index, Compilation: Peer Reviewed Medical Papers of *COVID Vaccine Injuries* [46] listed papers according to 50 adverse effects ranging from Acute Hyperactive Encephalopathy, Acute Kidney Injury, Acute Myelitis, Blood Clots, Cerebral Venous Thrombosis, Guillain–Barré Syndrome, Intracerebral Haemorrhage, Myocarditis, Neurological Symptoms, Systemic Lupus Erythematosus, to Vogt-Koyanagi-Harada Syndrome.

At the present time, litigations against COVID vaccines are piling up in courts, [47]and one manufacturer, Astra Zenica, has decided to pull her vaccine from the market. [48]

Our detailed article on COVID vaccine can be accessed at the churcharise blogspot [49].

vii. Other mRNA-based New Vaccines

Despite these glaring negative side-effects, the COVID vaccine remains endorsed all across the globe, including Nigeria. Interestingly, it turns out that a major impact of the COVID vaccine is its serving as fore-runner and legitimizing agent for the new and radically different mRNA format for vaccine formulation. Nucleic-acid format for vaccines had been tested (and serially rejected) for decades. [50] However, at the onset of COVID, the supposed unknown risks of the pandemic were deemed sufficient reasons to grant Emergency Use Authorization to the nucleic acid formulation for vaccines [51]. The little room then granted to mRNA vaccine has enlarged tremendously, and at the present time, global health authorities have determined that all the existing time-tested vaccines are now to be made available only in this mRNA format! [52]

According to Drew Weissman of University of Pennsylvania's Penn Medicine,[52] efforts are ongoing to develop mRNA Vaccines for "Every Imaginable Infectious Disease." Already, several mRNA products, which can now be labelled "vaccine", according to revision made to the original definitions, are at the final stages of their being released to the public. These include mRNA-based "vaccines" for malaria, Influenza (flu), Zika virus, Respiratory syncytial virus (RSV), HIV, Cytomegalovirus (CMV), and even Cancers [53, 54]

It is to be again emphasized that this new technology does not provide sterilizing immunity, and it is accepted as a vaccine, only because the definition of what constitutes a vaccine had been reviewed [55]. Until the advent of COVID vaccines late 2021, a vaccine was defined as "a product that stimulates a person's immune system to produce immunity to a specific disease, protecting

the person from that disease." Immunity, in turn, was defined as "Protection from an infectious disease," meaning that "If you are immune to a disease, you can be exposed to it without becoming infected." Since the COVID mRNA products which were to be marketed as "vaccines" did not meet these criteria, [56, 57] the US Center for Disease Control and Prevention (which gave the first authorizations to the mRNA products) changed the above definition of vaccine on their website (on 1st September, 2021) to now read: "A preparation that is used to stimulate the body's immune response against diseases." According to this new definition, vaccines no longer need to necessarily prevent infection or transmission of diseases, only that they be able to stimulate an immune response. [57].

The extension of these "New Vaccines" to non-infectious Cancer derives from the possibilities of their being used for very early detection (or more accurately, prediction) of cancers, together with the design of appropriate therapy personalized for the individual concerned according to their genetic composition -- all within few hours.

The new format also opens up the possibilities to deploy these products through air sprays, or incorporated into foods right from the farm through genetic modification.[58] Indeed, as recently announced by a Bill Gates funded NGO, the new vaccines can also be administered through "dental floss". [59] The expressed motivation for all these new developments is to contain "vaccine hesitancy" and assure that "vaccines" can be administered widely in populations, with or without consent of the people.

If this trend plays out as scripted, then it can be seen as the endgame to the entire vaccine enterprise, innocuously started two hundred and twenty-nine years ago.

CONCLUSION

In this document, we have attempted to clarify the distinction between the three related concepts of Vaccines, Vaccine Deployment, and New Vaccines.

Vaccines, which started out as products mimicking the natural immunity system of the body have come a long way in their over two centuries of existence. For economic reasons, deployment of vaccines have been prescribed in formats and schedules which do not necessarily align with the clear recommendations of the scientists who developed them. Amazingly, it has become the reality that vaccine products and schedules deemed unacceptable at the developed

nations, on account of established adverse health effects, could be pushed at the so-called Low- and Medium-income ones, and such action termed "magnanimity and philanthropy".

This is questionable considering the apparent desperation with which the products are literally shoved down our throats at the LMICs. For instance vaccine producers literally spend a fortune in what is euphemistically referred to as "shaping the market" for facilitate vaccine uptakes in the low- and middle-income countries [60,61]. The goal, as stated on the GAVI website is to guarantee: "long-term, high-volume and predictable demands" [62] from the LMICs, ahead of any other considerations.

Such records are available, documenting that apart from humongous funding invested into development and global deployment of vaccines, further huge fundings are deployed to facilitate their uptake. This is achieved by vigorously molding public opinions through the activities of so-called Influencers and Gaslighters. For instance, official records show the Bill and Melinda Gates Foundation allocating nearly $6 million to various groups in Nigeria to facilitate vaccine delivery in the funding cycle starting 2023. This included, for example, the Abuja-based Sydani group which received $2.8 million to promote the HPV vaccine in particular. [63]

The so-called conspiracies, attributing this sordid state of affairs to various hidden nefarious agenda, are unfortunately further fueled by the uncontroverted fact that the developed nations deliberately sabotaged long-existing thriving vaccine production facilities, in the developing nations (at least in Nigeria), so as to create the current dependency and associated tummy-turning risk assessments.

At the present time, the WHO has a system of classification, assigning so-called Maturity Levels to nations, that presumably qualify them to produce vaccines or restrain them from so doing. By this classification, Nigeria is currently assigned Maturity Level ML3 [64], and is proudly looking forward to attaining the final level ML4 by 2028 [65]. Until then, the country is deemed not competent or permitted to embark on vaccine production. Nigeria's once thriving vaccine production facility was unfortunately sabotaged in 1991, after more than 50 years of operation, when globalists offered to help with an upgrade.[66]

It should be considered a significant national security threat, that products which must be imported from other countries are insisted on, to be administered internally to the entire children population (the future of the nation). It is similarly illogical to promote these products with a narrative that those who hesitate to embrace them, asking critical questions, are somehow jeopardizing the health

and well-being of those who are already fully vaccinated and supposedly protected.

The LivingScience Foundation hopes this document will help readers make informed choices for themselves, as well as push for the sane development of this worthwhile product for the good of public health in Nigeria. We particular wish to reiterate that, in our opinion, the Church has no business pushing the mass vaccination solution -- as she is subtly being urged to do by nefarious forces. Her duty, rather, should be to cooperate with groups like the LivingScience Foundation and compel government to review and improve the vaccination situation in Nigeria.

We urge that the federal government declare an emergency on vaccination to ensure that development, production, and deployment of vaccines are geared towards sustainable development in Nigeria based on locally-assessed risk-to-benefit considerations.

Table 1: Nigeria Routine childhood Immunization Schedule

ROUTINE IMMUNIZATION SCHEDULE

Minimum Target Age of Child	Type of Vaccine	Dosage	Route of administration	Site
At birth	*BCG	0.05ml	Intra dermal	Left Upper Arm
	**OPV0	2 drops	Oral	Mouth
	***Hep B0 birth	0.5ml	Intramuscular	Anterolateral aspect of Right thigh
6 weeks	Pentavalent (DPT, Hep B and Hib) 1	0.5ml	Intramuscular	Anterolateral aspect of left thigh
	Pnemococcal Conjugate Vaccine 1	0.5ml	Intramuscular	Anterolateral aspect of Right thigh
	OPV1	2 drops	Oral	Mouth
	IPV1	0.5ml	Intramuscular	Anterolateral aspect of Right thigh (2.5cm apart from PCV)
	Rotavirus vaccine 1	**5 drops**	**Oral**	**Mouth**
10 weeks	Pentavalent (DPT, Hep B and Hib) 2	0.5ml	Intramuscular	Anterolateral aspect of left thigh
	Pnemococcal Conjugate Vaccine 2	0.5ml	Intramuscular	Anterolateral aspect of Right thigh
	OPV2	2 drops	Oral	Mouth
	Rotavirus vaccine 2	**5 drops**	**Oral**	**Mouth**
14 weeks	Pentavalent 3 (DPT, Hep B and Hib)	0.5ml	Intramuscular	Anterolateral aspect of the left thigh
	Pnemococcal Conjugate Vaccine 3	0.5ml	intra muscular	Anterolateral aspect of Right thigh
	OPV3	2 drops	Oral	Mouth
	Rotavirus vaccine 3	**5 drops**	**Oral**	**Mouth**
	IPV2	0.5ml	Intramuscular	Anterolateral aspect of Right thigh (2.5cm apart from PCV)
6 months	Vitamin A 1st dose	100,000 IU	Oral	Mouth
9months	Measles 1st dose (MCV1)	0.5ml	Subcutaneous	Left upper arm
	Yellow Fever	0.5ml	Subcutaneous	Right upper arm
12 months	Meningitis Vaccine	0.5ml	Intramuscular	Anterolateral aspect of Left thigh
	Vitamin A 2nd dose	200,000 IU	Oral	Mouth
15 months	Measles 2 dose (MCV2)	0.5ml	Subcutaneous	Left upper arm
9 years	****HPV	0.5ml	Intramuscular	Deltoid muscle (Left upper arm)

*BCG should be given at birth and can be given up until 11 months.

**OPV0 must be given before the age of two weeks

***Hep B0, should be given at birth, or within 24 hours

**** HPV to be introduced soon

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