

# QUARTERLY REPORT

Edition 2 – Apr 2024

**Produced by the Control Group**

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## Abstract

In this, the second edition of the Control Group *Quarterly Report*, our analytics team build upon the foundations laid down in the first report (released in January 2024), and take a deeper look at our COVID-related data, including the use and reliability of COVID tests, the severity of disease in those who report having COVID, and our data around 'Long COVID'.

We also reveal the number of COVID-vaccinated contributing to the Control Group database, the percentage of these participants who report having vaccine injuries, how many vaccines were taken before side-effects occurred, and what side effects are being reported.

We take a speculative glance at shedding, and some of the problems involved in reporting upon the phenomenon. And we also survey the present data we have on the prevalence of cancer, examining the most common types of cancer people in the Control Group survey report having, at what stage they received a diagnosis, and whether or not their condition has been resolved.

This report has been inspired by the questions posed to our analytics team by participants in the Control Group study through our 'Direction of Control Group Research?' questionnaire.

### Reference for this paper:

Fielder, D., van Kleeff, D., et al., *The Quarterly Report*, ed. 2, Control Group, (April 2024).



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## Purpose of the Control Group

Our data insights provide a window into – what appears to be – the rise in serious health conditions around the world. They are a starting point on the journey towards understanding the anatomy of health and wellbeing in the 21<sup>st</sup> century.

Our ambition is that these data insights captured by the Control Group will spark interest, and raise red flags in the public domain, encouraging the general public to demand further research and transparency from their governments and scientific communities.

We want our datapoints to serve as a provocation for further study within the established medical and academic institutions, with any promising discoveries from the Control Group database to be the initiating cause of in-depth research papers, tests, and studies refuting or corroborating our preliminary findings.

A static report like this is limited in its capabilities, and it is our ambition to provide this information via dynamic charting which will provide more capabilities and insight for our community, with further information available when hovering over the charts and capabilities to support drilling down into further detail.

Having a committed cohort of participants who keep their data up-to-date is essential for us to build trust and improve the value of our reporting. Our aim is to provide us all with a potent ‘yardstick’ with which we can compare data provided by our medical regulators and governing bodies, but we have significant hurdles to overcome to achieve this, and it will take commitment, integrity and strength from all of us to help grow, fund and protect this project, so it becomes an amazing legacy we can leave for the future of mankind.

As well as fighting to retain our rights and freedoms today we must take the time and effort to develop and support the solutions that can help develop a better and **healthier** future for ourselves and our offspring, based upon truth, and personal sovereignty.

<https://controlgroup.coop/>

### Past Reports

1. ‘Self-selected covid-19 “unvaccinated” cohort reports favorable health outcomes and unjustified discrimination in global survey’

Verkerk, R., PhD, et al., International Journal of Vaccine Theory, Practice, and Research, (August 2022).

<https://ijvtp.com/index.php/IJVTPr/article/view/43>

2. ‘The Quarterly Report’ – Edition 1 – January 2024

Fielder, D., van Kleeff, D., et al., *The Quarterly Report*, ed. 1, Control Group, (January 2024).

[https://www.controlgroup.coop/docs/CG\\_quarterly\\_report\\_edition1.pdf?acid=3b95b91cd7f6&mtm\\_campaign=qreped1](https://www.controlgroup.coop/docs/CG_quarterly_report_edition1.pdf?acid=3b95b91cd7f6&mtm_campaign=qreped1)



## Control Group Participation

### Worldwide Participation

In figure 1.1, the red bubbles are sized to reflect the number of *active participants*\* within each country – the bigger the bubble, the more active participants in that geographical region. This enables us to identify which countries have the highest participation. Currently, it is those in the developed Anglosphere who participate most in our study, followed by European and South American countries contributing in similar proportions.

Since our last report the number of active participants logged into the new CG2.0 platform has risen by nearly 3,000 to over 38,000 men, women and children. This gives us great encouragement and we hope that this number will continue to grow at even greater speed as people come to learn of the Control Group and see the potential of this communal, independent data source.

Collecting geographical statistics enables us to see not only where there are the most participants, but identify what illness, infections, and diseases are most common, or new to each location. Where participants log what treatments and therapies they took to resolve or manage their health conditions, our analytics team can see if the method or success of treatment varies upon location.

We can also zoom-in on each country and watch a disease spread in real time as participants register their symptoms.

This geographical function has particular utility when understanding the health effects a local environmental disaster such as an oil spill, chemical-plant fire, or area of heavy industry.

*\*Participants who have signed into and updated their records in CG2.0.*



## Regional participant distribution

Figures 1.2 and 1.3 show how the geographical distribution of participants within South America (fig 1.2) and Europe (fig 1.3). Again, the bubble size shows the comparative scale of participation at each location.

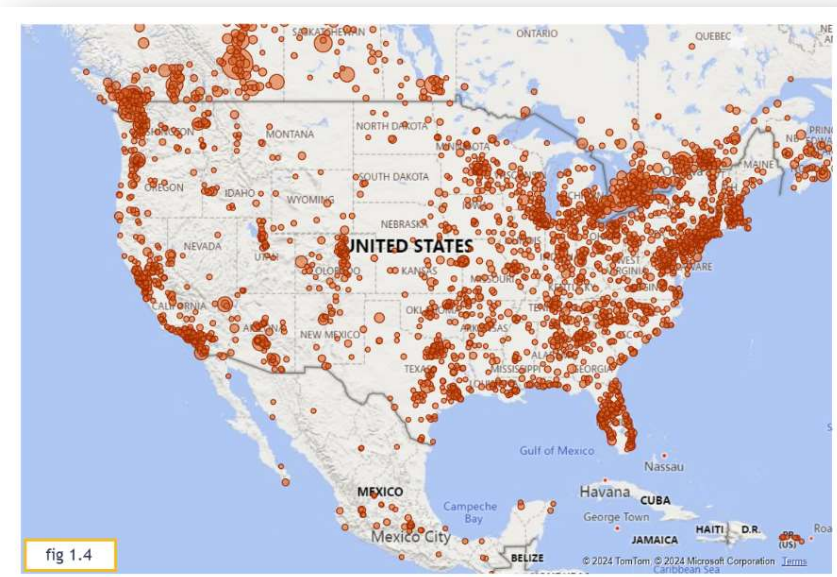
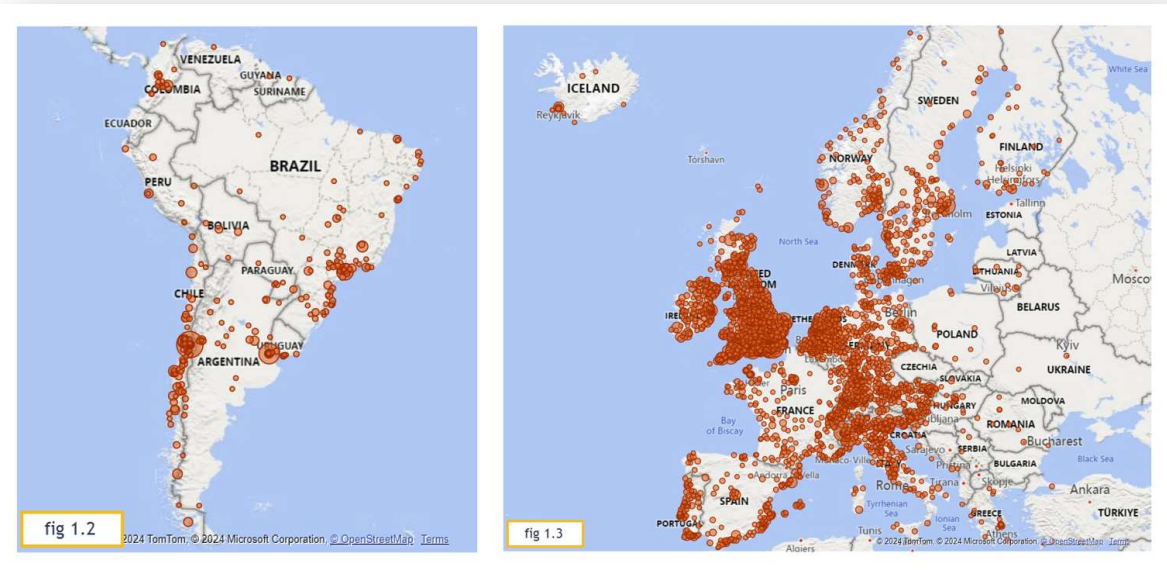
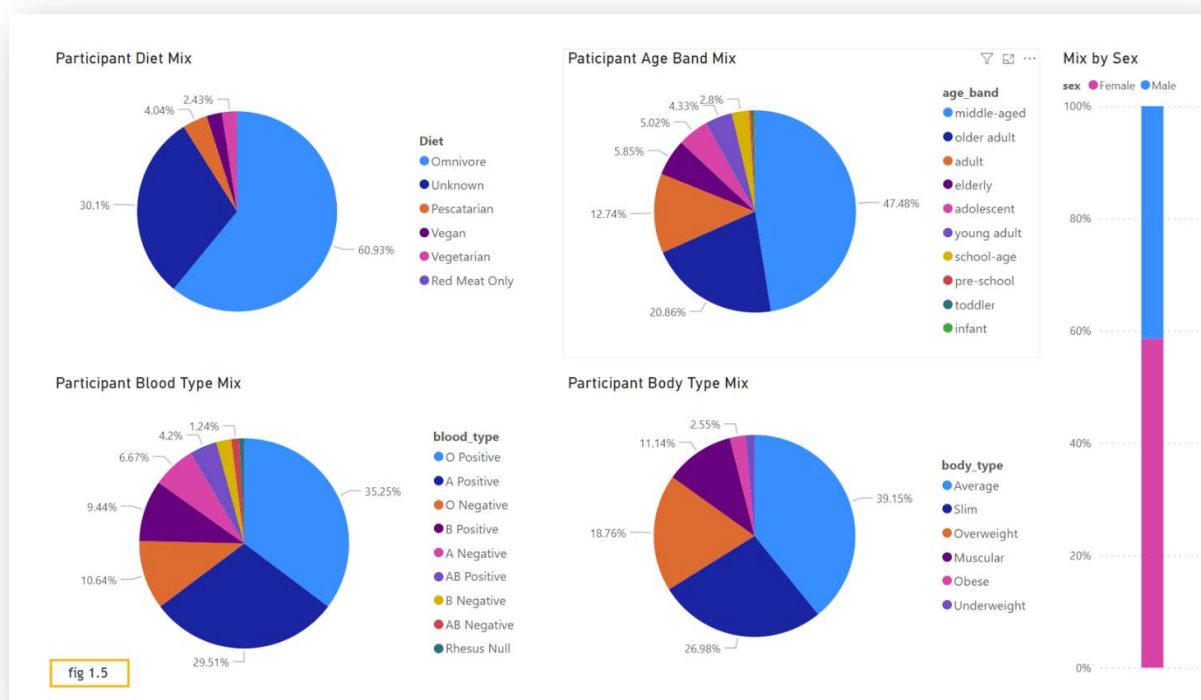


Fig 1.4 shows the distribution of participants across North America.

## Participation Demographics

Figure 1.5 shows the make up of our participant base across a number of different demographics, including sex, age, diet, blood type, and body type. At present, our sex make-up is weighed towards females – nearly 60 per cent of our participants. The majority of our participants are middle aged to older adult, 47 per cent and 21 per cent respectively; this is slightly above the mean age distribution of *industrialised\** nations. Around 65 per cent of participants classified themselves as either of slim or average build which falls in line with background figures in industrialised countries which report a range of 38 per cent to 49 per cent of their population as being overweight-to-obese. At a closer look, the weight classes of overweight and obese are actually under represented in our data, with more people reporting as muscular than obese.

*\*Industrialised countries have moved away from an agriculture-based economy into urban economy where productivity is focused in population-dense areas of industry, resulting in mass production, commercialism, international trade, and technological entrepreneurship.*



Our sample of younger people is unrepresentative of the background demographics of industrialised countries, with the number younger participants in the study being less than exists within the population. A challenge of the Control Group going forward will be recruiting more young adults and children into the study.



It will be particularly important to include newborns and their health outcomes in the study. Following the rise in vaccine hesitancy and a growing distrust in pharmaceutical intervention, we will be able to provide a real-time comparative analysis into whether this hesitancy is well-founded, or whether those who parents who choose to abstain from pharmaceutical interventions in the cultivation of their children's health have less favourable health outcomes.

There would also be the potential to analyse whether a newborn child's short-term or long-term health is impacted by their parent's COVID vaccination status.

*(See over page)*

## COVID-19

The following section will present several charts to help us understand the current status of COVID-19 – its prevalence and severity – within the participant cohort by looking at metrics such as testing, vaccination status, severity of illness and frequency of illness.

### COVID Testing

In the case of COVID tests, they have been grouped as ‘invasive’ or ‘non-invasive’. Invasive tests are all COVID tests that require a swab test, such as the PCR or LFT test. The spit/saliva tests are classified as non-invasive as nothing is entering the body in order to take a sample.

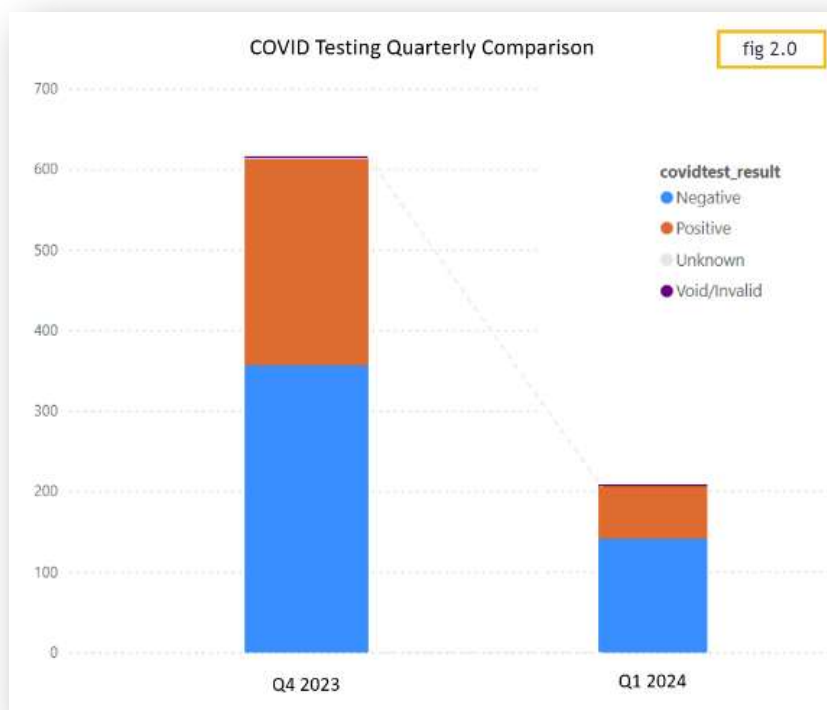
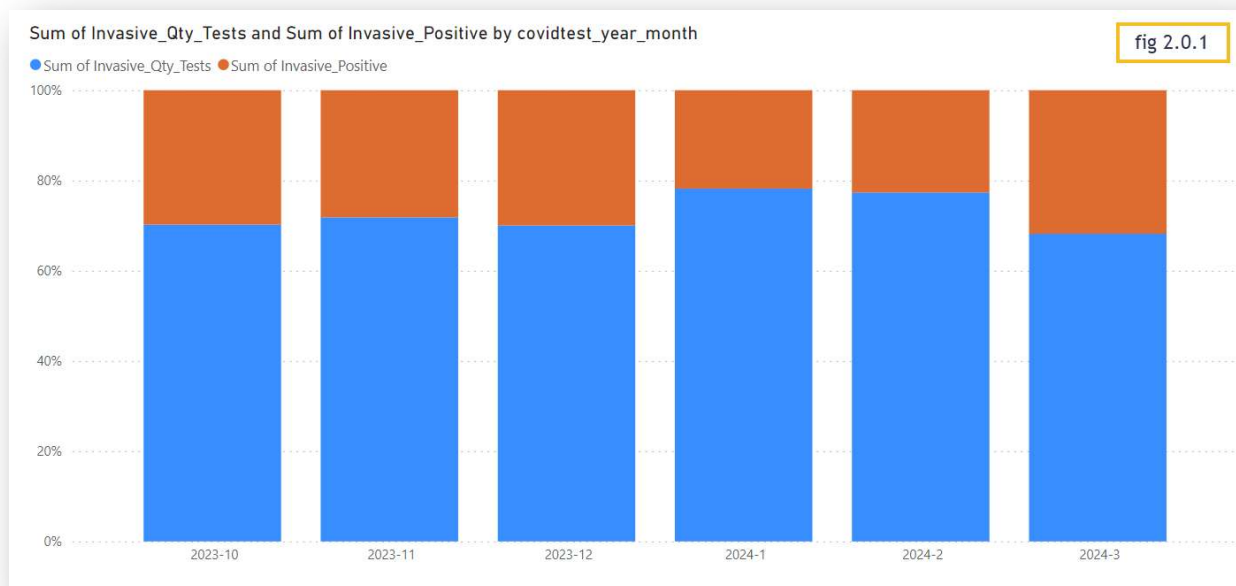


Fig 2.0 shows that we are seeing a significant decrease in the use of COVID testing from Q4 2023 to Q1 2024.

This indicates that COVID is: becoming less of a health issue, or less of a social concern, that people are less reliant upon testing, that they do not feel the need to test, no longer believe in the relevance of testing, are being asked to test less, or are increasingly distrustful of the efficacy, utility or safety of testing – or, of course, a combination thereof, or as yet unspecified factors, such as availability of the tests, or the fact that tests are no longer given out free of charge in many countries.



Looking at fig 2.0.1 we can see the percentage of positive test results is fairly consistent from month to month (October 2023 to March 2024). This could indicate that the prevalence of disease has stabilised (without indicating whether the severity of disease has changed.) This could also support the hypothesis that these tests have a significant and fairly consistent false positive (or, indeed, false negative) rate.

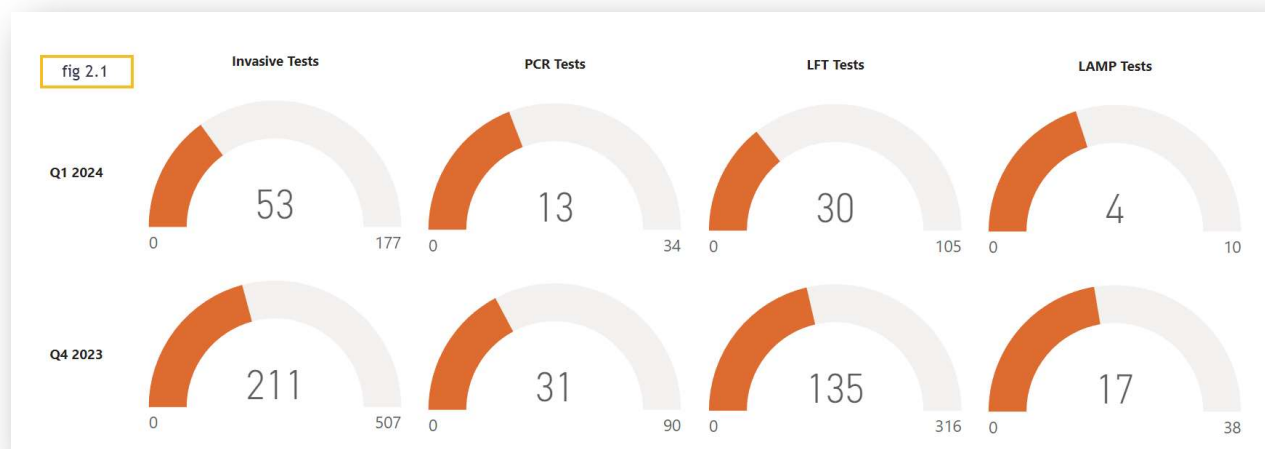


Understanding the rate of false positives would enable citizens to push back against civic restrictions and employer mandates with hard evidence.

Figure 2.1 features a series of gauges showing the number of COVID tests logged by our participants for Q1 2024 (January to March 2024) versus Q3 2024 (October to December 2023). The first column of charts is a combination of all the invasive tests taken, while the following columns look specifically at the 3 most common types of COVID tests. Each gauge reflects the total quantity of tests recorded with the coloured section reflecting the number of positive results.

(See over page)

Figure 2.1 shows that between the three main test types of COVID test there is little difference in the ratio of positive to negative results.



This chart (fig 2.1) better demonstrates the exact quantity of tests performed. The LFT tests is the most common type of test currently being administered.

In future, we can look at these tests by geographical region, to see if the choice of test is different from country-to-country, and if the type of test has any bearing up side-effects and side-effects with long-term health outcomes. This kind of analysis relies on having significant numbers of participants within each region reporting the instances in which they have take a test, and what type of test they took.

## COVID Illness

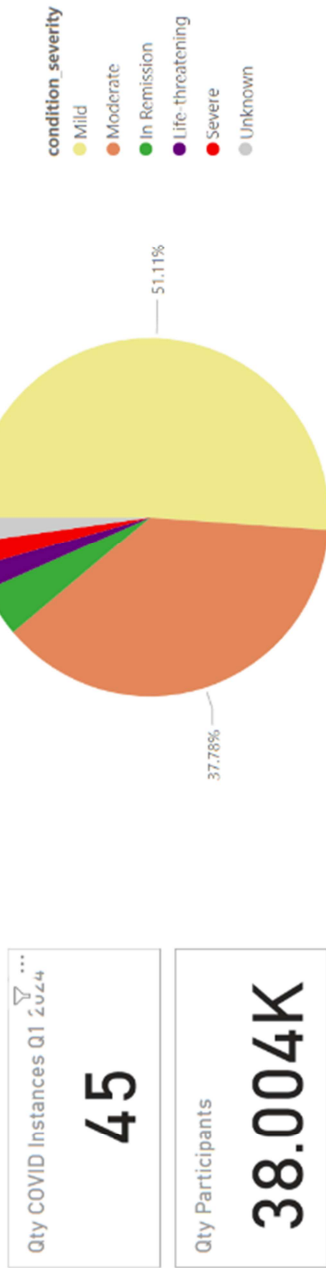
Fig 2.4 shows that within our cohort of 38,000 people, there have been only 45 newly reported cases of COVID within the first quarter of 2024. Nearly 90 per cent cases are reported as being mild to moderate in severity as shown in the yellow and orange segments of the pie chart.

The bar chart at the bottom of Fig 2.4 shows the reported variant of COVID, and as we have seen recently it is mostly reported as 'variant unspecified' which may be the result of self-diagnosis or a positive test result.

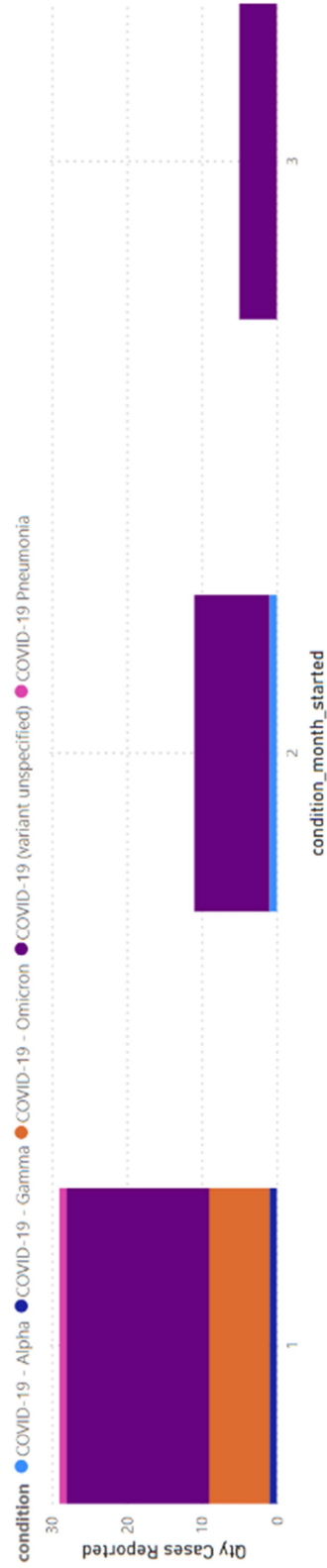
*(See over page)*

# Covid Instances and Severity Q1 2024

fig 2.4



## Logged Instances of Covid for Q1 2024





The self-diagnosis can be verified by looking at whether participants who reported having the condition also report their diagnosis being confirmed by a doctor. In fig 2.5 we can see that only 1 case of COVID was verified by a doctor's assessment.

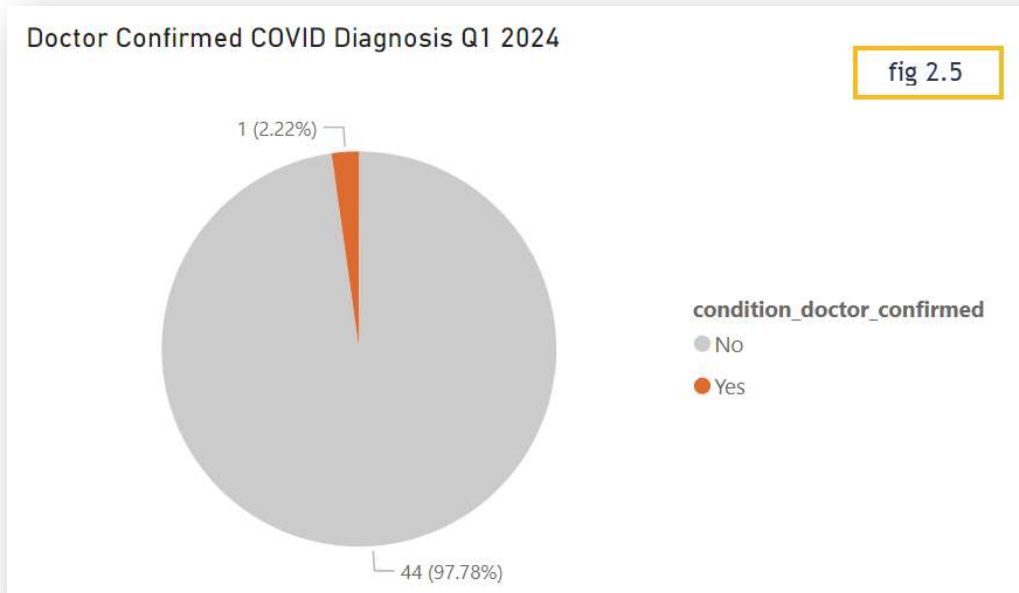
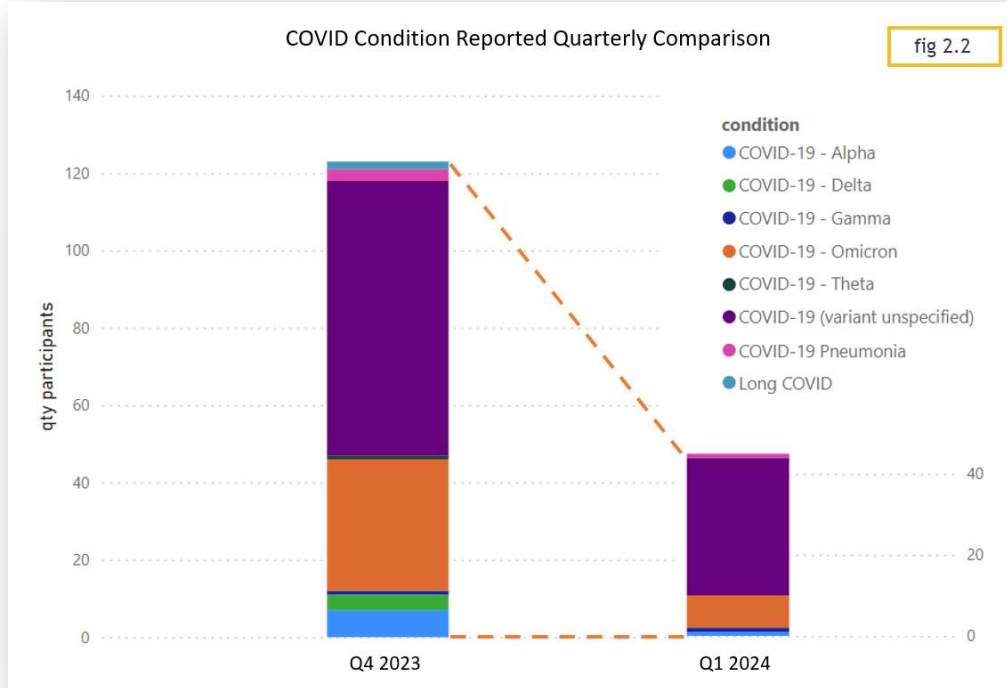


Figure 2.2 shows a substantial reduction in reported instances of COVID in Q1 2024, down 50 per cent from Q4 2023. The different coloured sections represent different variants of COVID reported.

This significant decrease could be attributed to the warming of winter into spring in the Northern hemisphere where a majority of Control Group participants report living. The decrease could be to a decrease in the severity of disease, decreased virulence of COVID, an increase in immunity whether acquired naturally or synthetically, a combination of the above, or, indeed, some other factor; this is a superficial glance at the resultant figures, but our database would permit a deeper dive into these figures to understand potential underlying causes to the change in quantity of disease being reported.

In most cases of COVID being reported, participants were unspecific about the variant of COVID.

*(See over page)*



## Severity of COVID

Figure 2.3 is a side-by-side comparison of the differences in severity of disease in those who reported having COVID in Q1 of 2024 (first column) versus all recorded cases of COVID since Control Group records began in July 2021 (second column).

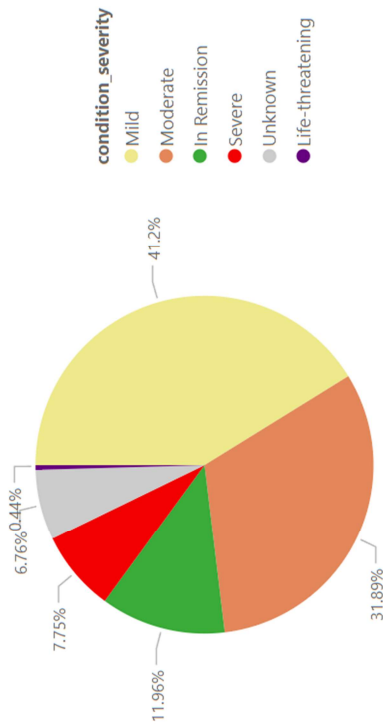
These charts illustrate the on-going decrease in the severity of COVID symptoms together with a lower rate of hospitalisation. In Q1 2024 we can see that 51 per cent of cases were reported as being mild with another 38 per cent being reported as moderate.

This trend would appear to corroborate the thesis that the disease potency reduces with each mutation and/or that a person develops an immunity that prevents them from succumbing to disease when it is encountered.

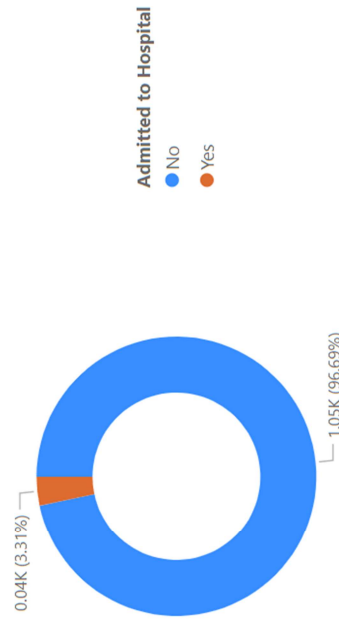
*(See over page)*

fig 2.3

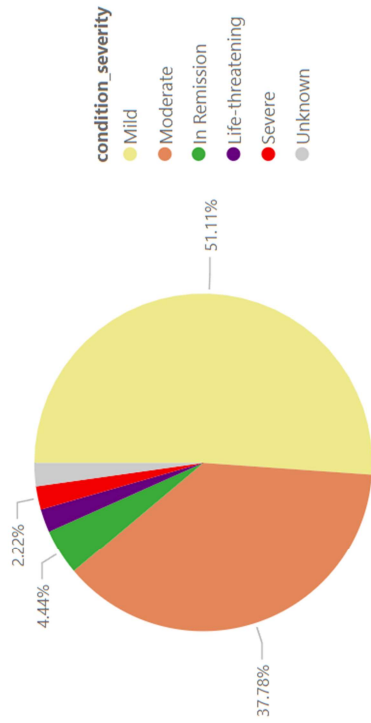
### Covid Severity - All Time



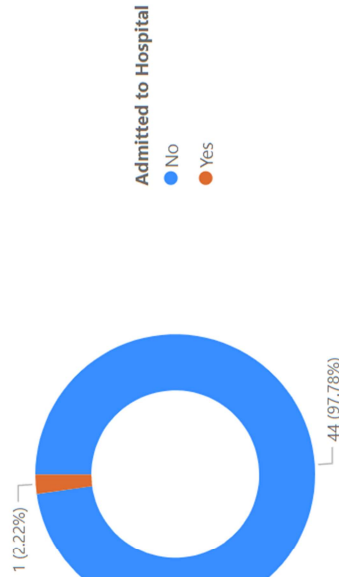
### Hospital Admissions with COVID (All Time)



### Covid Severity Q1 2024



### Hospital Admission with COVID Q1 2024



## Long COVID

Figure 2.3 looks specifically at the phenomenon of Long COVID examining how many of our participants have reported from suffering from this condition at any time, and how many continue to report themselves as suffering from this condition.

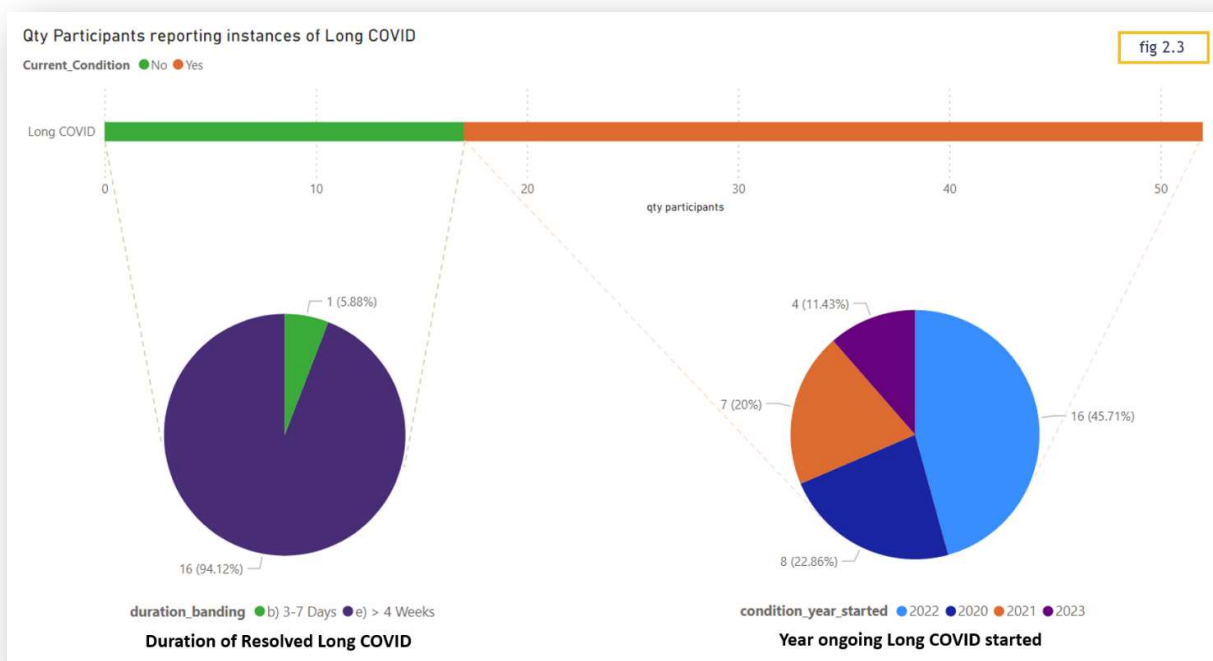


Figure 2.3 is not divided by COVID vaccination status but is inclusive of all demographics of participant in the Control Group.

The bar chart at the top shows of figure 2.3 the total number of registered cases of Long COVID (52 in 38,000 active participants) with the green portion representing the number of those who report the condition as having resolved (17 of 52 people), and the orange portion representing the quantity of cases which are still active or persisting (35 of 52 people). Around 70 per cent of the 52 participants who had Long COVID report that they continue to suffer from it.

The purple and green pie chart on the left shows the duration for which the illness persisted in those who report their Long COVID as being resolved, with nearly all cases lasting longer than 4 weeks.

The pie chart on the right shows which year, for those whose Long COVID remains unresolved, the participants first presented with the condition. Almost half of cases were reported in 2022, with a four-fold decrease in the number of cases reported in the subsequent year, 2023.

The Control Group do not attempt yet to speculate what exactly 'Long COVID' is – be it a protracted form of COVID, an auto-immune disease developed after an encounter with COVID, a form of chronic fatigue, a side effect of the COVID vaccines, or something else.

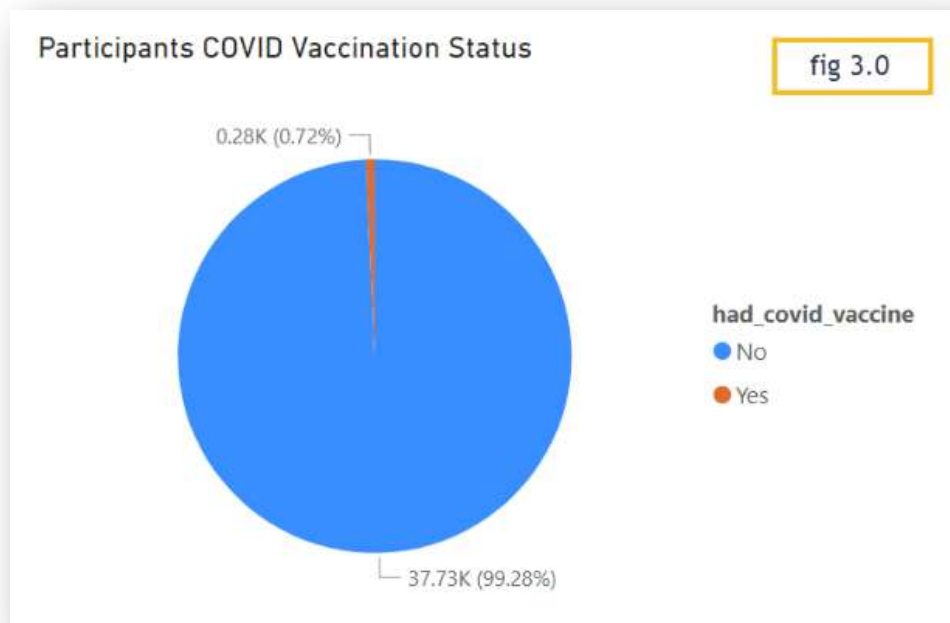
We do, however, encourage all those who have experienced, continue to experience, or have otherwise been diagnosed with Long COVID to report their experiences to the Control Group and enable our researchers to better understand the pathology and mechanisms behind Long COVID, as well as report upon which interventions and therapies (if any) have been helpful in resolving the condition or alleviated symptoms in those who suffer with it.



## COVID Vaccinations

### Vaccination Status

Figure 3.0 shows the percentage of our participant base who have received any variant of COVID vaccination – of our 38,000 active participants, 275 are vaccinated; this is less than 1 per cent of our cohort.



This is because the Control Group did not set out with the intention of collecting data on the COVID-vaccinated, expecting to use the statistics provided by pharmaceutical companies, governments, and research bodies as the data set to compare with our 'control group' data set.

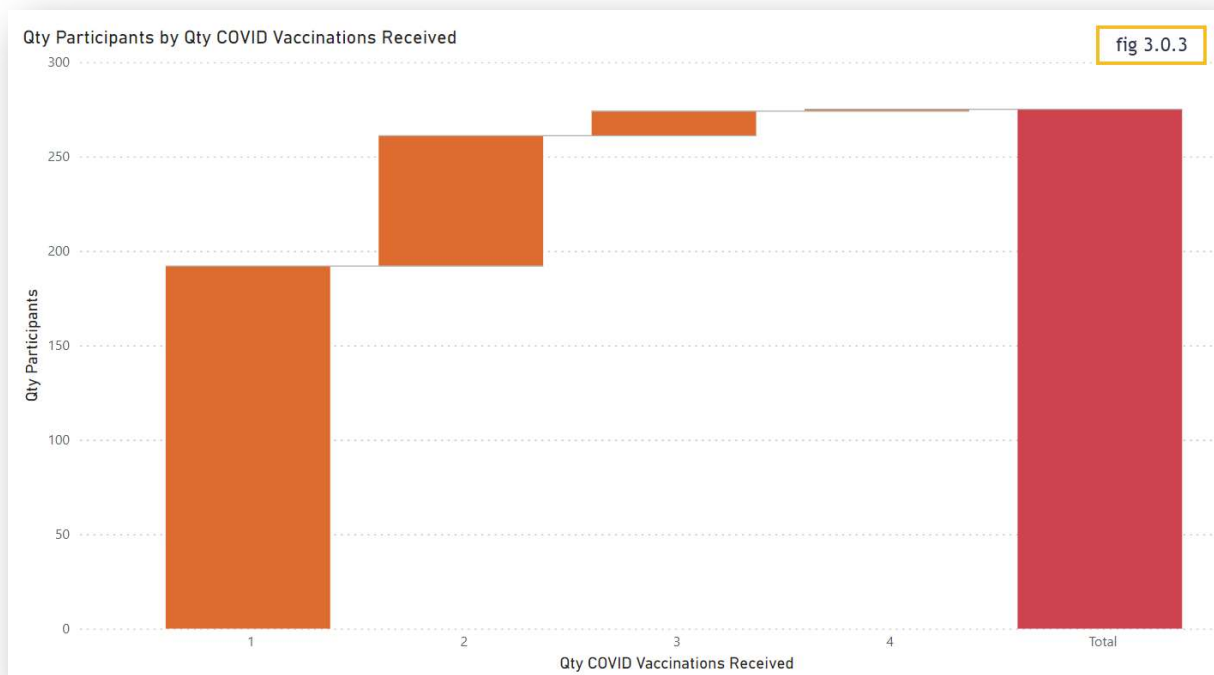
Since it has emerged that records on the vaccinated – when they were vaccinated, with what COVID injection, where they were vaccinated, any side effect suffered in the short term or long term – are either sketchy or non-existent, we have begun to invite the vaccinated into the Control Group to provide a more reliable and consistent comparison group.

To see a good comparison between those who did and those who did not take the COVID vaccinations, we need to achieve higher levels of adoption within the vaccinated community.



With figure 3.0.3, we can see the number of COVID vaccinations received by each of the participants who registered themselves as being vaccinated against COVID-19.

A majority of the registrants report having a single vaccination, with fewer people having a second vaccination, and fewer still receiving a third vaccination. Only a single participant reports having four vaccines. Four vaccines seem to be the standard number of vaccines offered by countries who had a free or insurance-covered vaccination programme, although many Westernised countries readily offer more than four to those who fall into the ‘vulnerable’ and ‘elderly’ categories.



### COVID Vaccine Injuries

In fig 3.0.1 we can see the number of COVID vaccines participants received prior to experiencing their first vaccination injury and how that is distributed across all vaccine injuries that have been recorded by the COVID-vaccinated with the Control Group.

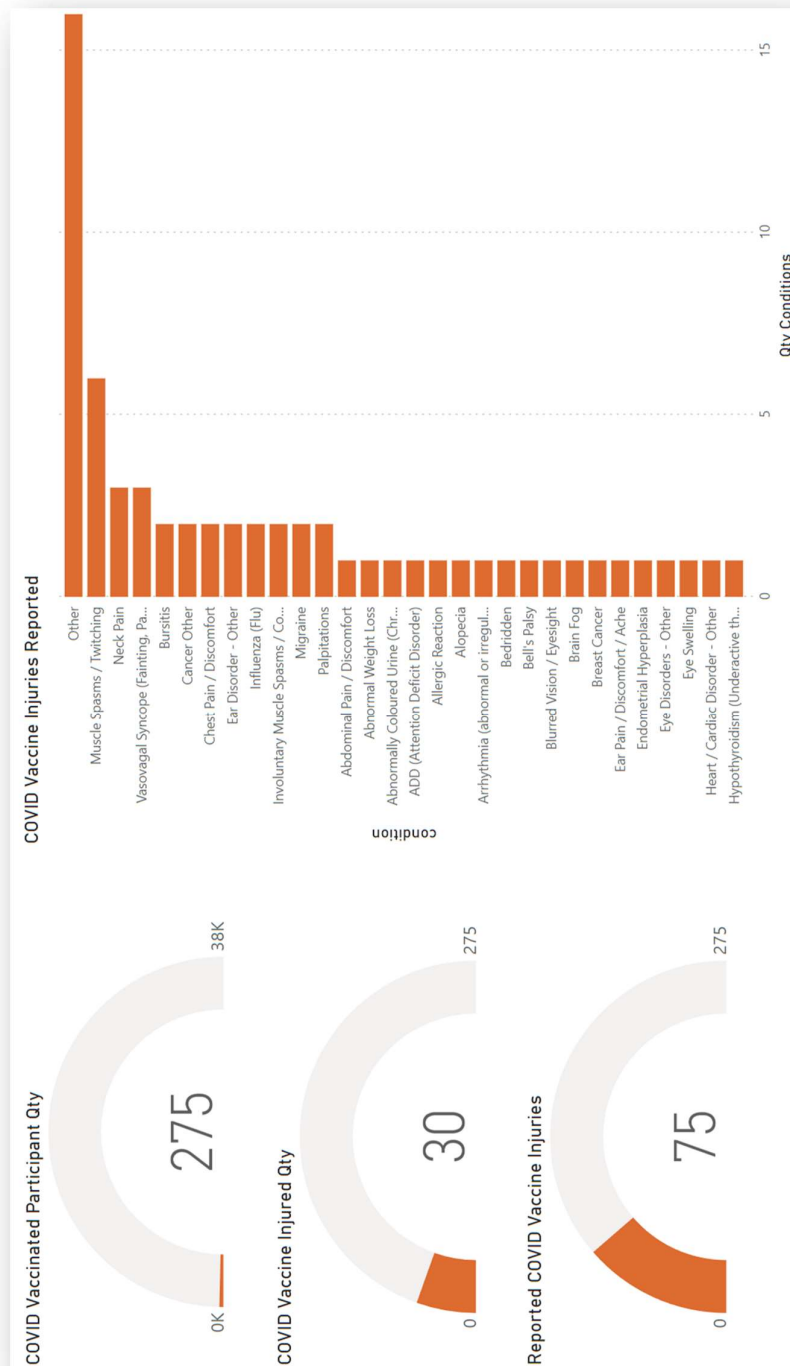
Of the 275 people who people report being vaccinated for COVID-19, 30 report being injured.

At a glance this would suggest a 9-10 per cent injury rate among those who received one or more of the COVID vaccinations. These are, however, only a preliminary number and it should be remembered that many of people who sign-up to the Control Group, and have had one or more COVID vaccinations, choose to donate their data *because* they have experienced side-effects or injury, or know people who have – the real figure may be lower, or indeed higher, in the general population given the lack of public knowledge surrounding vaccine injuries and a reluctance within the medical establishment to admit to or concede their products can cause the injuries with which people are presenting.



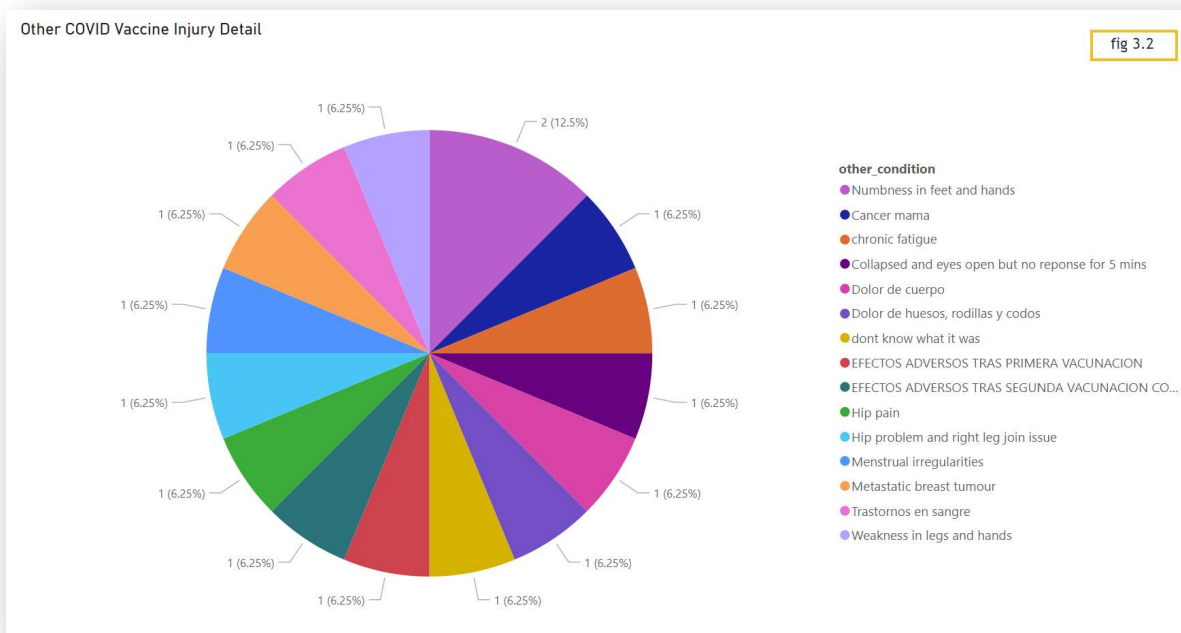
In Figure 3.1, we can see that of the 30 vaccine-injured participants, some report having multiple injuries, accounting for 75 of the health conditions being attributed to the COVID vaccination.

The bar chart of the right-hand side of fig 3.1 shows which injuries have been reported. Of the 75 injuries reported, 16 were listed as 'other' by participants, meaning that they report suffering with conditions not yet listed in our database.



In figure 3.2, we look at the precise description supplied for the injury when it was categorised as 'Other'.

We can see from the descriptions supplied by participants reporting vaccine injury that there is work to do to better categorise data and to help our participants be more precise with their reporting. This is an ongoing task and will require feedback from participants and advisory teams to build in translation layers and further standardised input options.



In figure 3.0.1, we can see that injuries are primarily occurring after the first and second vaccine, with fewer people experiencing their first vaccine injury upon their third injection and no-one reporting injuries occurring after their fourth (for those who took four).

We have not taken the severity of the injury into account in this particular analysis.

It will be interesting to see if this distribution of vaccine injuries remains the same as more of those with vaccine injuries join our study.

(See over page)

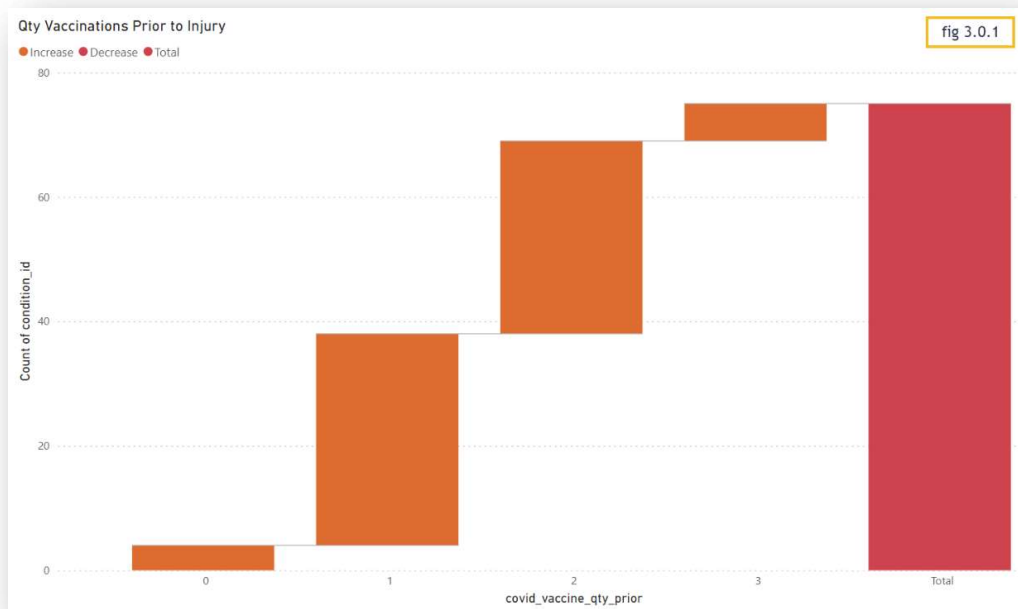
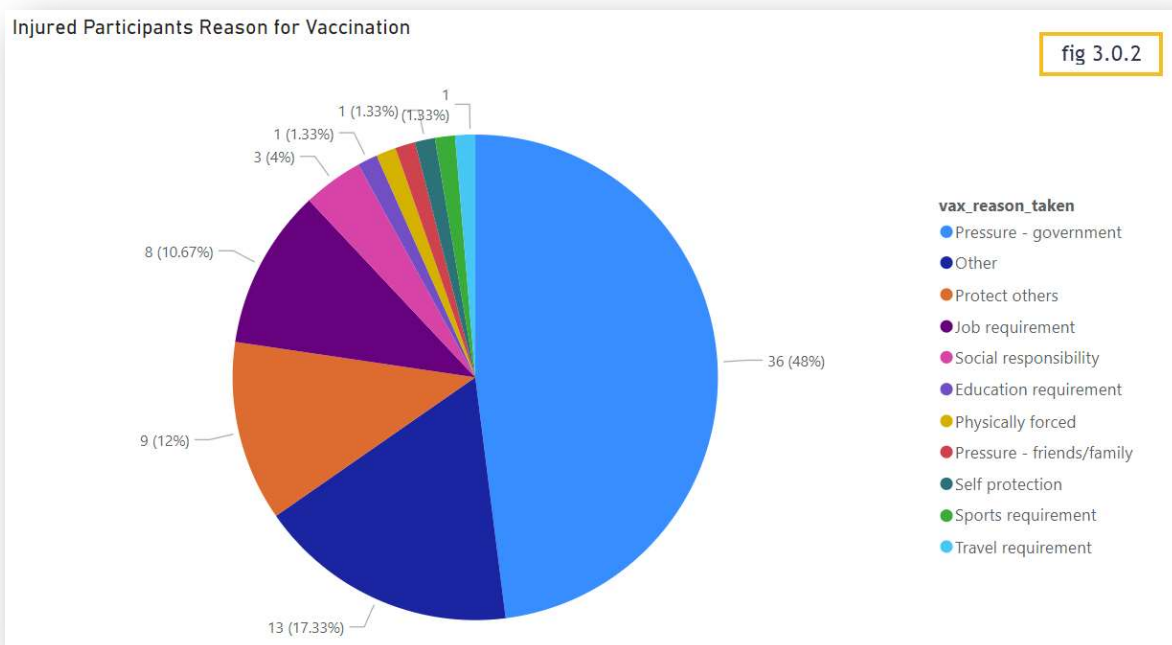


Figure 3.0.2 looks at the primary reason those with vaccine injuries chose to have a vaccine administered. Almost half, 48 per cent, report that they were vaccinated as a result of governmental pressure; a belief that taking the vaccine would protect others was the second biggest reason named by participants who took the vaccine, followed then by work mandates being the third most common reason.





## Shedding

Shedding is the single most common topic the Control Group has been asked to investigate. The phenomenon of 'shedding' – the spreading of spike proteins by those with COVID-19 or by those who took one or more COVID vaccines – is hotly contested, with many different theories about the mechanisms, purpose behind, side-effects of, and evidence for spike proteins and their transmission.

The matter, at this moment in time, being an ambiguous one, means that reporting on shedding is something that is subjective and difficult to capture. Many of our participants report being concerned about becoming ill after being in the company of others who have been COVID vaccinated. Some report becoming ill after being in contact with newly vaccinated or 'heavily' vaccinated people. And some report unusual changes to their body after being in contact with one or many vaccinated people, such as a loss of smell or menstruation changes.

The main area within our data that we see the phenomenon of shedding being mentioned is in relation to menstruation, where it has been often reported that exposure to the vaccinated as the causes abnormal changes in menstruation – particularly post-menopausal women experiencing something akin to menstrual bleeding.

In the treemap chart below we show some of the responses provided by respondents as to what they believe is the cause to changes in menstruation they have experienced.

The menstruation changes responses have not undergone any sanitisation and are provided as entered. You can see from this example why the Control Group are working hard to provide standardised input options wherever possible. Without these standardised responses, we end up with data that has to be heavily manipulated in order to provide any insight.

*(See over page)*

| Shedding type responses to cause of menstruation change |                                                           |                                      |                                           |                                            |                                            |                                            |                                                     |                                          |                                              |                                            |                                           |
|---------------------------------------------------------|-----------------------------------------------------------|--------------------------------------|-------------------------------------------|--------------------------------------------|--------------------------------------------|--------------------------------------------|-----------------------------------------------------|------------------------------------------|----------------------------------------------|--------------------------------------------|-------------------------------------------|
| shedding                                                | being around vaccinated people                            | Being around recently vaccinated     | Being around vaxed people or...           | Being close to vaccinated people -...      | being covid positive4 times                | Being in close contact with...             | Being in close proximity to covid...                | Being in close proximity to lots of...   | Being in contact with vaccinee...            | being in proximity with people who have... | being near recently vaccinated/boosted... |
|                                                         |                                                           | being around recently vaccinated...  | close contact with vaccinated person      | drinking and eating bad foods and being... | early onset menopause due to exposure...   | Exposed to vaccinated people               | Exposure after someone else was...                  | Exposure to COVID-19 shedding            | Exposure to people who have just had the.... | Exposure to vaccinated individuals         | exposure to vaccinated person             |
|                                                         |                                                           | Being around the vaccinated          | Contact with Covid Vaccinated individuals | Exposure to vaccinated.                    | I suffered vaccine injury from detoxing... | maybe vaccine shedding from other...       | only happened a couple of times in...               | Others around me getting vaccinated...   | Period stopped after exposure...             | Possibly shedding                          | ?shedding                                 |
|                                                         | Shedding?                                                 | Being around those who were...       | contact with spike protein shedding       | from what understand the cause might be... | Shedding - I am around many vaxed...       | Shedding from covid injected persons....   | shedding from covid vaccinees right after...        | Shedding from flatmate                   | Shedding from my husband's J&J...            | shedding from other vaccinated persons     | shedding from people who have bee...      |
|                                                         |                                                           | Being around vaccinated clients....  | Covid 19 Vaccination shedding after...    | Got a vaccinated flatmate. Started...      | shedding & Chem Trails                     | shedding from vaccinated friends           | Being around a lot of vaccinated...                 | Shedding other people's vaccine...       | shedding around other newly vaccinated...    | Being around newly vaccinated...           | Spike Protein Shedding                    |
|                                                         | Exposure after someone else was freshly covid vaccinated. | Being around vaccinated individuals  | COVID vaccination shedding from high...   | Husband had 1st vaccination. I had...      | shedding affect, happened when I ha...     | shedding from vaccinated people...         | Spike proteins contagion                            | Surround... by other females (most...    | Surround... by vaccinated female...          | The change happened after I...             | Thought this could be perimen...          |
|                                                         |                                                           | Being around vaccinated people -...  | Covid vaccine shedding                    | Husband had one vaccination                | shedding during vaccination or others i... | shedding from vaccinated persons           | spike proteins from being near ...                  | transmission from jabbed                 | Vax shedding                                 | Vax Shedding. Return to normal away...     | viral shedding                            |
|                                                         | Shedding of vaccinated people                             | Being around vaccinated people. I... | COVID Vaccine Shedding onto me...         | husbands covid vaccination                 | shedding from being in close quarters...   | Shedding from vaxed persons                | spike proteins from fully vaccinated...             | being around people that got the covi... | When my husband had his first C19...         | Working closely with vaccinated people     | working with clients who have had mRN...  |
|                                                         |                                                           | Being around vaccinated/boosted...   | Cv19 shot shedding                        | I believe shedding from other persons      | Shedding from being in company of covid... | Shedding of spike protein from covid 19... | Started after husband was mandated to get CV jab... | Vaccine Shedding - changes...            | Whenever I spend several hours in close...   | working with clients who have had mRN...   |                                           |
|                                                         | Being in close contact with vaccinated individuals.       |                                      |                                           |                                            |                                            |                                            |                                                     |                                          |                                              |                                            |                                           |



## Cancer

In the last couple of months, we have seen a lot of social media commentary about cancer, with high-profile persons and celebrities bringing attention to the issue of cancer, cancer diagnosis, and cancer treatment. As a topic, cancer is the second most requested topic participants ask us to examine.

### Grade and Stage

Different geographies have different methodologies for determining the severity of cancers. The most common phrases used are Stage and Grade, and sometimes both. And they are not directly correlateable so we capture and analyse these independently.

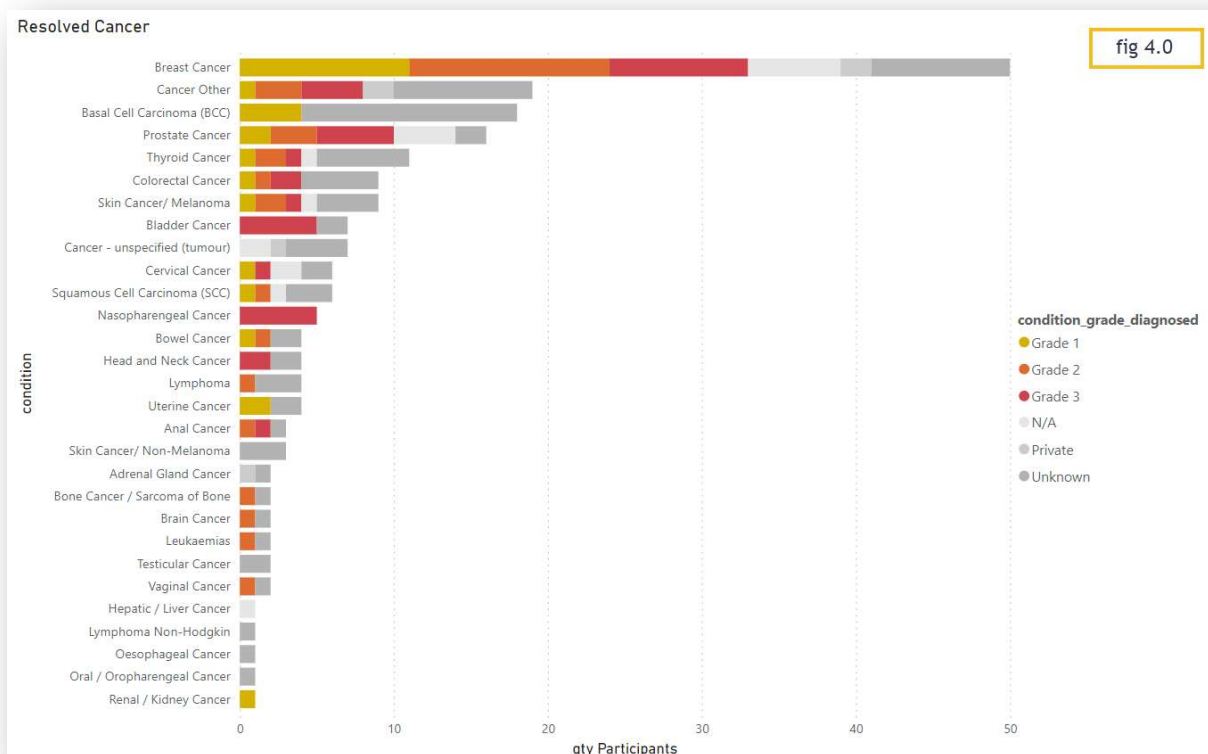
When analysing either of these metrics in isolation, it may be that the unknown or 'N/A' choices are the result of this methodology not being used within the participant's country.

When participants report themselves or their loved ones as having cancer, we request they provide a stage/grade at the time of diagnosis and provide them with the ability to enter and manage the current stage/grade as the condition evolves or subsides.

### Resolved Cancer

In figure 4.0, we can see the frequency with which cancer conditions are resolved, as listed by our cohort of active participants.

The bars are colour coded to reflect the Grade at which the cancer was diagnosed. We have used a colour coded key to visualise the cancer stage with shades of grey used for undertermined data.





One feature of interest is that even cancer diagnosed at a late stage (grade 3 cases of cancer, shown in red) have been successfully resolved. Of course, there may be some misdirection in this data as the Control Group – whilst having mechanisms available to report on death – will, more often than not, remain unaware that a participant has died of their condition. This is perhaps most self-evident in that we have no resolved cases in those whose cancer was diagnosed at Stage 4.

## Unresolved Cancer

In figure 4.1 we look at the unresolved cases of cancer, and type of cancer that they are. The bar graph on the left-hand side lists the most common cancers and the stage at which they were diagnosed in our participants. The right-hand bar graph lists the most common cancers and the stage they are currently reported as being.

As before each stage has been coloured differently so it is easier to identify within the charts with variants of grey being used for unknown/private and N/A choices.

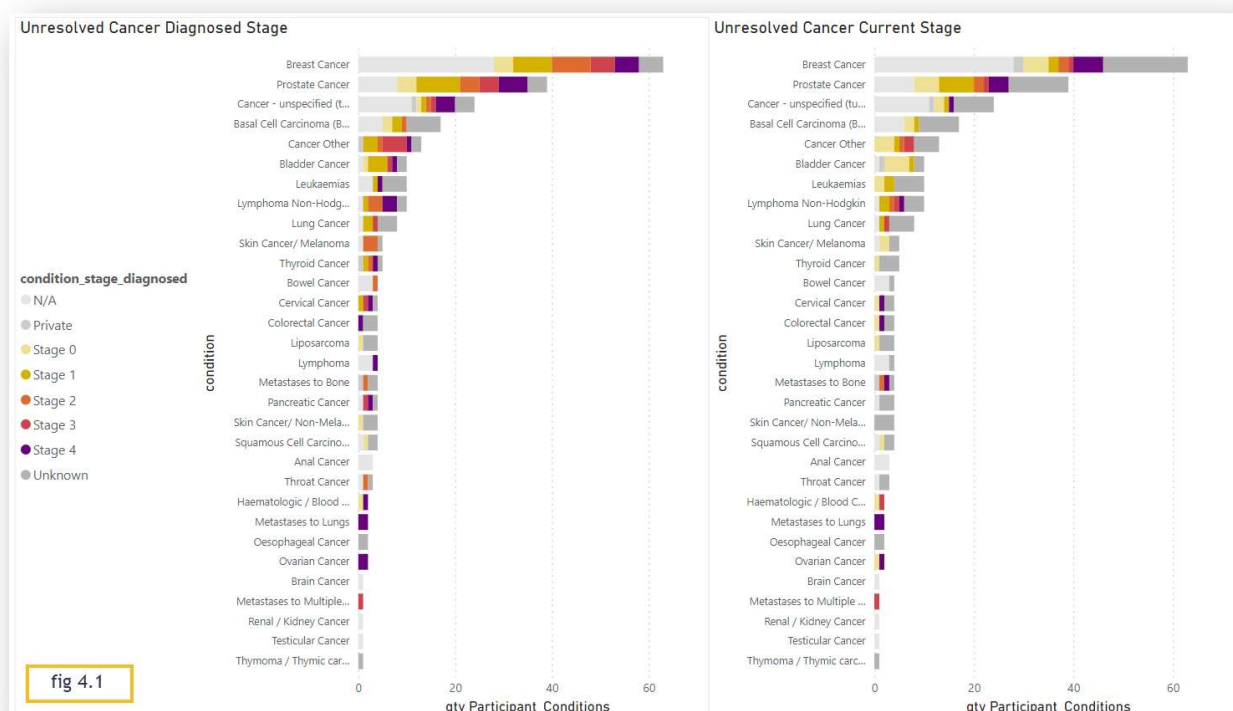


Figure 4.1 is intended to show which types of cancer cases are most common, and how the cancer Stage has progressed since diagnosis. We can see that we have several cases of cancer being diagnosed at Stage 4, shown in purple.



It is surprising to see that a large proportion of participants suffering with an active cancer report the current stage of their cancer as 'unknown'. Further investigation will be needed to understand why that is the case.

Taken in isolation, it may look like we are seeing a broad range of cancers and a high number of cancers. So, in figure 4.2, we look at this in respect of all our active participants.

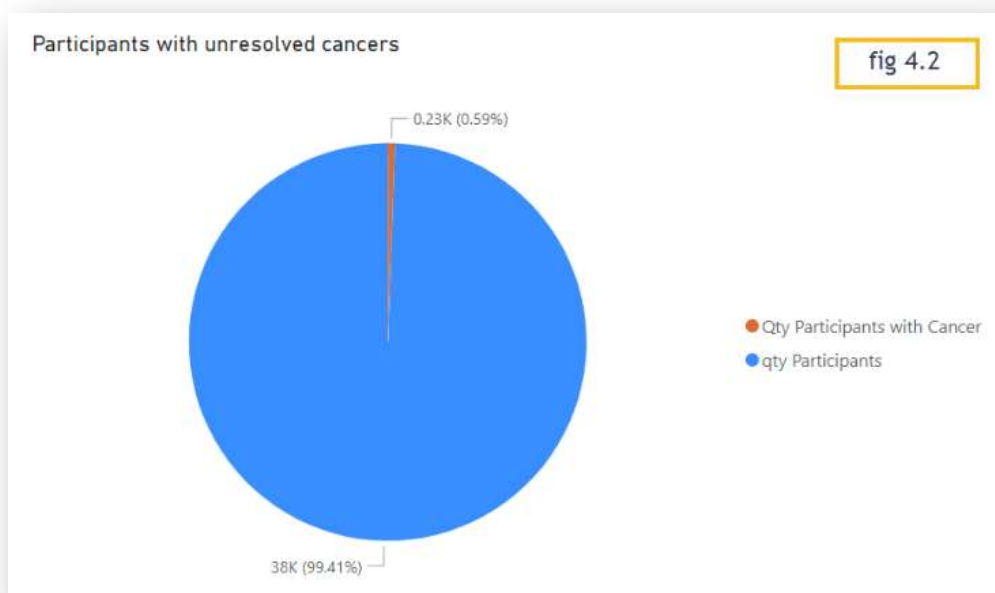


Fig 4.2 shows that we have 0.59% of our participants as currently suffering from cancer, which is around 230 participants in total. Background figures for the prevalence of cancer varies between countries. In industrialised countries, it is estimated that 0.49 - 0.66 per cent of people are presently living with a cancer diagnosis. This indicates, with what data is available, that the percentage of people with cancer in the Control Group database is proportionate to the wider population at this time.

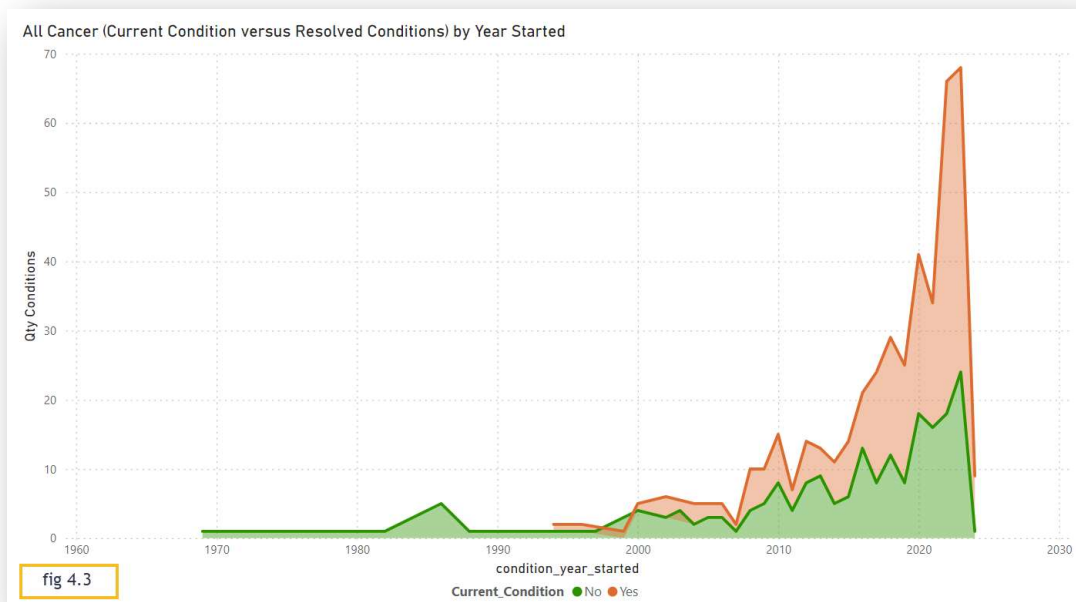
### Cancer Instances over time

In figure 4.4, we are looking at all types of cancer reported and plotting them by the year in which the condition started. The green line represents the number of cancers that have been recorded with the Control Group as being resolved that year, and the orange line represents the number of ongoing cases of cancer reported to the Control Group by year.

*(See over page)*



At a glance, our data would suggest that cancer cases are significantly more likely to be resolved within the last ten years than it has historically. However, there also appears to be a trending increase in the rates of cancer over all in recent years.



At present we would caution about reading too much into these figures. There could be many factors at play here, such as more social awareness, better diagnostic equipment, more effective treatments, more cases of reoccurrence – particularly in an aging population, demographic changes, population growth, having more cancer survivors who are able to participate in research. The factors at this stage are almost endless.



## Data Limitations

All data reported has been collated from anonymised health records recorded using the Control Group data management portal at [www.controlgroup.coop](http://www.controlgroup.coop)

Our quarterly reports only include data from 'active users'; meaning those who have logged in and updated their record in our new CG2.0 database, which was introduced in September 2023.

Each Quarterly Report focuses upon information collected in the 3 months that precede its publication, and looks to compare this against the data reported in prior quarters.

Currently, the majority of our participants are unvaccinated against COVID. However, as more vaccinated people join the Control Group, we will be able to provide more in-depth health outcome comparisons between vaccinated and unvaccinated people.

All data is given voluntarily and is self-reported. It is therefore subjective, and open to interpretation. Self-reports should be regarded with inquisitiveness and respect whilst retaining the necessary scepticism due when negotiating the relationship between empirical evidence and issues of phenomenology, and epistemology.

Our on-going challenge is to promote good data maintenance practices across our participant base and we are actively working on policies and processes to encourage accurate participation, as well as methodologies to screen out data that is not well maintained from our reporting.

There is a large amount of work to do to validate the currency of our participants data and we exploring ways in which we can add layers of trust to the data, which will help us filter out data that may be poorly maintained, sparse, or incomplete.

Phenomena such as shedding will remain speculative until a time in which there is identifiable, recurrent, and verifiable evidence than can be ascribed a metric which can be reported upon by participants in our study.

## Unbiased Data

The Control Group is a cooperative which means there are no shareholder interests involved in the generation of profit – there are no dividends from the group's success. Our study receives no finance from universities, products or pharmaceutical giants. All monies and assets made are returned to the cooperative to further and better the project. We have no financial bias towards a particular outcome.

Those who support the Control Group are skeptical of the 'Big' industries, and the impact they are having upon our health and wellbeing. Participants choose to work with us because we reject a profit-driven healthcare system, and defend every person's right to the freedom of choice and bodily autonomy.



## The Importance of Your Continued Data Contributions

**We cannot succeed without your input.**

This project will only work if we have huge quantities of people filling in their health data. To best demonstrate what is (or is not) happening to those who refused the COVID vaccine, the data source has to be multi-national and substantial.

The most important information we need is: your COVID vaccination status, any health conditions that you suffer from, and any medications and supplements that you take.

Independent data, diligence and time will secure us a future in which there is health, freedom, and a person's body autonomy is sacred.

**UPDATE YOUR RECORD TODAY**

**Login:** <https://prod.controlgroup.coop/account/login>

**Participant Support:** <https://controlgroup.coop/support/index.htm>

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If you enjoyed this report, consider making a one-time [donation](#) to the Control Group.

If you are interested in supporting the long-term success of the Control Group study, the best thing you can do is become a subscriber to our website.

**[BECOME A SUBSCRIBER TODAY](#)**

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