Two new studies on mucosal vaccines and Long COVID underscore the criminality of the “forever COVID” policy

Benjamin Mateus
30 September 2024

The ninth wave of the COVID-19 pandemic in the United States is finally receding, with estimated daily new infections based on wastewater data now standing at 669,000 per day, down from the August peaks of over 1.3 million. However, experts predict that the tenth wave will begin in late fall and continue through the winter holidays, as has taken place every year of the pandemic so far.

With one in 70 individuals currently infectious, the risk of coming into contact with someone in a classroom, at work, or dining at a local facility with 25 to 50 people is considerable. And despite the relative lull in cases, there is more COVID-19 transmission now than during 56.1 percent of the pandemic. In other words, the “forever COVID” policy essentially means that COVID is now everywhere all the time.

Under these conditions, forced upon society by the capitalist ruling class, repeat infections act like a battering ram, taking a growing toll on the foundation of everyone’s overall wellbeing. There is a growing body of evidence that each hit weakens the organ systems, aging them biologically beyond the person’s stated age until sufficient injury begins to manifest in physically measurable symptoms.

At present, more than one billion cumulative COVID infections have occurred in the US, at a rate of around one per year per person, with somewhere between 3-4 infections on average among the entire population. Estimates place the number of Long COVID cases at over 410 million globally in just the first four years of the pandemic, while excess deaths are nearing 30 million.

Clearly, the pandemic is ongoing and remains a significant health risk for the global population. The criminality of the “forever COVID” policy is highlighted by the fact that virtually no funding is allocated to the development of next-generation mucosal vaccines, improved treatments during the acute phase of infection, or any treatments for Long COVID patients. While trillions are squandered on war and bank bailouts for the rich, nothing is provided for critical life-saving research.

Last week, results from the first clinical trial of a mucosal vaccine were released, showing remarkable levels of efficacy after a second dose.

The important study published by Chinese investigators demonstrated that an intranasally administered anti-COVID vaccine can induce robust mucosal immunity against the coronavirus in human subjects (128 healthcare workers). The study found that the vaccine provided substantial immune protection against COVID while demonstrating safety and tolerance.

Esteemed clinical researcher Dr. Eric Topol wrote on Twitter/X, “[two] doses of a COVID nasal vaccine spray led to more than a 50-fold increase in spike specific secretory IgA antibodies against 10 strains of SARS-CoV-2, indicative of potent mucosal immunity.” Furthermore, Topol added, “At least 86.2 percent of participants who completed two nasal vaccines doses maintained *uninfected status*, likely without even asymptomatic infection, for at least three months.”

Emergency room physician and indoor air quality proponent Dr. Kashif Pirzada replied, “This could potentially give a real ending to the pandemic. No more waves of illness, no more rushing for tests and antivirals if you’re elderly or vulnerable. Hope this comes out soon!”

However, large Phase 3 clinical trials are costly, requiring multiple participants to obtain statistically relevant information on clinical endpoints, not to speak of the research and development investment to identify a therapeutic that can be tested. Thus, under capitalism, there is virtually no investment in these large-scale trials and nothing is being done beyond offering boosters of the current vaccine, despite their greatly reduced efficacy in preventing transmission.

The mucosal vaccine study was conducted just as Chinese officials acquiesced to the demands of the imperialist powers to abandon their life-saving Zero-COVID public health program, resulting in the infection of virtually the entire population and the deaths of 1-2 million people. What could such a vaccine have meant to these millions who perished needlessly and the millions more globally since then?

This raises the broader question of why the international community, facing a devastating pandemic, could not bring its accumulated scientific expertise and infrastructure to bear on developing a preventative treatment against COVID?

As a trigger event in world history, the COVID-19 pandemic has only accelerated and exposed the deep-seated contradictions in global capitalism, which demands the accumulation of profit at any cost. The ruling class has nothing but contempt for workers, refusing to invest in any social programs that can improve the lives of masses of people. Shortsightedness, corruption, mistrust, and

suspicion epitomize their actions, which are rapidly progressing to a world conflagration carrying the danger of nuclear war.

Simply put, the ruling class cares not one iota about mucosal vaccines, just as it harbors resentment against any public health policy that infringes on its ability to conduct business.

Refusing to invest in these life-saving technologies, the capitalist ruling class has condemned humanity to face a lifetime of reinfections with COVID-19. What are the implications of this criminal policy?

Multiple previous studies have highlighted the dangers posed by reinfections with SARS-CoV-2. A recent study uploaded as a pre-print publication on *Research Square* (under review with the journal *Nature Portfolio*) by the Patient-Led Collaborative has once again found similar results when attempting to characterize the association between reinfections and the chronic debilitating condition known as Long COVID.

Among 3,382 participants (22 percent never had COVID, 42 percent with one prior infection and 35 percent with two or more infections), the risk of Long COVID was 2.14 times more likely among those with two COVID infections and 3.75 times more likely among those who had three or more COVID Infections compared to just one. Limitations in physical functioning measured in their study included ability to dress, bathe, perform moderate activities like vacuuming and functioning socially. Reinfections led to poorer overall health and worse immune health, including more severe outcomes and longer recovery from other infections.

As the authors wrote:

> Relative to those who did not report infections or experienced COVID-19 once, reinfections were associated with increased likelihood of severe fatigue, post-exertional malaise, decreased physical function, poorer immune health, symptom exacerbation before menstruation, and multiple other Long COVID symptoms. While vaccinations and boosters prior to infection are associated with lower likelihood of Long COVID, reinfections diminish their protective effect. The probability of reporting Long COVID remission is generally low (11.5 percent to 6.5 percent).

Another interesting finding of the study, which underscores the complete abandonment of public health efforts regarding COVID, is that a tiny number of those infected were prescribed antivirals during their acute COVID infections. Those with reinfections were also less likely to test, as the “forever COVID” policy has inured people against taking any protective measures to prevent infections.

The current alphabet soup of COVID strains sees KP.3.1.1 dominate across the US and Europe, accounting for nearly 60 percent of all strains. However, a new variant known as XEC that was first detected in Germany in June has spread to more than 27 countries and accounts for six percent of all recently sequenced SARS-CoV-2 viruses in the US. Virologists expect this strain, derived from JN.1 through a complex recombination event and with nearly twice the growth advantage, to overtake KP.3.1.1 and be the dominant variant during the winter season.

In a COVID update by TACT [Together Against COVID Transmission], the authors explain the dangers posed by these evolutionary developments of the SARS-CoV-2 viruses, writing:

> These variants can evade much of the immune responses from both vaccines and recent infections. Since they can evade antibodies to earlier variants, then that raises the risk of organ damage, vascular and neurological dysfunction, brain damage, and persistent infections which often leads to Long COVID. The unmitigated spread is raising concerns about their impact in the coming months.

Hospitalization rates for those 65 years and older and for children were among the highest during the summer from COVID and remain on par with the prior year’s summer/fall wave. The number of people who died from COVID in the week ending August 31, 2024 climbed to 1,239, four times higher than the lows seen in June. At the present rate, it is expected that at least 60,000 people will lose their lives from acute COVID this year, according to official figures, not including deaths incorrectly attributed to another cause or due to the impact on the population’s health from accumulated infections.

These are not incidental and speculative issues. In a provocative report released by the Swiss Re Group, titled, “The future of excess mortality after COVID-19,” one of the world’s leading providers of reinsurance and insurance, which specializes in translating the risk of death into money, said, “[If] the ongoing impact of the disease is not curtailed, excess mortality rates in the general population may remain up to three percent higher then pre-pandemic levels in the US and 2.5 percent in the UK by 2033.”

The Swiss Re Group advised its investors:

> Based on current medical trends and expected advancements, we conclude that COVID-19 is still driving excess mortality both directly and indirectly. In the long term, lifestyle factors that contribute to poor metabolic health and lead to obesity and diabetes may become another compounding factor in population excess mortality. Insurers may wish to continue to monitor excess mortality and its underlying drivers in the general population closely, as well as the differences between general and insured populations.