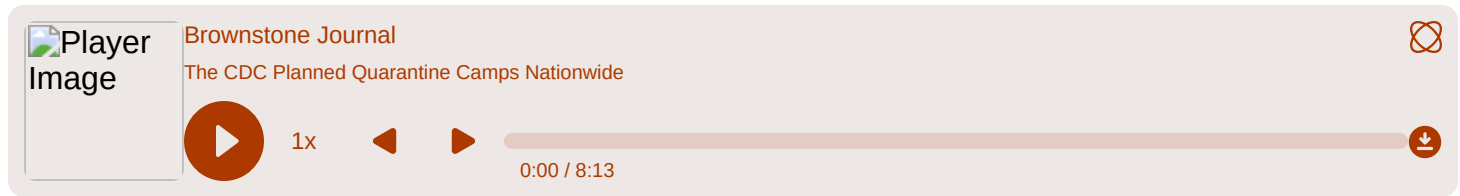


The CDC Planned Quarantine Camps Nationwide

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No matter how bad you think Covid policies were, they were intended to be worse.

Consider the vaccine passports alone. Six cities were locked down to include only the vaccinated in public indoor places. They were New York City, Boston, Chicago, New Orleans, Washington, D.C., and Seattle. The plan was to enforce this with a vaccine passport. It broke. Once the news leaked that the shot didn't stop infection or transmission, the planners lost public support and the scheme collapsed.

It was undoubtedly planned to be permanent and nationwide if not worldwide. Instead, the scheme had to be dialed back.

Features of the CDC's edicts did incredible damage. It imposed the rent moratorium. It decreed the ridiculous "six feet of distance" and mask mandates. It forced Plexiglas as the interface for commercial transactions. It implied that **mail-in balloting** must be the norm, which probably flipped the election. It delayed the reopening as long as possible. It was sadistic.

Even with all that, worse was planned. On July 26, 2020, with the George Floyd riots having finally settled down, the **CDC issued a plan for establishing nationwide quarantine camps**. People were to be isolated, given only food and some cleaning supplies. They would be banned from participating in any religious services. The plan included contingencies for preventing suicide. There were no provisions made for any legal appeals or even the right to legal counsel.

The plan's authors were unnamed but included 26 footnotes. It was completely official. The document was only removed on about March 26, 2023. During the entire intervening time, the plan survived on the CDC's public site with little to no public notice or controversy.

It was called "Interim Operational Considerations for Implementing the Shielding Approach to Prevent COVID-19 Infections in Humanitarian Settings."

The screenshot shows the CDC's official page for COVID-19. At the top, the CDC logo and name are visible. A search bar and a 'Coronavirus' dropdown menu are on the right. Below the header, a teal banner reads 'Coronavirus Disease 2019 (COVID-19)'. A navigation bar includes links for 'Your Health', 'Community, Work & School', 'Healthcare Workers & Labs', 'Health Depts', 'Cases & Data', and 'More'. On the left, a 'More Resources' sidebar lists 'CDC in Action', 'Global COVID-19', 'Guidance Documents', and 'Communication Resources'. The main content area features the title 'Interim Operational Considerations for Implementing the Shielding Approach to Prevent COVID-19 Infections in Humanitarian Settings', dated 'Updated July 26, 2020', with a 'Print' button and social media sharing icons.

“This document presents considerations from the perspective of the U.S. Centers for Disease Control & Prevention (CDC) for implementing the shielding approach in humanitarian settings as outlined in guidance documents focused on camps, displaced populations and low-resource settings. This approach has never been documented and has raised questions and concerns among humanitarian partners who support response activities in these settings. The purpose of this document is to highlight potential implementation challenges of the shielding approach from CDC’s perspective and guide thinking around implementation in the absence of empirical data. Considerations are based on current evidence known about the transmission and severity of coronavirus disease 2019 (COVID-19) and may need to be revised as more information becomes available.”

By absence of empirical data, the meaning is: nothing like this has ever been tried. The point of the document was to map out how it could be possible and alert authorities to possible pitfalls to be avoided.

The meaning of “shielding” is “to reduce the number of severe Covid-19 cases by limiting contact between individuals at higher risk of developing severe disease (‘high-risk’) and the general population (‘low-risk’). High-risk individuals would be temporarily relocated to safe or ‘green zones’ established at the household, neighborhood, camp/sector, or community level depending on the context and setting. They would have minimal contact with family members and other low-risk residents.”

In other words, this is what used to be concentration camps.

Who are these people who would be rounded up? They are “older adults and people of any age who have serious underlying medical conditions.” Who determines this? Public health authorities. The purpose? The CDC explains: “physically separating high-risk individuals from the general population” allows authorities “to prioritize the use of the limited available resources.”

This sounds a lot like condemning people to death in the name of protecting them.

The model establishes three levels. First is the household level. Here high-risk people are “physically isolated from other household members.” That alone is objectionable. Elders need people to take care of them. They need love and to be surrounded by family. The CDC should never imagine that it would intervene in households to force old people into separate places.

The model jumps from households to the “neighborhood level.” Here we have the same approach: forced separation of those deemed vulnerable.

From there, the model jumps again to the “camp/sector level.” Here it is different. **“A group of shelters such as schools, community buildings within a camp/sector (max 50 high-risk individuals per single green zone) where high-risk individuals are physically isolated together.** One entry point is used for exchange of food, supplies, etc. A meeting area is used for residents and visitors to interact while practicing physical distancing (2 meters). **No movement into or outside the green zone.”**

Yes, you read that correctly. The CDC is here proposing concentration camps for the sick or anyone they deem to be in danger of medically significant consequences of infection.

Further: “to minimize external contact, each green zone should include able-bodied high-risk individuals capable of caring for residents who have disabilities or are less mobile. Otherwise, designate low-risk individuals for these tasks, preferably who have recovered from confirmed COVID-19 and are assumed to be immune.”

The plan says in passing, contradicting thousands of years of experience, “Currently, we do not know if prior infection confers immunity.” Therefore the only solution is to minimize all exposure throughout the whole population. Getting sick is criminalized.

These camps require a “dedicated staff” to “monitor each green zone. Monitoring includes both adherence to protocols and potential adverse effects or outcomes due to isolation and stigma. It may be necessary to assign someone within the green zone, if feasible, to minimize movement in/out of green zones.”

The people housed in these camps need to have good explanations of why they are denied even basic religious freedom. The report explains:

“Proactive planning ahead of time, including strong community engagement and risk communication is needed to better understand the issues and concerns of restricting individuals from participating in communal practices because they are being shielded. Failure to do so could lead to both interpersonal and communal violence.”

Further, there must be some mechanisms to prohibit suicide:

*Additional stress and worry are common during any epidemic and may be more pronounced with COVID-19 due to the novelty of the disease and increased fear of infection, increased childcare responsibilities due to school closures, and loss of livelihoods. Thus, in addition to the risk of stigmatization and feeling of isolation, this shielding approach may have an important psychological impact and may lead to significant emotional distress, exacerbate existing mental illness or contribute to **anxiety, depression, helplessness, grief, substance abuse, or thoughts of suicide among those who are separated or have been left behind.** Shielded individuals with concurrent severe mental health conditions should not be left alone. There must be a caregiver allocated to them to prevent further protection risks such as neglect and abuse.*

The biggest risk, the document explains, is as follows: “While the shielding approach is not meant to be coercive, it may appear forced or be misunderstood in humanitarian settings.”

(It should go without saying but this “shielding” approach suggested here has nothing to do with focused protection of the [Great Barrington Declaration](#). Focused protection specifically says: “schools and universities should be open for in-person teaching. Extracurricular activities, such as sports, should be resumed. Young low-risk adults should work normally, rather than from home. Restaurants and other businesses should open. Arts, music, sport and other cultural activities should resume. People who are more at risk may participate if they wish, while society as a whole enjoys the protection conferred upon the vulnerable by those who have built up herd immunity.”)

In four years of research, and encountering truly shocking documents and evidence of what happened in the Covid years, this one certainly ranks up at the top of the list of totalitarian schemes for pathogenic control prior to vaccination. It is quite simply mind-blowing that such a scheme could ever be contemplated.

Who wrote it? What kind of deep institutional pathology exists that enabled this to be contemplated? The CDC has 10,600 full-time employees and contractors and a budget of \$11.5 billion. In light of this report, and everything else that has gone on there for four years, both numbers should be zero.

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