Corona-Solution Online-Konferenz
WHO – Diktatur zu Deinem Besten
26.05.2023

Prof. Dr. Klaus Steger

Frage 1

Beruhen die Empfehlungen der WHO auf wissenschaftlicher Evidenz? Eine Analyse am Beispiel des PCR-Tests.

Frage 2

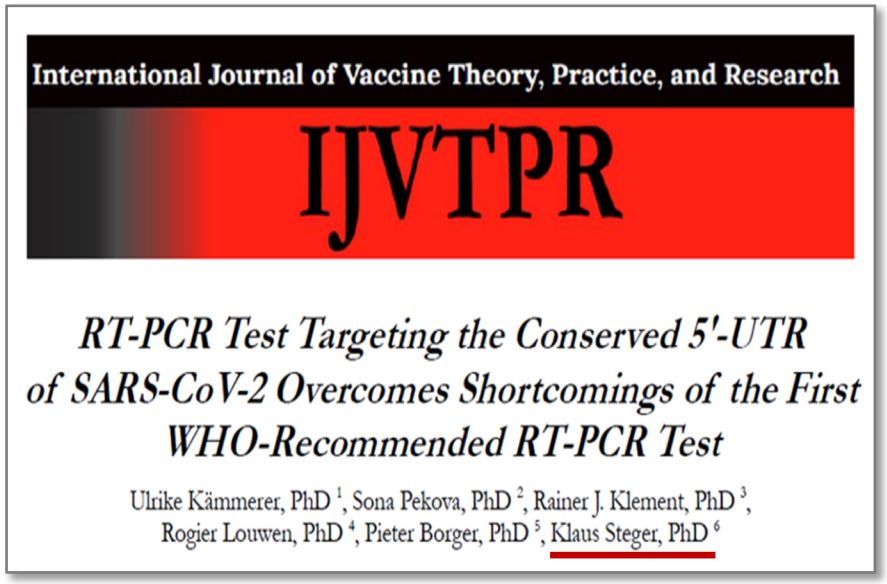
Viele konventionelle Impfstoffe sollen laut WHO auf RNA-Technologie umgestellt werden. Welche Chancen/Gefahren bergen die von EU/WHO propagierten RNA-basierten „Impfungen?“

WHO – recommendations…

… in regard with COVID-19 were intransparent and pseudo-scientific

Exemplarily shown for the RT-PCR test for the detection of SARS-CoV-2

Details & References



16. March 2020

According to ourworldindata.com

13.982 PCR-positive “cases” worldwide

871 deaths (“of” or “with”) worldwide

WHO definition of pandemic influenza, changed in 2009:

An influenza pandemic occurs when a new influenza virus appears against which the human population has no immunity, resulating in several simultaneous epidemics ~~worldwide with enormous numbers of deaths and illness~~.

For details, refer to: Doshi P (2011) The elusive definition of pandemic influenza. Bulletin WHO 89:532-538.

https://www.aerzteblatt.de/nachrichten/115217/T-Zellen-gegen-saisonale-Coronaviren-erkennen-auch-SARS-CoV-2
Ärzteblatt (31.07.2020): **T-Zellen gegen saisonale Coronaviren erkennen auch SARS-CoV-2**

https://doi.org/10.21203/rs.3.rs-35331/v1
SARS-CoV-2 T-cell epitopes define heterologous and COVID-19-induced T-cell recognition

Immunity = MORE THAN antibodies!
Infection = Update (Cross-immunity)
New is NOT highly infectious is NOT highly mortal

30.12.2019 Wuhan Hospital reports 7 patients with severe pneumonia of unknown origin

⇒ **0.000002%** of the 11-million-city of Wuhan

09.01.2020 Chinese Center of Disease Control (CCDC) informed the WHO on

⇒ virus sequence and RT-PCR protocol

13.01.2020 The WHO publishes the first RT-PCR protocol on the WHO-webpage

⇒ NOT the CCDC-protocol, BUT the Charité-protocol


Detection of 2019 novel coronavirus (2019-nCoV) by real-time RT-PCR

Victor M Corman[1], Olfert Landt[2], Marco Kaiser[3], Richard Molenkamp[3], Adam Meijer[4], Daniel KW Chu[5], Tobias Bleicker[1], Sebastian Brünink[1], Julia Schneider[1], Marie Luisa Schmidt[1], Daphne GJC Mulders[3], Bart L Haagmans[3], Bas van der Veer[4], Sharon van den Brink[4], Lisa Wijsman[4], Gabriel Goderski[4], Jean-Louis Romette[6], Joanna Ellis[7], Maria Zambon[7], Malik Peiris[5], Herman Goossens[8], Chantal Reusken[4], Marion PG Koopmans[3], Christian Drosten[1]

21.01.2020
Submission to Eurosurveillance

↓

23.01.2020
Publication in Eurosurveillance
25 deaths worldwide

- **Authors used sequence deposited in GISAID database by the CCDC for primer design - NO patient samples and NO virus material was available to validate the test.**
- **No identification of a Ct-value and a cut-off window to discriminate between potenitally infectious and certainly not infectious individuals.**
- **Recommendation of 45 PCR cycles** → Have NOT been corrected – even after it was known that the infectious viral load correlates with Ct 30 and later Ct 25.

Where is the evidence for changing the test strategy?

WHO-recommendation from 13.01.2020

Testing of 100.000 healthy individuals with 3 genes (E, RdRp, N)
will result in 100.000 x (0.0269 x 0.0577 x 0.0692)
= **10** false-positive results

WHO-recommendation from 17.01.2020

Testing of 100.000 healthy individuals with 2 genes (E, RdRp)
will result in 100.000 x (0.0269 x 0.0577)
= **155** false-positive results

WHO-recommendation from 02.03.2020

Testing of 100.000 healthy individuals with 1 gene (E)
will result in 100.000 x 0.0269
= **2690** false-positive results

Target gene SARS-CoV-2	No. of tests performed with different test kits	Specificity-Test 1 Cell culture (virus-free) Correctly identified as negative Cases [%]	Specificity-Test 2 Cell culture (with HCoV229E*) Correctly identified as SARS-CoV-2 negative Cases [%]	Mean specificity from samples 1 and 2 [%]	Mean error rate (false-positives) (100 – mean specificity) [%]
E-gene	373	371 [99.46]	355 [95.17]	97.31	2.69
RdRp-gene	182	178 [97.80]	165 [90.66]	94.23	5.77
N-gene	166	164 [98.20]	146 [87.95]	93.08	6.92

Ringversuch 340 Virusgenom Nachweis SARS CoV 2

Kary Mullis
established PCR in 1983 and was awarded the Nobel Prize in 1993:

EVERYTHING WAS KNOWN FROM THE BEGINNING

Where is the evidence for asymptomatic testing?

WHO Information Notice for Users 2020/05

Nucleic acid testing (NAT) technologies that use polymerase chain reaction (PCR) for detection of SARS-CoV-2

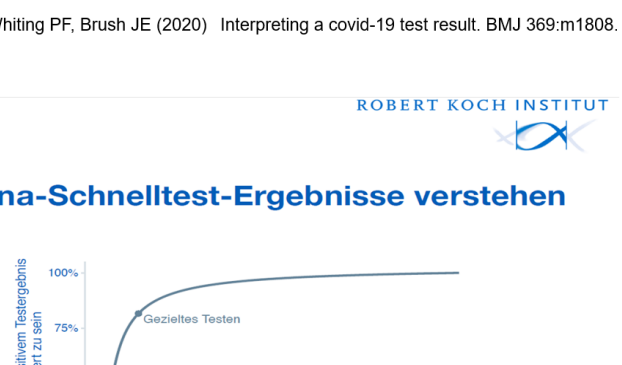
20 January 2021 Medical product alert | Geneva | Reading time: 1 min (370 words)

WHO guidance Diagnostic testing for SARS-CoV-2 states that careful interpretation of weak positive results is needed (*1*). The cycle threshold (Ct) needed to detect virus is inversely proportional to the patient's viral load. Where test results do not correspond with the clinical presentation, a new specimen should be taken and retested using the same or different NAT technology.

WHO reminds IVD users that disease prevalence alters the predictive value of test results; as disease prevalence decreases, the risk of false positive increases (*2*). This means that the probability that a person who has a positive result (SARS-CoV-2 detected) is truly infected with SARS-CoV-2 decreases as prevalence decreases, irrespective of the claimed specificity.

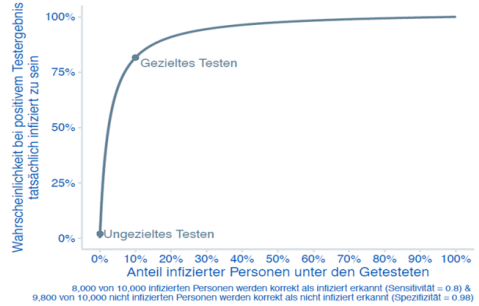
Most PCR assays are indicated as an aid for diagnosis, therefore, health care providers must consider any result in combination with timing of sampling, specimen type, assay specifics, clinical observations, patient history, confirmed status of any contacts, and epidemiological information.

Watson J, Whiting PF, Brush JE (2020) Interpreting a covid-19 test result. BMJ 369:m1808.



ROBERT KOCH INSTITUT

Corona-Schnelltest-Ergebnisse verstehen



The Ct-value is inversely proportional to the viral load:

- Weak positive test results [= high Ct-values] need careful interpretation.
- **BUT**: Still no recommendation of any cut-off window!

Decreasing prevalence increases the risk for false-positive test result – independent from specificity and sensitivity!

PCR can only support, but not replace medical differential diagnosis!

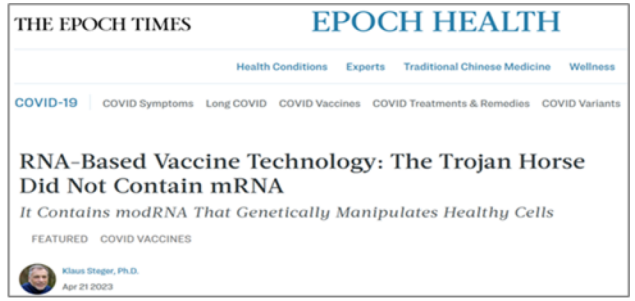
RNA-based „vaccine“ technology

“Gene Therapy Products (GTPs) are all products that mediate their effects by transcription and/or translation of transferred genetic material and/or by integrating into the host genome and that are administered as nucleic acids, viruses, or genetically engineered microorganisms.” (FDA).

Already in 2005, the WHO excluded nucleic acid-based injections against infections from GTPs and grant them the status of a vaccine: *“Antigens produced in vivo in the vaccinated host following administration of a live vector or nucleic acid or antigens produced by chemical synthesis in vitro.”* (WHO guidelines on non-clinical evaluation of vaccines, Annex 1, TRS No 927, 1 January 2005).

RNA-based products for a small proportion of the human population, i.e., cancer patients, require strict controls…, but
RNA-based products – to prevent an (even mild) infection - for the majority of the human population in good health require NO strict controls… !?!

RNA-based injections cause harm on at least 5 levels


THE EPOCH TIMES EPOCH HEALTH

Health Conditions Experts Traditional Chinese Medicine Wellness

COVID-19 COVID Symptoms Long COVID COVID Vaccines COVID Treatments & Remedies COVID Variants

RNA-Based Vaccine Technology: The Trojan Horse Did Not Contain mRNA

It Contains modRNA That Genetically Manipulates Healthy Cells

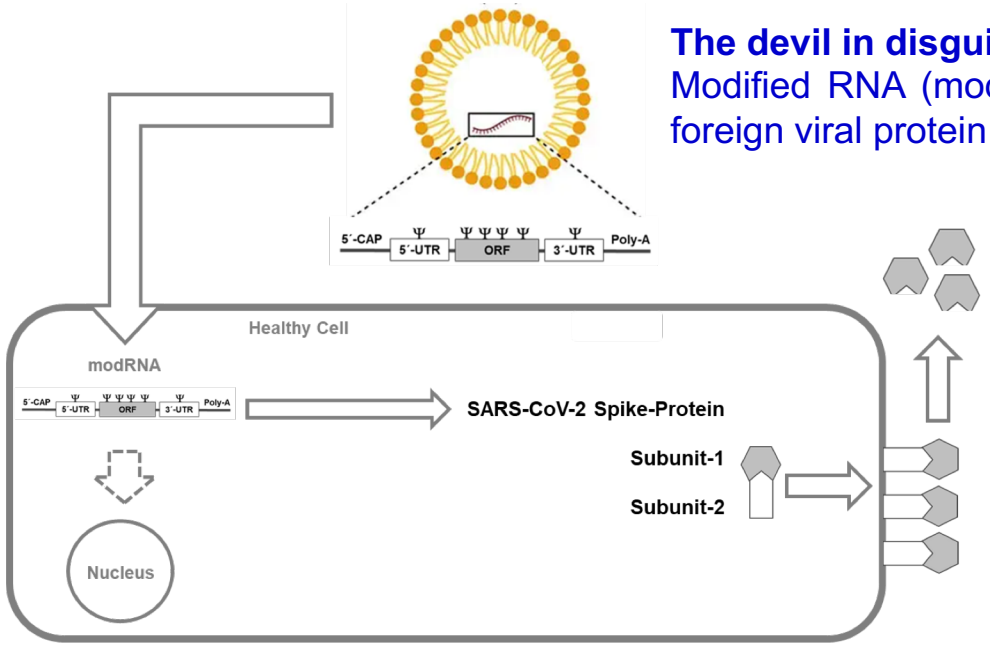
FEATURED COVID VACCINES

Klaus Steger, Ph.D.

Apr 21 2023

The Trojan Horse

Lipid Nanoparticles (LNPs) mimic exosomes, which pass biological barriers and smuggle modRNA in cells → contain allergic polyethylene glycol and toxic cationic lipids (→ ROS → DNA fragmentation, apoptosis)



The devil in disguise

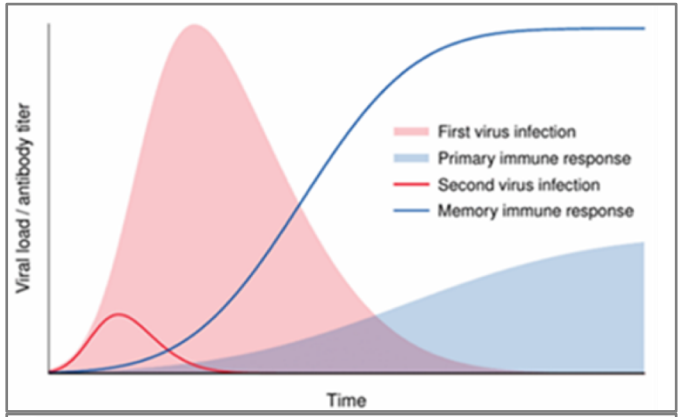
Modified RNA (modRNA) mimics messenger RNA (mRNA), but forces healthy cells to synthesize a foreign viral protein → contain methyl-pseudouridine → longevity → maximal translational efficiency

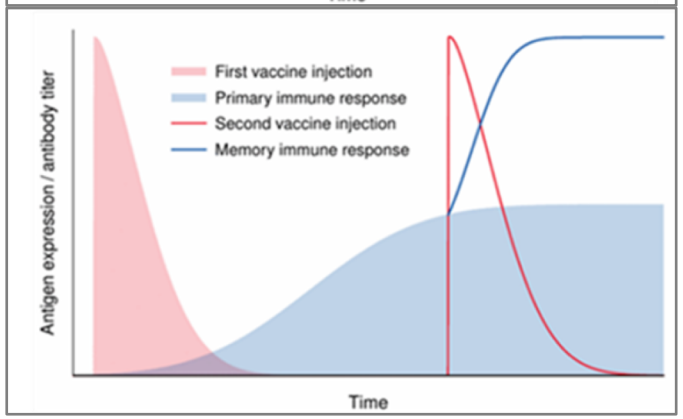
The "red cloth"

Omnipresence of foreign antigen in body results in hyper-inflammation

The "kill-me" signal

Foreign antigen presented at cell surface transforms cell from friend to foe





Worst Case Scenario: Genome integration of modRNA / contaminating DNA

→ Dysregulated gene expression, mutations (i.e., cancer), hereditability (germ cells)

RNA: https://doi.org/10.3390/cimb44030073

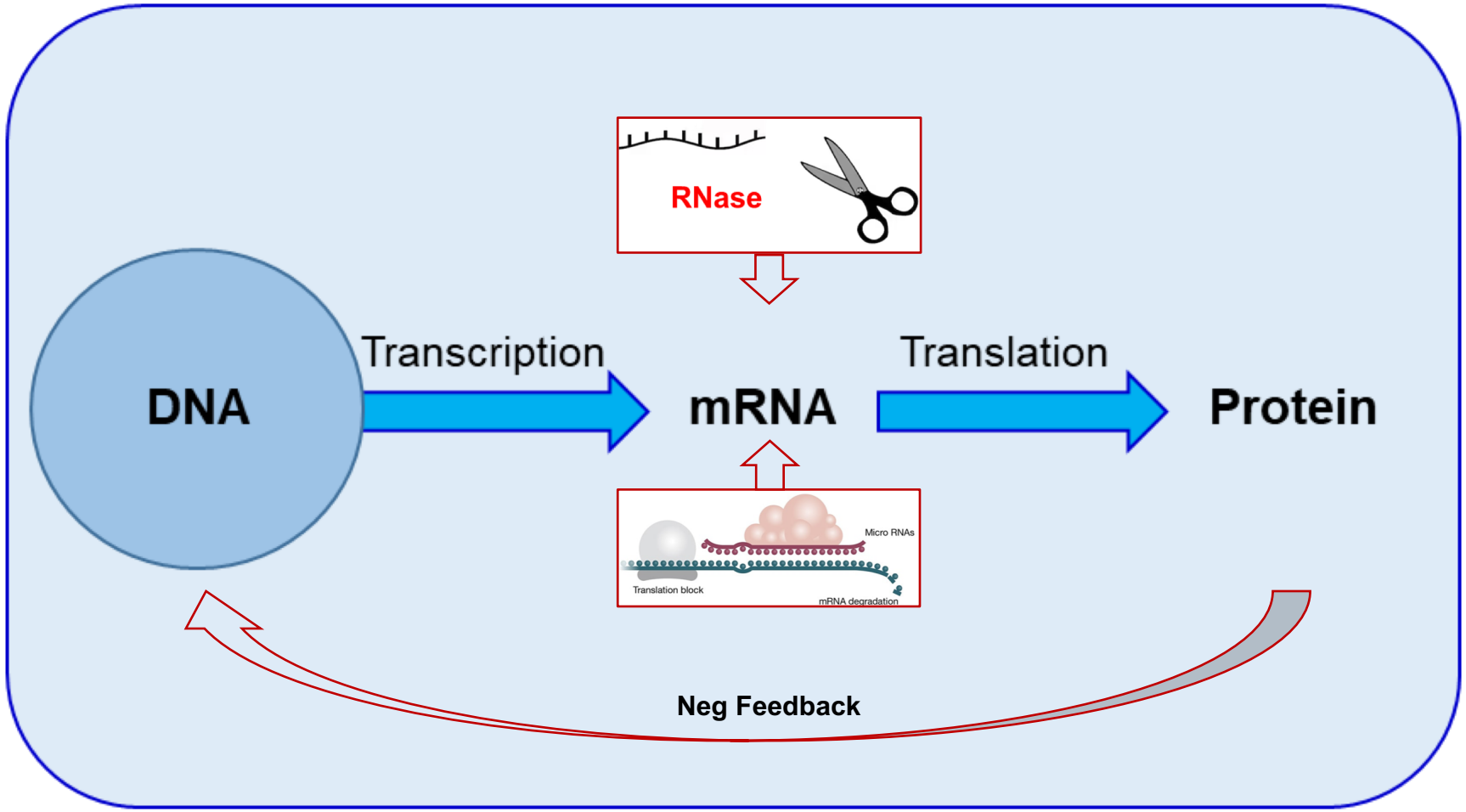
DNA: https://kevinmckernan.substack.com/

https://doctors4covidethics.org/alternate-mechanisms-of-mrna-vaccine-toxicity-which-one-is-the-main-culprit/ by Michael Palmer

mRNA

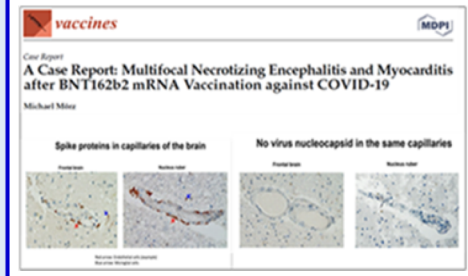
- Lifetime: Minutes/Hours
- Cell-specific

Adaptation of cell metabolism to changing living conditions



modRNA

- Lifetime: Weeks/Months
- Ubiquitous


vaccines

Case Report

A Case Report: Multifocal Necrotizing Encephalitis and Myocarditis after BNT162b2 mRNA Vaccination against COVID-19

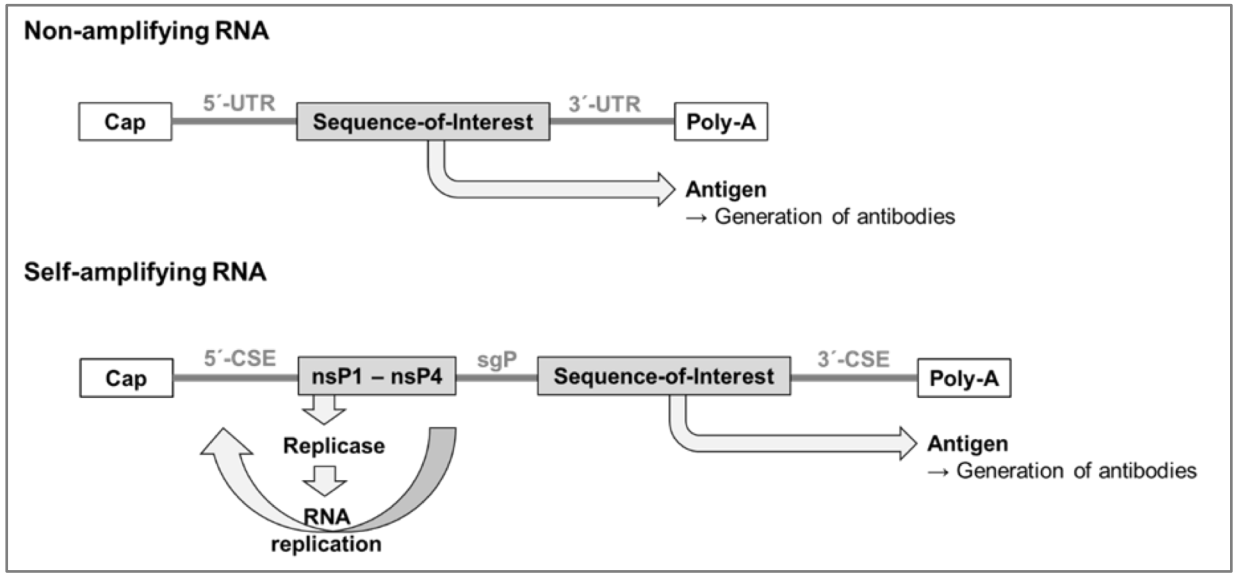
Michael Mörz

Spike proteins in capillaries of the brain

No virus nucleocapsid in the same capillaries

There is NO rationale at all why any cell of our body should produce as many molecules of a foreign viral protein as possible for as long as possible - which in addition transforms this cell into a target to be attacked by our immune system.

Perspective: Self-amplifying RNA



An Update on Self-Amplifying mRNA Vaccine Development

by Anna K. Blakney [1,*], Shell Ip [2] and Andrew J. Geall [2]