MEETING OF THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP)
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Mark Gibbons
President and Chief Executive Officer
RetireSafe Organization

Dr. Romero and members of the committee, good afternoon. My name is Mark Gibbons. I'm President and CEO of the RetireSafe Organization. RetireSafe is an organization whose mission is to educate and advocate on behalf of older Americans on issues including Social Security, Medicare, health, safe retirement, and financial well-being. We believe that older Americans must have a voice in public healthcare policies that affect them. Older Americans are an important population. Currently, there are nearly 70 million Americans over the age of 60. Due to immune system decline as part of aging, as well as the prevalence of chronic disease comorbidities, many of them are particularly vulnerable to infectious diseases such as influenza, pneumococcal pneumonia, and of course COVID-19. Vaccines for these and other conditions can truly be a matter of life or death for so many. We must keep this population, their increased risk, and their access needs at the forefront of vaccine development and ACIP consideration. One of our major concerns is a need for more expertise and representation for older Americans among ACIP members. As ACIP deliberates on important vaccine issues, we need to hear from experts who understand health factors and needs of older adults, as well as how their behaviors and lifestyles impact being able to fully benefit from these immunizations. The make-up of ACIP members should better reflect clinical expertise in these areas such as gerontology and the ability of vaccinations to work well for patients with chronic diseases and conditions often associated with advancing age. Even before the pandemic, older Americans face challenges in accessing care. The pandemic has obviously made that worse. There is a clear need to not only develop new vaccines, but also to consider the technology and innovation of new methods of making them available, accessible, and usable to those who need them, including the potential for oral options. We believe that we need to incorporate that reality into ACIP thinking. We urge ACIP to be open to expansion of working groups and panel membership to include both clinical and cultural expertise. We need to keep looking at innovative platforms and solutions to providing immunizations to our vulnerable population. Please let our voices be heard. Thank you.

Joanna Colbourne
Deputy Executive Director
National Foundation for Infectious Diseases

Good afternoon. Hello, my name is Joanna Colbourne. I am the Deputy Executive Director of the National Foundation for Infectious Diseases, or NFID. The 2020-2021 influenza season is expected to be characterized by an unprecedented dual threat, co-circulation of influenza and the novel coronavirus SARS-CoV-2 that causes COVID-19. In addition, amidst the pandemic, immunization rates have decreased for recommended vaccines across all age groups, with demand plummeting as much as 95% for some vaccines. We must reverse this trend now to avoid seeing outbreaks of flu and other vaccine-preventable diseases across the country. Influenza, or flu, and COVID-19 can be dangerous for anyone, but for more than 6 in 10 US adults living with a chronic health condition, including heart disease, lung disease, and diabetes flu and COVID-19 may be especially dangerous. Adults with chronic health conditions experience an inflammatory reaction caused by influenza infection that can worsen their underlying disease and lead to a number of serious outcomes including hospitalization, heart attack, or stroke, catastrophic disability, and death. To make matters worse, many of the underlying health conditions that make adults vulnerable to flu are also linked to increased vulnerability to COVID-19. Although there is currently no approved COVID-19 vaccine in the US, there are safe and effective vaccines they can help protect against flu and many other vaccine-

preventable diseases. To address this urgent public health threat, NFID has launched the “Keep Up The Rates” flu awareness campaign in recent months. “Keep Up the Rates” is a national campaign to encourage all individuals to receive recommended vaccines that may have been delayed during the COVID-19 pandemic. To date, more than 100 leading organizations have joined and are sharing information and resources in support of this critical public health initiative. Earlier this month, NFID released a new “Call to Action: The Dangers of Influenza and COVID-19 in Adults with Chronic Health Conditions,” which was the result of a multidisciplinary roundtable to explore the potential impact of influenza and COVID-19 on adults with chronic health conditions. The campaign includes more than 35 leading medical organizations that are sharing best practices for administering flu vaccines amidst COVID-19 mitigation efforts. NFID and its partners are urging all healthcare professionals, particularly specialists treating adults with chronic health conditions, to implement strategies from the “Call to Action” and utilize tools or resources from the “Keep Up the Rates” campaign, all of which are available at www.nfid.org. It is the responsibility of all healthcare professionals to educate, motivate, and insist that patients prioritize annual flu vaccination this season and stay up-to-date on all recommended vaccines. Thank you for your time and attention today and special thanks to the members of ACIP for the work you continue to do.

Michael Arnold
Parent and Activist

Yes, hello. My name is Michael Arnold and I’m here to talk about vaccine problems and solutions. Vaccines are not tested against placebo, saline, and manufacturers have no liability for serious injury or death. Vaccine ingredients, as explained by Dr. Sherri Tenpenny, have many toxins in them such as aluminum, formaldehyde, mercury, polysorbate 80, and aborted fetal tissue deoxyribonucleic acid (DNA). There is a chart from the journal of the *American Academy of Pediatrics* (*AAP*), December 2000, which shows how vaccines did not play a major role in the decline of disease. It was clean running water. The book, “How to End the Autism Epidemic” by J.B. Handley explains in Chapter 5 how aluminum plays a major role in the autism epidemic by causing encephalitis. In the book, “Vaccines: Are They Really Safe and Effective?” by Neil Z. Miller, there is a graph. Doctors, pediatricians, were surveyed and they were asked about the Hepatitis B vaccine, and 87% said they did not believe that that vaccine was necessary for their patients. Okay, well there’s Justice for Evee. Evee died 36 hours after her vaccinations. The Medical Examiner (ME) said it was because of sudden infant death syndrome (SIDS), but Evee’s mother is fighting for a tissue sample so that she can prove that it was actually VIDS, vaccine-induced death syndrome, not SIDS. Christopher died shortly after the GARDASIL® vaccine for human papillomavirus (HPV). You can learn about him from learntherisks.org and #neverforgetChris. Adam got autism after his wellness visit like thousands of other babies, and you can learn about that from the documentary about him. Solutions. Take Hepatitis B off the schedule as soon as possible. Ask Congress to terminate the National Childhood Vaccine Injury Act (NCVIA)of 1986. Ask Congress to change vaccines from a biologic to a drug. Ask the CDC and WHO to get clean water and proper sanitation for the world’s poorest 1 billion people and work with the Behavior Analyst Certification Board (BACB), bacb.com.

Michaela Jackson
Prevention Policy Manager
Hepatitis B Foundation

My name is Michaela Jackson. I am the Prevention Policy Manager for the Hepatitis B Foundation. The current health emergency has shown that prevention truly is essential for the health of the public. As one of the primary causes of liver cancer and an underlying condition that can increase severe outcomes from COVID-19, preventing Hepatitis B infection should be an immunization priority. Today, we are advocating for a universal Hepatitis B vaccination recommendation to help protect the 75% of adults who are susceptible to Hepatitis B virus. Adult HepB vaccination rates are low amongst healthcare workers despite recommendations. They comprise 6% of the US population and face significant exposure to blood-borne diseases daily. Yet only 61% of health care workers have completed a full vaccine series. The disproportionate emphasis on the flu vaccine and the lack of targeted immunization messaging for healthcare workers have been identified as major barriers to increasing this percentage. In addition, the average age of a nurse in America is 50 years old. The majority of the nurse population are between 45 and 59 years old. This highlights issue that current guidelines fail to capture. Susceptible individuals were born before the universal infant HepB vaccine recommendation. These individuals are relying upon their providers to recommend the HepB vaccine, which becomes problematic if the providers are unaware of a person's job or other risk factors. Other essential workers are at risk as well. In the past decade, there have been 18 documented outbreaks of HepB in non-hospital settings. Our foundation has heard stories from essential workers who have developed HepB after being stuck by a needle on the job. Studies show that 95% of needles are still discarded in municipal waste streams, despite national and state protocols for disposal. The average risk of contracting HepB from a needlestick exposure ranges from 6% to 30%, placing all unvaccinated workers who may come in contact with a needle, such as food service employees or sanitation workers, at significant risk for infection. Protection should not be contingent upon which job you have. Accessing the vaccine is another barrier to increasing immunization rates. Some state and federal programs recover the cost of HepB vaccines for adults if they're in one of the high-risk categories named by ACIP. However, some of those risk factors, such as diabetes or fatty liver, can go undetected for years. This means that a person who is at risk may not be able to access the vaccine due to costs simply because the risk factor has yet to be identified. Despite ACIP recommendations that anybody who wants to be vaccinated for HepB can get immunized, many Insurance programs, including Medicare, will not cover this group. Current HepB vaccination guidelines are simply not enough. The complexities of the current recommendations act as a barrier to achieving satisfactory adult HepB immunization rates, but ACIP has the power to change that. With a recommendation for universal adult HepB vaccination, we could be one step closer to eliminating viral hepatitis in the United States. Thank you for your time today.

Kimberly Hall
Florida Freedom Keepers

Good afternoon. My name is Kimberly Hall. When I was 25, I lost twin girls at 23 weeks gestation. The doctors told me it was unexplainable. My twins would be 5 years old this year. I am 5 years still recuperating from the memory of the profound pain, confusion, trauma, and complete upheaval of my entire life. It was at 22 weeks with the nurse taking my basic vitals requested me to take a shot for pertussis. When I stated that I didn't know what pertussis even was, the nurse shortly explained to me that it would protect me from obtaining this disease and alongside that, I would be passing on protection to my twins. I was not given any further information about this medical intervention. What information is there really that shows it

provides any protection that she claimed? What is available states that a Proceedings of the National Academy of Sciences (PNAS) study, and I quote, “While all groups possessed robust antibody responses, key differences in T-cell memory suggest that aP vaccination induces a suboptimal immune response that is unable to prevent infection.” There is also available a 2017 review of 15 published articles that determined that while vaccination boosted maternal antibodies, evidence was lacking on whether or not this had any impact on reducing the incidence of pertussis, serious complications, or death in infants. It seems the Tdap vaccine does not prevent the spread of disease or even prevent you from catching the disease. If today I pull up the CDC website, I very clearly see that the CDC recommends pregnant women to get the whooping cough vaccine between 27 and 36 weeks of each pregnancy. Why was I offered this at 22 weeks? That nurse represents this country’s entire lack of any informed consent with these injected biologics. The Food and Drug Administration (FDA) has classified Tdap as a Category C drug because of this complete insufficient evidence regarding any administration in pregnant women. The argument is used that it could be seen as unethical to test such a vaccine, but it is being pushed and coerced on woman every day as a complete off-label use. Furthermore, the FDA has never even approved a vaccine specifically for use in pregnancy to prevent disease in the infant. I was not given any information of the injected ingredients: formaldehyde, glutaraldehyde, aluminum hydroxide, polysorbate 80, phenoxyethanol, ammonium sulfate. In what doctor’s insane mind does this ingredient list seem like an injectable concoction for a pregnant woman carrying an undeveloped fetus? Why is it the GARDASIL® package insert reference to page 10, where it shows the use in populations of pregnancies within clinical trials? The GARDASIL® vaccine contains 225 micrograms of aluminum hydroxide and 7 of 55 women lost their babies (12.7%). GARDASIL® vaccine was made with more than a 50% increase of aluminum, 500 micrograms and 17 of those 62 women lost their babies. That percentage spiked up 27.4%. It is shown through the studies and science that aluminum hydroxide alone plays a major role, causing fetal demise and spontaneous abortions with the Tdap containing more than 300 micrograms. The CDC and vaccine manufacturers are both completely exempt from liability, exempt from providing randomized control trials (RCTs), and exempt to provide any evidence to do what you claim it will do and only to show it could create antibodies. That doesn’t equal immunity. It is awfully disappointing that in 2020, we have such a widespread knowledge deficit within the scientific community. Thank you.

Albert Faro, MD
Vice President of Clinical Affairs
Cystic Fibrosis Foundation

Good afternoon. My name is Dr. Albert Faro and I’m the Vice President of Clinical Affairs at the Cystic Fibrosis Foundation (CF Foundation). On behalf of the foundation, thank you for this opportunity to provide comments to the Advisory Committee on Immunization Practices regarding developments in allocation of COVID-19 vaccines. The CF Foundation is a national organization actively engaged in the research and development of new therapies for cystic fibrosis (CF), a rare life-threatening genetic disease that affects over 30,000 people in the United States. The build-up of thick, sticky mucus in the lungs characteristic of the disease makes people with CF particularly prone to chronic airway infections, punctuated by pulmonary exacerbations, events associated with morbidity and mortality in people with CF. A significant proportion of pulmonary exacerbations are triggered by respiratory viral infections. With continued progression of the disease, individuals with CF and advanced lung disease may pursue lung transplantation. Due to the known risks posed by respiratory viral infections, the unique dangers of the SARS-CoV-2 virus and the multi-system manifestations of CF, some people with CF, such as those with advanced disease or who are post-transplant and therefore immunocompromised, should be considered at high-risk for poor outcomes from COVID-19

infection. The strongest evidence to date on the dangers of COVID-19 for people with CF comes from a forthcoming global analysis of 181 COVID-19 cases among people with CF. From that analysis, it appears CF patients with advanced lung disease and those that are post-lung transplantation, are at risk of severe outcomes, including death. We therefore urge the advisory committee to consider information beyond the CDC's list of comorbid conditions to inform prioritization determinations. That list may mischaracterize the true risk for some rare disease populations like CF. We further urge the advisory committee to give equal priority to anyone with a condition that puts them in a high risk for severe disease from COVID-19 instead of adopting the National Academy of Medicine's (NAM) recommendation to first prioritize people with multiple comorbid conditions for access to a vaccine—a focus that relies on multiple conditions and neglects other indications of disease severity and vulnerability. We believe that scenario inappropriately disadvantages someone whose underlying disease condition is advanced or severe. This segment of the population should be prioritized for early access to a vaccine and includes patients with CF with advanced disease or who are post-transplant. Thank you again for your attention and consideration of people with CF as you tackle these critical issues.

Del Bigtree
Founder
Informed Consent Action Network

I want to thank the committee for giving me this opportunity to speak. I want to say that, you know, given that almost everything we talk about these days involves discussion of COVID-19, I want to say I found it shocking that in the discussion about the flu shot this morning, there was no discussion about the risk of COVID-19 being increased by flu shots, given the fact that there's so many studies that are showing this type of connection. Specifically, we have the Cleveland Clinic study that's entitled "Safety of Influenza Vaccine During COVID-19." It found a highly statistically significant increased rate of mortality, ICU admission, and hospitalization for COVID-19 among those that received a flu shot in 2019 as compared to those that did not. In fact, it reflected that those receiving the flu shot in 2019 had a 175% increased rate of mortality and a 195% increased rate of ICU admissions. Additionally. There was a gigantic study that just came out looking at 39 countries called "Positive Association Between COVID-19 Deaths and Influenza Vaccine Rates in Elderly People Worldwide." Given that there are those studies and studies out of Japan that have shown 400% increased risk in other upper respiratory infections amongst those that got flu shots compared to those that didn't. All of this science around the world is pointing to there may be a real danger to giving flu shots during COVID-19, yet the CDC seems to plow forward with this idea of a twindemic and using it as a way to force the largest flu vaccine campaign in US history. We're also watching the 59 deaths from flu shots and growing in South Korea where they are involved in this mission, yet none of this seems to matter to you at the Advisory Committee of Immunization Practices, which is really shocking. Given the lack and waning confidence that the American public now has in the CDC, it seems by many articles to be at the lowest point in history, how do you expect to be relevant or even be considered necessary in a process of protecting our population when you're not even having the most obvious conversations you should be having when it comes to vaccinations. This is your world. This is what you're supposed to be looking at. We are supposed to have confidence that when there are studies all around the world showing a risk of delivering a flu shot vaccine and the increased risk of death from COVID-19 that certainly it's a conversation and you'll be able to bring up studies to discount or, you know, somehow refute this issue. Instead, you avoid it altogether, which is continuing to drive the confidence in the work that you do down to the floor. I would like to see you be a little more responsible with these conversations, given that they are so important and may include and involve the risk of death for hundreds of thousands if not millions of people in this country and around the world. Thank you.

Erin Olszewski, RN
US Citizen

Yes. Hello. Good afternoon and thank you for having me today. My name is Erin Olszewski and I'm a Registered Nurse (RN). This year, I also became a COVID whistleblower who uncovered the fraud, negligence, greed, and unnecessary deaths being covered up in New York City's (NYC's) Elmhurst Hospital and the CDC at the height of that pandemic, with actual video and audio indisputable proof. So, we both know the numbers you're basing your new COVID vaccine recommendations off of are inflated and fraudulent. You cooked the books on vaccines just like you've been cooking the books on COVID. You've rigged the studies, you've covered up the data, you've buried the injuries and deaths, you've removed yourselves and the vaccine manufacturers from all liability, and you've lied to the American people long enough. I needed to alert the American public to something they may not know. There is a CDC scientist whistleblower named Dr. William Thompson who the CDC is attempting to cover up. Dr. Thompson discovered that the measles, mumps and rubella (MMR) vaccine was causing a dramatic rise in autism in African American boys. However, his CDC bosses have ordered him to silence. I believe that this is the year of the whistleblower and accountability, especially as it relates to our minority populations. Most recently, yesterday in fact, whistleblower Tony Bobulinski came forward exposing even more fraudulent activity happening within our government. If there is any hope in recovering the trust of Americans, the executive government needs to step up, do what's right, and immediately subpoena Dr. William Thompson and all his CDC co-authors to testify before Congress. Congressman Bill Posey here in Florida has thousands of damning CDC documents Dr. Thompson handed to him. If forced to testify, Dr. Thompson stated he's not going to lie. The public deserves the truth before this panel continues their unethical practices of adding even more vaccines to the already overly crowded, toxic, liability-free schedule. Each one of you on that panel know that the science has been corrupted. Yet, you continue to dish out fraudulent data because money, power, and greed is much more lucrative than protecting public health. The CDC and mainstream media continue to bury this information. They know that vaccines are causing detrimental harm and death to children and adults. Yet here we are today watching you discuss a fast-tracked, liability-free COVID vaccine for a virus with a 99% survival rate. A quote from your very own silenced CDC scientist, Dr. William Thompson, in 2004 to Dr. Brian Hooker, "That's the deal. That's what I keep seeing again and again and again where the senior people at CDC just do completely unethical vile things and no one holds them accountable. Your time is running out, because the American people are waking up and accountability is coming for you mark my words. First, do no harm. I hope all of you do some soul-searching and remember why you're here. Thank you.

Susie Olson Corgan
Representing Self

Hello. My name is Susie Olson Corgan. Thank you so much for the opportunity to speak today. I have been attending the ACIP meetings, as well as Board of Health (BOH), Department of Justice (DOJ), and National Vaccine Advisory Committee (NVAC) meetings. The thread among these meetings has been vaccine hesitancy. The one thing I have heard many of you say is that vaccine hesitancy is due in large part to anti-vaccination campaign. As you know, most of these campaigns are carried out on social media. However, social media censorship is at an all-time high. Major platforms such as YouTube, Facebook, Instagram, Pinterest, Linked-In, Vimeo, and even search engines like Google are frequently removing contents and banning accounts without warning or explanation that even has the slightest appearance of questioning the current vaccination program. Despite the fact that this information is being censored, vaccine hesitancy is still on the rise. Some of the reasons that people are questioning vaccine are the following:

the withholding of the COVID-19 vaccine trial data, lack of transparency regarding adverse events (AEs) in the trials, using another vaccine as the placebo—a placebo to be an inert substance, concurrent studies phases, lack of liability if something goes wrong—and this applies not only to the COVID-19 vaccine candidates, but also to those currently on the recommended childhood vaccination schedule, partnerships with organizations such as the Gates Foundation to create marketing campaigns, and questioning whether there has been corporate capture of our regulatory agencies. I know that some of these issues are out of your scope, but you have enormous influence among the medical and scientific communities worldwide. They will consider any recommendations that you make. I urge you to consider increased transparency throughout this process. Vaccine hesitancy will continue to rise and if and when a COVID-19 vaccine candidate is approved for distribution, supply will not be your primary issue—demand will be. Thank you.

Charles Lee, MD
President Elect
American College of Correctional Medicine

Thank you very much. I am Charles Lee. I am the President Elect of the American College of Correctional Physicians (ACCP). I'd like to thank the academy for allowing me to give this presentation on behalf of the inmates and correctional workers throughout the country. Just yesterday, there was a news release that 75% of inmates at the Marquette Michigan Prison were positive for coronavirus. In addition to that, 42% of the employees were positive. Also, about a month ago, there was an article about in Virginia, 70% of the inmates were positive. Inmates' rate of infection of coronavirus is 5 times that of the general population and the death rate is 1.5 times that of the general population. Correctional workers and inmates go home. They contract the illness, disease, coronavirus, within the institution and conceivably can spread it to their family, friends, neighbors, stores, and wherever they may be. Ninety percent of inmates are released at some point in time. They, too, are our friends, family, and neighbors. In a correctional facility, it is extremely challenging to follow the CDC guidelines of masking, sanitizing, and distancing. Consequently, it is a big challenge to keep them safe. In October, the National Academy of Science, Engineering, and Medicine (NASEM) developed a framework of prioritization for coronavirus. It was Phase 1b in rural facilities where there are older patients with comorbidities in congregate settings, and Phase 2 for employees and inmates in correctional facilities. I will be submitting a resolution to the American Medical Association (AMA) along these same lines that hopefully in November will be approved. We asked the ACIP to adopt the National Academy's framework of prioritization for the vaccine of a safe, and effective, and FDA-approved vaccination. I thank you very much.

Kermit Kubitz
Individual

Thank you. I am 73 years old and was a polio pioneer in 1954. My wife and I have just gotten our flu shots in the last two weeks—in my case, the high-dose flu shot. I support Emergency Use Authorization (EUA) of COVID-19 vaccines showing preliminary efficacy and safety with the 3 following recommendations. First, there should be a substantial review of effectiveness for a group of 5,000 to 10,0000. Second, use new serology methods to study immune response. Third, give similar EUA approval for follow-on vaccines, including those with adjuvants for better protection. On the first point, the effectiveness of COVID-19 vaccine may be uncertain. Uncertainty results from the novel technologies used, the possibility of differential effectiveness for different groups, and the number of degrees of freedom (i.e., behavior variability among trial program participants, including NPIs; that is, non-pharmaceutical interventions such as masks

and social distancing). Therefore, I recommend follow-up studies of effectiveness, not just safety, in approximately 5,000 to 10,000 vaccinated patients, including stratified groups of older patients and those with other health conditions. Second, follow-up on effectiveness for vaccinated patients should include serology studies to permit evaluation of the types of immune responses resulting from vaccination. Just as we are using novel vaccines such as mRNA, we should use innovative serology techniques such as the Multiplexed Identification of T-cell Receptor Antigen (MIRA) available now. Third, the FDA and CDC must be prepared through EUA follow-on vaccines which show greater effectiveness or duration of immunity. This should include single dose vaccines or vaccines using newer adjuvants like AS03 or CPG1018 which can stimulate a stronger immune response. But in order to do this, that is included follow-on vaccines, the FDA and CDC also need to understand and evaluate the effects of multiple vaccination iterations (i.e., what if you get an mRNA vaccine and then a subunit or inactivated virus vaccine?). We need to understand what happens if you have antibody response to a subsequent vaccine. Thank you for your work. Keep it up. Keep it up.

Antony Hsu, MD, FACEP
Clinical Emergency Physician
American Colleges of Emergency Physicians

Good afternoon, ACIP. Thank you for what you do. I'm an actively practicing Clinical Emergency Physician with a concern for my family, children, community, city, state, nation, and humanity in that order. I'm not an epidemiologist or health care economist, but I do know a few and as a frontline emergency physician balancing community practice and academic pursuits with national advocacy, I base my advice on the more than 60,000 patient encounters and diverse work and life background I have had. The topics I'd like to address first are SARS-CoV-2 vaccine safety concerns that I've heard and thought about while working on an Indian Reservation in Montana in September: 1) Regarding generating trust on sufficient testing and safety, open up the books about side effect profiles of each vaccine. Transparency is needed in times of rationing to promote trust in government; 2) Consider community nomination committees to reach out to social influencers, faith-based, elected government representatives, and medical and scientific representatives for trust-building teams; 3) Consider anonymous polling by a panel of renowned experts about whether they would immunize themselves and their families, but their votes must remain anonymous to engender trust; and 4) Consider ranking the efficiency of each vaccine for each population profile. On the second larger topic of vaccine distribution, my thoughts are: 1) Ensure complete informed consent based on continuously updated benefit and risk profiles; 2) Consider buy-in for healthcare workers and gradually broadening the enrollment as safety and efficacy numbers are sustained and continuously reevaluated; 3) Consider calculating a relative risk reward or r^3 ratio for each person. This r^3 ratio addresses the risk of vaccination versus the risk of delayed vaccination. Gradually slide scale the availability based on the r3 ratio. This can defer depending on local, regional, and national priorities. The r^3 ratio method might avoid the concern of favoritism with an A, B, C, D or a 1, 2, 3, 4 approach and replaces it with a straightforward sliding scale. Each manufacturer can then provide what their sliding scale criteria are, especially since the safety profile for each vaccine may differ; 4) As availability improves, consider peer navigators and influencers discussed previously to step up messaging; 5) The nation must buttress its system for the distribution of preventive healthcare. Specifically, emergency departments (EDs), which operate 24/7/365 already vaccinate for tetanus, diphtheria, and pertussis. They have not been included in outreach, but they are at the frontline for pandemic responses. There are pilot projects in the States of Michigan and Washington that vaccinate for influenza and hepatitis A. Hospitals have the facilities to store vaccines that require extremely low temperatures and have security 24/7; and 6) EDs are uniquely positioned to work with public agencies for the work of

mass immunization to ensure all people can be reached, including those facing homelessness and the underinsured for whom Eds may be the most likely source of care. Thank you so much for taking the time to listen to my suggestions and thank you for what you do.

Kim Freitas
Mother

Hello, and thank you for the opportunity to speak. I would like to discuss some critical areas of concern regarding the COVID vaccine. It is unethical to vaccinate a person using a high-risk, untried, liability-free vaccine when you have a safe and proven medicine available. Per the CDC, over 98% of the population recovers from COVID-19. We cannot risk injury to an otherwise healthy person using a vaccine we know very little about. One of the biggest areas of concern is enhanced illness, when the vaccine triggers a reaction which causes a person to acquire the exact virus you are trying to protect them against. We have seen this happen in previous coronavirus animal trials, which are currently being skipped during COVID trials. These trials are also being conducted on healthy people, yet the vaccine is due to be administered to our most vulnerable populations first, who typically have the health issues with at least 1 if not 3 underlying conditions that makes them high-risk. How can we use an untested vaccine on them when we have no idea what the outcomes will be? Also, how can we disperse a product that is free from liability, especially a warp speed vaccine using mRNA technology that has never been used before? No contraindications have ever been studied regarding administering the COVID vaccine with other vaccines. This means it should not be administered in the same day, week, or even month with other vaccines. Who is going to monitor and control that? Which leads to my next concern, viral priming. This occurs from the heavily pushed flu vaccine. Studies have shown that the flu vaccine makes us 36% more likely to get an upper respiratory illness (URI), which includes COVID-19. We should be warning against use of the COVID vaccine for those who have already received the flu vaccine. Let’s also be very clear that the recipient of the vaccine should be given the vaccine insert—not a short list of information. True informed consent involves knowing all of the risks, not just watered-down points. Lastly, we must have transparency from the Data and Safety and Monitoring Boards (DSMBs) who oversee these trials. J&J, AstraZeneca, and Oxford trials only provided fragmented information that we are not clear about adverse reactions during the ongoing trials. At one point, transverse myelitis was mentioned by the media, but then the wording was changed to a much vaguer language on the trial patient information sheets. In closing, we demand tested, tried, and proven vaccines that offer benefits greater than the already 98% recovery time with little to no interventions. These vaccines might be liability-free by the makers, but that does not make you, the advisory committee, morally free from the harm that can be caused by the decisions that you make. Please remember, where there is risk there must be choice. Thank you.

Acronyms

AAP	Academy of Pediatrics
ACCP	American College of Correctional Physicians
ACEP	American Colleges of Emergency Physicians
ACIP	Advisory Committee on Immunization Practices
AE	Adverse Event
AMA	American Medical Association
BACB	Behavior Analyst Certification Board
BOH	Board of Health
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CF	Cystic Fibrosis
CF Foundation	Cystic Fibrosis Foundation
DNA	Deoxyribonucleic Acid
DOJ	Department of Justice
DSMB	Data and Safety and Monitoring Board
ED	Emergency Department
EUA	Emergency Use Authorization
FDA	Food and Drug Administration
HPV	Human Papillomavirus
ME	Medical Examiner
MIRA	Multiplexed Identification of T-cell Receptor Antigen
MMR	Measles, Mumps and Rubella
NASEM	National Academy of Science, Engineering, and Medicine
NAM	National Academy of Medicine
NCVIA	National Childhood Vaccine Injury Act
NFID	National Foundation for Infectious Diseases
NPI	Non-Pharmaceutical Interventions
NVAC	National Vaccine Advisory Committee
NYC	New York City
PNAS	Proceedings of the National Academy of Sciences
RN	Registered Nurse
RCT	Randomized Controlled Trial
SARS	Severe Acute Respiratory Syndrome
SIDS	Sudden Infant Death Syndrome
US/USA	United States of America
VIDS	Vaccine-Induced Death Syndrome