Appeal

University of Waterloo
Vaccine Mandates

Collectively by University of Waterloo, Staff, Faculty and Students

December 2021

Dear Respected University of Waterloo Senate and Senior Administration

- We write to you today on behalf of all University of Waterloo employees and students that face the threat of termination due to the inability to follow UW's coronavirus mandatory vaccination policy. We sincerely request your attention and consideration towards the information contained in this document.
- The current climate at the University of Waterloo adopts principles of discrimination and intolerance towards staff, faculty and students. As of this date, employees and students at the University of Waterloo are facing termination of employment, or termination of program of study due to a firmly held personal conviction to remain Covid vaccine free.
- Since its inception, the University of Waterloo has always welcomed diversity among the campus community. Through values of acceptance and embracing differences amongst people, UW has thrived. The current hardline approach to vaccine mandates is in direct opposition to UW's founding principles.
- Thousands of employees and students have submitted requests for accommodation and have completed the required paperwork with the correct signatories for the University of Waterloo vaccine accommodation process. These documents required a great deal of time, effort and mental energy to gather and prepare. However, the university has denied accommodation requests and will no longer allow employees to perform employment related duties as unvaccinated but equal members of the university.

- We feel this is a gross injustice and betrayal to the incredible dedication and commitment we have all shown the university throughout our time here. Overnight, the University of Waterloo has transformed heroes of the pandemic to villains of the university, with no sound or demonstrably justifiable reasons.
- The University of Waterloo also refuses to consider **natural Covid immunity** as equivalent status to vaccination. There are employees and students that have natural immunity and can prove this with serum blood tests. The data and consensus within the scientific community regarding natural Covid immunity is robust and proven in a large number of medical journals and clinical trials [1][16][17][18]. If UW considered natural immunity, many people could be saved from the strife of job loss/education loss.
- We sincerely request the University of Waterloo to reconsider its current Covid vaccine mandate and adopt a more inclusive and humane approach to the implementation and execution of a vaccine policy for UW employees and students.
- We sincerely request your time and attention to all the details contained within this document.

Students

- There are 5000+ students coming to campus for the Winter 2022 term that the UW coronavirus task force has labelled as vaccine non-compliant (VNC). Many of these students have submitted accommodation requests and have not heard a decision while others are receiving rejections.
- What is the university's intention with these students? Will they be issued a 100% refund if they are removed from their courses for being labelled as VNC? Does the university intend to indefinitely bar students who are unvaccinated from beginning or completing their studies in absence of any evidence of misconduct or poor academic performance?
- Anything less than a 100% refund is injustice to these students, the university must make its intentions clearly known in advance for the sake of these students. Currently many of the 5000+ students stand in limbo.
- These students could be allowed to continue in their program if the University of Waterloo considered allowing students to attend in-person classes based on negative antigen testing. Covid vaccine free faculty, staff and students are willing to come to campus based on negative antigen testing, however, this approach has never been accepted as a reasonable compromise by the UW coronavirus task force.
- It is also perfectly possible for UW to make sincere efforts to hold online sections for required courses. The university has moved all courses to fully online for the past two years. To be fair to these students, online study could easily allow students to continue in their program of study.
- There is no logical reason that these students cannot continue online if antigen testing or natural immunity is not being considered for access to campus. Therefore, returning campus operations to "normal" with increased in-person offerings with a policy that only allows vaccinated students on campus is only a punitive, repressive measure that insists on students vaccinating and nothing else.
- There are many possible approaches to allow students to continue in their program of study. Online content can be posted for students that cannot attend campus. Alternative course outlines and grading schemes can be worked out for these students. There are many possibilities if UW was willing to demonstrate respect for students that have had their accommodation requests denied.

Students

- However, UW continues to follow only a very rigid, hardline approach to vaccine mandates, without giving accommodation requests any form of consideration or offering possible alternative measures of work/study. What is the justification behind such an unyielding approach? No justification has been provided to date.
- As the number of daily Covid cases amongst the vaccinated is rapidly rising all over the world, the efficacy of Covid-19 vaccines is self-evident. Yet, the University of Waterloo is unwilling to reconsider restructuring its vaccine mandate to save its own people from the strife of job/education loss.
- The university recently announced courses will remain online in Winter 2022 until at least January 24th. The shift from fully online for two years to fully in-person in Winter 2022 was an unrealistic policy from the onset. There are a large number of dynamic variables requiring consideration.
- Faculty, staff and students had voiced their concerns with the proposed Winter 2022 model, yet the university continued to push for fully back to campus in the winter, unwilling to offer online options in the majority of faculties and courses across campus.
- Students with disabilities and international students have made requests for online accommodations within their departments and faculties, but these requests continue to be denied.
- With the recent announcement to continue online, staff and students are upset that the administration took an unyielding approach in the first place, without consideration for online sections and online students. The university is failing to consider the current shortages in student accommodations, student travel and living expenses, students with physical disabilities and students moving to Waterloo from other parts of the world only to find the Winter 2022 term beginning and possibly continuing online.
- If the University of Waterloo continues to follow **an inflexible approach** to course offerings and vaccination mandates, this will serve to deter staff and students away from UW and further harm the university.
- The world has moved on from education models of 2019; institutions that insist on in-person models as the only approach to education will be left behind.
- There are many aspects of the policies in place at UW that demonstrate a lack of consideration for varying circumstances amongst staff and students. We ask UW administrators and policy makers to consider adopting policies of inclusion and compromise that are suitable to a larger volume of people.

Faculty and Staff

- Many of the UW vaccine free staff and students have filed human rights complaints and sought assistance and representation through the UW Staff Association and Faculty Association. These associations exist to support and defend the rights of staff and faculty across campus, yet the vaccine free are not privileged to this representation. We have been completely ignored and turned aside by these associations. Our multiple letters and meeting requests to the Associate Provost and President's Office have also been ignored.
- At a university that trumpets equitable and fair treatment for all university personnel, **where is the equity and inclusion for those who are not vaccinated? Why has this group been marginalized, continually ignored and unrepresented at the University of Waterloo?** The only crime of this group is a firmly held conviction that they do not wish to take the currently available Covid-19 vaccines. There are a wide range of reasons why people do not wish to take Covid-19 vaccines. This is a personal choice, a firmly held conviction and the University of Waterloo cannot take away an individual's right to bodily autonomy.
- The current implementation of the vaccine mandate at the University of Waterloo punishes these individuals for their beliefs and values. Where is the equity and fair treatment for these individuals that simply wish to follow their private system of beliefs? What is the justification for the differences in accommodation and inclusion in the situation of vaccines compared to other matters based on religious freedom, medical freedom and academic freedom, when **alternatives exist to both accommodate all members of the university and keep campus safe?**
- Furthermore, the university has not attempted to work out alternative employment or study arrangements for people who are not welcome on campus. Upon accommodation request rejection, an employee or student is given a fixed duration of time to become *vaccine compliant* or permanently lose their job or program of study.
- The approach strongly mirrors dictatorial leadership where only cruel and harmful alternatives are offered. What has happened to the moral compass of this university and the people who administer these policies?
- How is this approach acceptable to the vaccinated faculty and staff at the University of Waterloo who wish to remain unharmed and unquestioned while they are consciously aware of the suffering and dire state of others within the same institution?

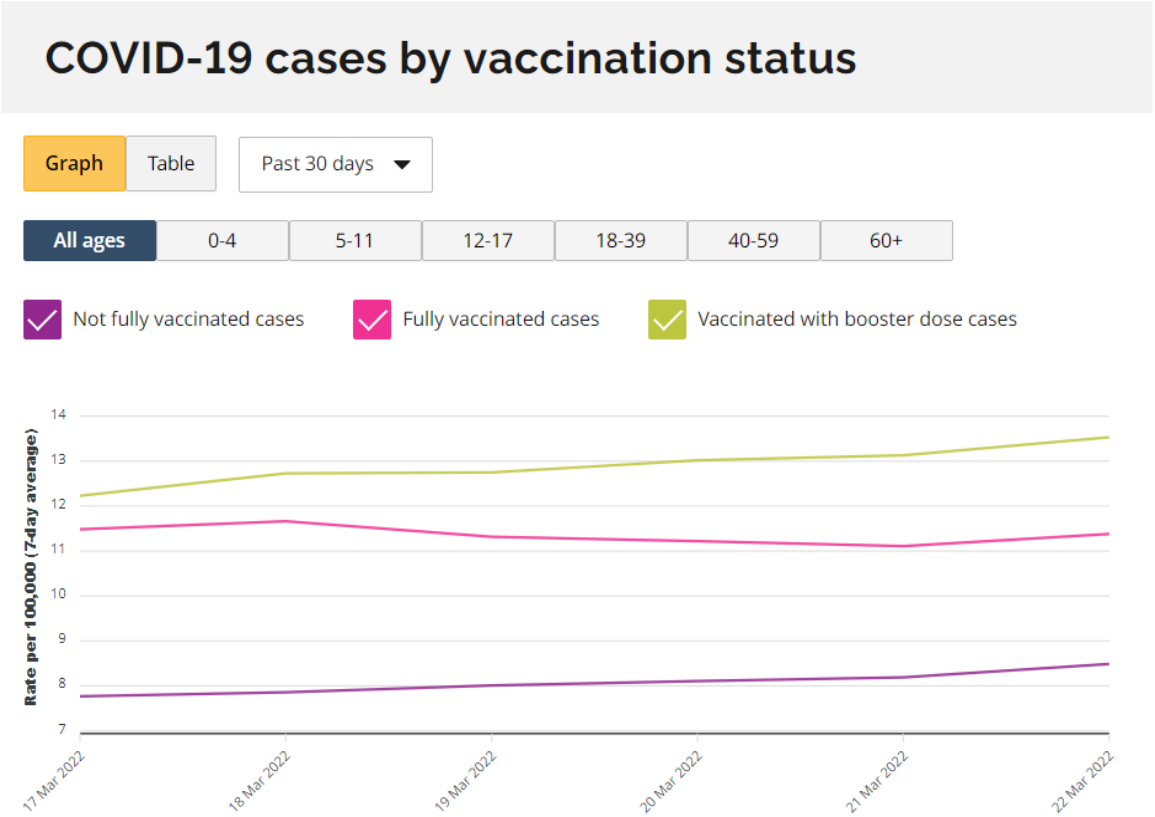
Current Data: (Excerpt from Vaccine Mandate Appeal sent to UW senior administration)

Daily cases show the number of double vaccinated getting Covid is higher than those who remain vaccine free. The data indicates those with two or more doses of a vaccine are more likely to get the Omicron variant. The rates of infection clearly indicate that the implementation of a forced vaccination mandate is **neither protective nor fair to the unvaccinated.**

Blanket policies against the unvaccinated must be reconsidered at this time.

- **Government of Ontario Website consistently indicated the unvaccinated have the lowest rates of infection /100 000**

- **Jan 01st Covid cases**
  - 14,703 fully vaccinated ***rate of infection per 100 000: 128.19**
  - 2,679 unvaccinated ***rate of infection per 100 000: 106.85**
- **Dec 31st Covid cases**
  - 13,436 fully vaccinated ***rate of infection per 100 000: 117.75**
  - 2,278 unvaccinated ***rate of infection per 100 000: 88.26**
- **Dec 29th Covid cases**
  - 8,221 fully vaccinated ***rate of infection per 100 000: 72.11**
  - 1,514 unvaccinated ***rate of infection per 100 000: 58.16**
- **Dec 24th Covid cases**
  - 7,425 fully vaccinated ***rate of infection per 100 000: 65.22**
  - 1,536 unvaccinated ***rate of infection per 100 000: 58.42**
- **Dec 22th Covid cases**
  - 3,243 fully vaccinated ***rate of infection per 100 000: 28.51**
  - 746 unvaccinated ***rate of infection per 100 000: 28.10**
- **Dec 21th Covid cases**
  - 2,500 fully vaccinated
  - 673 unvaccinated
- **Dec 20th Covid cases**
  - 2,781 fully vaccinated
  - 746 unvaccinated



- The above data clearly indicates that this is indeed **not a pandemic of the unvaccinated.**
- *The average rate of infection (per 100 000) based on daily data
  - Full computations here
  - https://covid-19.ontario.ca/data

Current Data:

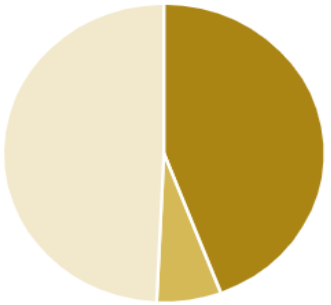
Although there are a number of discrepancies in the hospitalization data, the current number of unvaccinated individuals in Ontario hospitals is lower than fully vaccinated individuals.

Blanket policies against the unvaccinated are unjust; vaccinated individuals are catching Covid and spreading Covid at much higher rates of infection. Vaccinated individuals are experiencing repeat Covid cases.

Specific penalties against the unvaccinated are completely illogical.

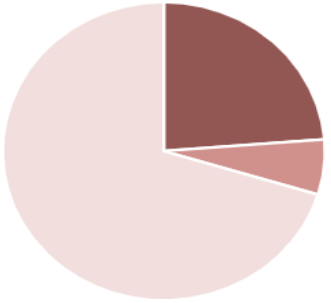
- https://covid-19.Ontario.ca/data : **January 9th, 2022**

In ICU

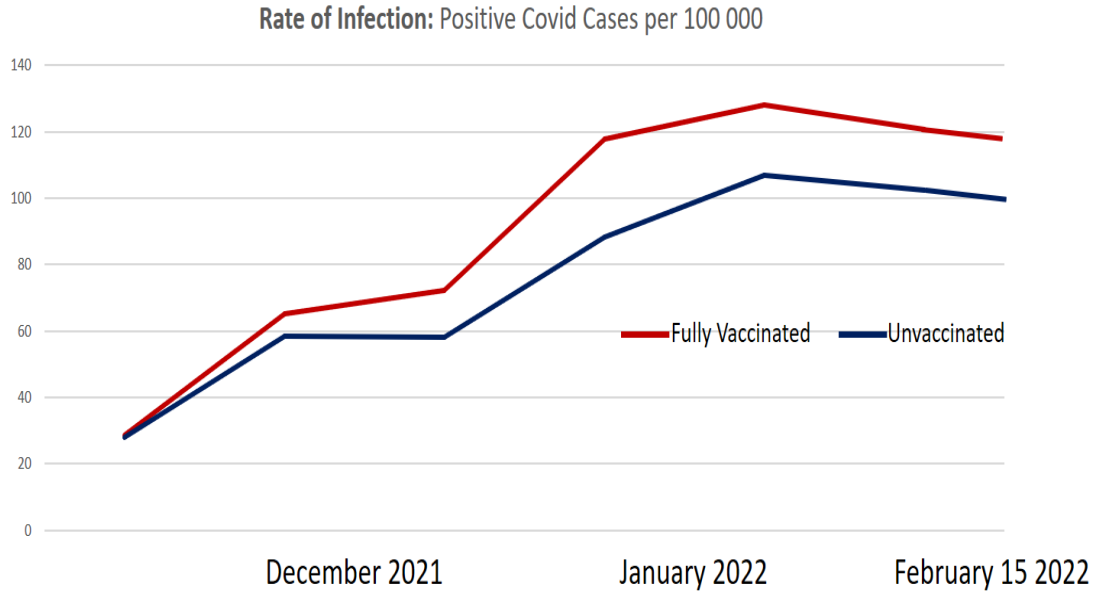


Unvaccinated cases	123
Partially vaccinated cases	18
Fully vaccinated cases	137

In hospital but not the ICU



Unvaccinated cases	457
Partially vaccinated cases	115
Fully vaccinated cases	1353



Negative Impacts of the Proof of Vaccination Policy

- Throughout the last 4 months, since UW announced the required mandatory vaccinations, we have testimony from university members in the following troublesome circumstances:
  - A UW Custodian who lost his job almost immediately in September when he informed his supervisor of his decision to remain vaccine free.
  - Other employees who were required to be on campus were performing their duties with the immediate threat of losing their jobs. Anxiety and fear over the vaccine mandate drove many to seek medical leave or early retirement. Many of these employees are the sole source of income to their families. Now they have been terminated or face the impending threat of termination.
  - Single family providers are losing their jobs at UW and left to depend on the generosity of local food banks and social assistance services. **This has been verified to be the real situation of former UW employees.**
  - More than just a few staff at UW have shared messages about crying every night - they loved their jobs, believed in the mission and values of the university and they are in shock that they have been removed from UW after decades of service to this university.
  - Staff at UW are in despair about the fact that they had to get vaccinated against their personal beliefs. They are extremely angered that their personal beliefs that are normally protected on human rights grounds were pitted against their employer's vaccination mandate.
  - Two employees working at the UW Print and Retail Solutions were working in addition of 200+ hours of overtime during the pandemic to get the entire university prepared for fully online course delivery. Now they are facing termination. Overnight, they went from pandemic heroes to vaccine villains based solely on their vaccination status.
  - UW staff worried about the catastrophic results of losing their jobs and the impact on their families. Some are struggling to deal with the traumatic effects on their mental health. **Some, in their own words, are worried about putting food on the table at Christmas and plummeting into depression.**

Negative Impacts of the Proof of Vaccination Policy

- Faculty and employees across all departments on campus are stressed, confused, and not sure what to do. A few individuals have stated they do not recognize the people they have worked with and known for 20+ years. They have heard so many derogatory and demeaning comments about the unvaccinated that they do not wish to work in a poisoned and discriminatory environment any longer.
- Students all across the university registering for courses in W22 are worried, fearful, and unsure of what to do upon receiving an accommodation request rejection.
- Staff/faculty at UW in senior positions were very upset by the vaccine mandates, recognizing this was an illegal and atrocious manner to treat employees and students. They believe the vaccine mandate was an unjustifiable measure to force on university personnel.
- Increasing distress and anxiety over this issue from people that had dedicated their lives to their positions at UW.
- People selling their homes to support their families after losing their jobs at UW.
- Students being removed from their programs due to firm personal choice to remain Covid vaccine free. Students that are graduating, but are not given their graduation degree due to the fact that they are unvaccinated
- Extreme mental anguish faced by students that are still unsure if their accommodation requests will be accepted. They are finding it very hard to focus on their academics since August 2021 when the vaccination requirement of UW was announced.
- Hundreds of UW employees submitted accommodation requests requiring a great deal of time and effort, only to have their requests rejected without a clear and justifiable explanation.
- This is the underside, the true face of UW's mandatory vaccination policy.
- **The unthinkable has occurred at the University of Waterloo:** open policies in direct violation of human rights.

A Path Forward

- Such experiences have been ongoing since August 2021 when UW announced the university-wide vaccine mandate. The University of Waterloo chose to follow this specific implementation of the province-wide vaccine policy recommendations. It is clear that universities were left to their own discretion with respect to the implementation details. The province made recommendations - not requirements – regarding implementation, none of which necessitated an absolute and unforgiving requirement for proof of vaccination with no exceptions or accommodations.
- However, UW has specifically chosen a particular implementation pathway which follows a more severe approach, enabling detrimental consequences on individuals that wish to remain vaccine free. There are many UW employees that are the sole providers for their families. **Stripping away their jobs will plummet these families into poverty. Is this acceptable practice to the University of Waterloo administrators when alternative measures exist that would allow people to keep their jobs?**
- Alternative implementations of the province-wide vaccine recommendations are perfectly possible and have been demonstrated as such by other academic institutions.
- The University of British Columbia decided against a mandatory vaccination policy on any of its campuses [2]. They require rapid testing only and not mandatory enforced vaccination. The UBC Senate noted, "**In public health, we have an ethical obligation to go with the least restrictive but effective means to achieve a goal**"[3]. They have chosen to respect and honour their university community members, allow students to continue in their program of study and all employees to continue their duties as vaccine free citizens of the UBC community. Saskatchewan Polytechnic also allows testing (3x per week) in lieu of vaccines. St. Clair College pays for unvaccinated employees to be tested every 72 hours.
- **Sweden**: The country did not follow the world in lock downs, masking or school closures and most businesses were allowed to remain open. Vaccines have been available on a voluntary basis. Sweden has faired well relative to other nations. As Jeffrey Tucker shows in *Liberty or Lockdown*, Sweden's comparatively favourable results came about "because it refused to violate human rights." [45]
- **Japan:** "Although we encourage all citizens to receive the COVID-19 vaccination, it is not compulsory or mandatory…Please do not force anyone in your workplace or those who around you to be vaccinated, and do not discriminate against those who have not been vaccinated." Japan has a Covid mortality rate of 14.6 per 100 000 [39].

A Path Forward

- The suffering could easily be averted by introducing more inclusive policies while maintaining safety within the university community. **Why has UW chosen to reject the majority of the vaccine accommodation requests when ethical alternatives to accommodate exist?**
- The discrimination and abuse of UW employees and students continues. Policy makers are unwilling to restructure the vaccine mandate at any cost. UW has moved from a democratic public institution to a dictatorship style of governance, unwilling to appraise letters from within the UW community pleading for reconsideration, nor examine the plethora of data that contradicts the policies in place, against the values of academic freedom and scientific inquiry.
- The individuals mentioned previously are being terminated or placed on unpaid leave for not vaccinating, but they are no harm or threat to anyone. The fact that they are willing to test and only come to work based on a negative Covid test clearly indicates a willingness to cooperate and take responsibility to keep our campus safe.
- Please see the reference section on breakthrough infections. We have presented this and similar data to the UW coronavirus task force, Associate Provost and President's office since August 2021. We have not heard a response to our multiple requests for meetings.
- It is more clear on a daily basis that the number of breakthrough infections are on the rise. The CDC and FDA confirmed that the vaccinated and unvaccinated carry the same viral load [13]. The vaccinated do not indicate **lower rates of spread of infection.** Therefore, it is becoming increasingly apparent, with mounting data, that the specific restrictions on the unvaccinated are unnecessary and unfair.
- There is data indicating that the infection rates amongst the vaccinated are growing at an alarming rate. There are medical publications, research reports and clinical trials confirming these findings from around the world. [4]
- CDC Report: 80% of U.S. Omicron Cases in Fully Vaccinated
  - SARS-CoV-2 B.1.1.529 (Omicron) Variant — United States, December 1–8, 2021
  - Female cases outnumbered male cases (58% and 40%, respectively). Fully vaccinated people accounted for 47% of cases and fully vaccinated people with a booster accounted for an additional 33% of cases, totaling 80% fully vaccinated Omicron cases compared to 19% unvaccinated cases. [5]

UW Complicit in Discriminatory Practices

- A recent letter published in *The Lancet* by Günter Kampf at the University Medical Centre in Greifswald, Germany, states that high-level officials and policy enforcement agencies should desist from stating that it is "a pandemic of the unvaccinated" [10]. He says this is "stigmatising" and not backed by scientific evidence. Kampf states, “There is increasing evidence that vaccinated individuals continue to have a relevant role in transmission.” The Lancet ranks second in the world amongst global internal and general medical journals.
- At UW, the vaccinated will be attending campus without indication of a negative Covid test.

  (1) the vaccinated are much greater in number

  (2) the vaccinated will represent a high-risk group for the spread of Covid-19
- However, Covid vaccine free individuals who are willing to come to campus and test are barred from campus and terminated from their positions. **We would like to ask, where is the justice in this?** What is the logic behind this?
- **If this was about health, the unvaccinated would not be prevented from coming to campus when testing negative on a weekly or daily basis. If this was about health, a person that teaches an online course would not be removed from their position because they choose to remain vaccine free. If this was about health, a student graduating from their program would not be prevented from graduation for not vaccinating.**
- As of January 4, 2022, hundreds of UW employees are facing termination due to their vaccination status and strong personal conviction to remain so. Thousands of students are in a position where they will be removed from their program of study for remaining vaccine free. As of this writing, many UW employees have already been fired.

UW Complicit in Discriminatory Practices

- Given the high failure rate of Covid-19 vaccines, a person with a recent negative test would pose less of a risk of transmission than someone who is vaccinated but not tested.
- It completely defies logic to bar the unvaccinated from coming to campus and fulfilling their employment duties when we see daily reports of breakthrough infections and it is now well understood that the vaccinated and the unvaccinated carry the same viral load [20]. It defies logic to willingly continue to cause human suffering when alternative measures could immediately release people from their loss of job or loss of education.
- Another daunting question that the UW administration is unable to answer: **Why is the University of Waterloo unwilling to consider natural Covid immunity as an equivalent status to vaccination?** It has been repeatedly demonstrated that individuals with natural antibodies from prior Covid-19 infection have superior immunity to those vaccinated with Covid-19 vaccines [16] [17] [18] [19]. UW administrators are failing to examine critical evidence that would allow UW personnel to keep their jobs and UW students to remain in their program of study.
- These are only some of the many aspects to the UW-enforced vaccine mandate that are highly questionable and lack scientific backing. A significant proportion of vaccinated individuals at the University of Waterloo are angry and distressed for having to vaccinate against their personal choice as a result of the mandate. An anonymous survey from the university distributed to the UW community would make this clear.
- **Senior administration at UW have confirmed that the university will continue to follow the same timeline for termination of UW employees and students in spite of the decision to continue online until January 24th.**
- "As this field continues to develop, clinicians and public health practitioners should consider vaccinated persons who become infected with SARS-CoV-2 to be no less infectious than unvaccinated persons. These findings are critically important, especially in congregate settings where viral transmission can lead to large outbreaks." MedRxiv [23]

Conclusion

- Unvaccinated faculty, staff and students comprise at least 12% of the university's population. Many of these individuals have had their accommodation requests rejected.
- Forcing 5000+ students to vaccinate against their beliefs is neither a respectable nor a humane approach to achieving safety on campus. We can clearly see that vaccination does not stop the spread of infection.
- We need all voices of compassionate and reasonable UW citizens to help counter the destructive effects of the current vaccine mandate. We ask the UW community, faculty, staff or students who do not agree with the vaccine mandate to share your views with your Dean, Associate Provost's Office and the President's Office.
- The remainder of this document covers supporting reference information. The point is not necessarily agreement or convincing anyone of one view over another. The point is to illustrate that data and supporting evidence exists to adopt alternative approaches to pandemic management at the University of Waterloo. This supporting evidence is backed by research and science.
- Academics and researchers that are willing to think critically and evaluate, not necessarily agree with, opinions outside the singular vaccine solution should follow the documents provided in the reference section.
- The daily Covid case count in Israel continues to rise in spite of being the world's first heavily vaccinated country and having the highest rates of administered booster injections. Gibraltar boasts a 100% vaccination rate, yet continues to follow measures of lockdowns and public restrictions due to consistently rising Covid cases.

Conclusion

- The University of Waterloo, an institution of reputable academic research, should recognize that current public health measures in Canada are insufficient for the management of Covid-19. Vaccination does not equal prevention, that is very clear today. To date, public health measures are in flux. A vaccine mandate based on division, exclusion and punishing the unvaccinated is neither logical nor effective.
- Study after study indicates the waning efficacy of vaccine immunity [46] [47], the robustness of natural immunity [1][16][17][18]. Why is the University of Waterloo unwilling to examine the scientific evidence. Why has UW followed a vaccine only solution to the pandemic when multiple alternatives exist. Alternatives that would benefit the UW community at large and support inclusivity and respect for all university personnel.
- There are globally hundreds of thousands of medical professionals, doctors and experts that strongly advocate Covid-19 treatment protocols [40] [41] [42] [43] [44]. The effectiveness of these treatments has been repeatedly illustrated in study after study for the past two years. If Health Canada chooses to deny the existence of Covid-19 early intervention, that does not justify an institution of research and innovation to completely overlook the scientific evidence.
- Universities were not required to follow a hardline approach to vaccination mandates, yet the University of Waterloo chose to follow this specific implementation of the province wide recommendations.
- The lives of UW employees and students should not be **irrevocably altered** based on temporary convictions of best practice. This is indeed a grave injustice. We strongly request University of Waterloo senior administrators to reconsider the policies surrounding the university's vaccine mandate.
- If these policies persist and continue to cause harm and undue hardship on UW personnel, we are certain that in the years to come, the University of Waterloo will see the ramifications of enforcing inhumane punitive measures against its own people.

Thank you kindly for your time and attention,

Undersigned UW Staff, Faculty, Students

- **Note**: All signatures below came from individuals in the UW community that have been negatively impacted by the vaccine mandate. Some individuals wish to be unnamed due to the threat of additional bias against them.

- **Name** **Position /Department**

- **Signatures:** **University of Waterloo Faculty, Alumni, Staff & Students have been removed in this print**

Breakthrough Infections:

- It more and more clear on a daily basis that the number of breakthrough infections are on the rise. This is particularly true with the new Omicron variant all across Ontario and around the world.
- The CDC and FDA confirmed that the vaccinated and unvaccinated carry the same viral load. [13]
- The vaccinated do not indicate **lower rates of spread of infection.**
- Therefore, it is becoming increasingly apparent, with mounting data, that the specific restrictions on the unvaccinated are unnecessary and unfair.
- There is data indicating that the infection rates amongst the vaccinated are growing at an alarming rate. There are medical publications, research reports and clinical trials indicating this from around the world.
- Please review the following supporting information:

Breakthrough Infections:

- “The largest clinical research funder in the United Kingdom, the National Institute for Health Research (NIHR)’s Health Protection Research Unit in Respiratory Infections, the National Heart and Lung Institute, and Imperial College of London recently had results from an important study published in the prominent peer-reviewed medical journal The Lancet. Titled ‘Community transmission and viral load kinetics of the SARS-CoV-2 delta (B.1.617.2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study,' the group sought to study transmission and viral load kinetics in both individuals that are vaccinated as well as unvaccinated in the community. While the study team made a point of declaring that vaccination does help with not only risk reduction of infection but also expedited viral clearance, nonetheless they came to a disturbing conclusion. **Fully vaccinated people with breakthrough infections, and those who are accelerating, experience peak viral load comparable to unvaccinated people.** Vaccinated people can efficiently transmit SARS-CoV-2 in household settings too, **meaning the vaccinated serve as vectors of the disease just like the unvaccinated.**”
- The Lancet [13]
- ***Even the CDC has acknowledged that vaccinated people can become infected, carry equal nasal viral loads, and transmit the virus at least as much as the unvaccinated.*** (https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7031e2-H.pdf)

Breakthrough Infections:

- COVID-19: Stigmatising the unvaccinated is not justified
- “In the USA and Germany, high-level officials have used the term pandemic of the unvaccinated, suggesting that people who have been vaccinated are not relevant in the epidemiology of COVID-19. Officials’ use of this phrase might have encouraged one scientist to claim that “the unvaccinated threaten the vaccinated for COVID-19”.[1]
- **But this view is far too simple.**
- There is **increasing evidence that vaccinated individuals continue to have a relevant role in transmission.** In Massachusetts, USA, a total of 469 new COVID-19 cases were detected during various events in July, 2021, and **346 (74%) of these cases were in people who were fully or partly vaccinated**, 274 (79%) of whom were symptomatic. Cycle threshold values were similarly low between people who were fully vaccinated (median 22·8) and people who were unvaccinated, not fully vaccinated, or whose vaccination status was unknown (median 21·5), indicating a high viral load even among people who were fully vaccinated ”.[2]
- The Lancet [10]

Breakthrough Infections:

- **COVID-Related Factors Behind Breakthrough Infections**
- Lisa Maragakis, MD, MPH senior director of infection prevention **at Johns Hopkins Health System**, and Gabor David Kelen, MD director at the department of emergency medicine at Johns Hopkins Medicine, explain that since the spread of the Delta variant, breakthrough infections are getting more common.
- Although vaccines protect the body in case of a severe infection, they are not very effective in terms of preventing the infection. This is also commonly reported by the countries with increasing numbers. And it is for this reason that many vaccinated people end up transmitting the virus to others.
- [15]

Breakthrough Infections:

- European Journal Of Epidemiology
- “The sole reliance on vaccination as a primary strategy to mitigate COVID-19 and its adverse consequences needs to be re-examined, especially considering the Delta (B.1.617.2) variant and the likelihood of future variants. Other pharmacological and non-pharmacological interventions may need to be put in place alongside increasing vaccination rates. Such course correction, especially with regards to the policy narrative, becomes paramount with emerging scientific evidence on real world effectiveness of the vaccines.
- For instance, in a report released from the Ministry of Health in Israel, the effectiveness of 2 doses of the BNT162b2 (Pfizer-BioNTech) vaccine against preventing COVID-19 infection was reported to be 39% [6], substantially lower than the trial efficacy of 96% [7]. It is also emerging that immunity derived from the Pfizer-BioNTech vaccine may not be as strong as immunity acquired through recovery from the COVID-19 virus [8]. A substantial decline in immunity from mRNA vaccines 6-months post immunization has also been reported [9]. Even though vaccinations offers protection to individuals against severe hospitalization and death, the CDC reported an increase from 0.01 to 9% and 0 to 15.1% (between January to May 2021) in the rates of hospitalizations and deaths, respectively, amongst the fully vaccinated [10].”

Breakthrough Infections:

- Community transmission and viral load kinetics of the SARS-CoV-2 delta (B.1.617.2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study
- “Vaccination reduces the risk of delta variant infection and accelerates viral clearance. Nonetheless, fully vaccinated individuals with breakthrough infections have peak viral load similar to unvaccinated cases and can efficiently transmit infection in household settings, including to fully vaccinated contacts. Host–virus interactions early in infection may shape the entire viral trajectory.”
- [14]

- COVID-19 vaccine surveillance report [11]
- UK Health Security Agency

Not vaccinated				
	Cases	Cases presenting to emergency care	COVID-19 deaths within 28 days of positive specimen or with COVID-19 reported on death certificate	COVID-19 deaths within 60 days of positive specimen or with COVID-19 reported on death certificate
Under 18	298 507	591	7	9
18-29	25 567	259	8	9
30-39	26 841	501	21	29
40-49	16 020	572	40	53
50-59	6 922	565	84	107
60-69	2 646	354	124	160
70-79	1 006	264	140	151
≥80	514	207	163	185
	378 023	3 313	587	703

Vaccinated				
	Cases	Cases presenting to emergency care	COVID-19 deaths within 28 days of positive specimen or with COVID-19 reported on death certificate	COVID-19 deaths within 60 days of positive specimen or with COVID-19 reported on death certificate
Under 18	37 406	27	0	1
18-29	46 526	115	1	3
30-39	82 930	297	12	16
40-49	134 220	594	40	56
50-59	104 390	882	107	144
60-69	61 262	1 224	355	431
70-79	34 620	1 888	780	925
≥80	11 792	1 759	1 527	1 833
	513 146	6 786	2 822	3 409

- [COVID-19 vaccine surveillance report]
- UK Health Security Agency

	Cases	Cases presenting to emergency care	COVID-19 deaths within 28 days of positive specimen or with COVID-19 reported on death certificate	COVID-19 deaths within 60 days of positive specimen or with COVID-19 reported on death certificate
Not vaccinated	378 023	3 313	587	703
Vaccinated	513 146	6 786	2 822	3 409

	Cases presenting to emergency care	Death
Not vaccinated	0,876%	0,341%
Vaccinated	1,322%	1,214%

- Vaccinated have 50% higher hospitalization rate
- ~400% higher death rate compared to the unvaccinated

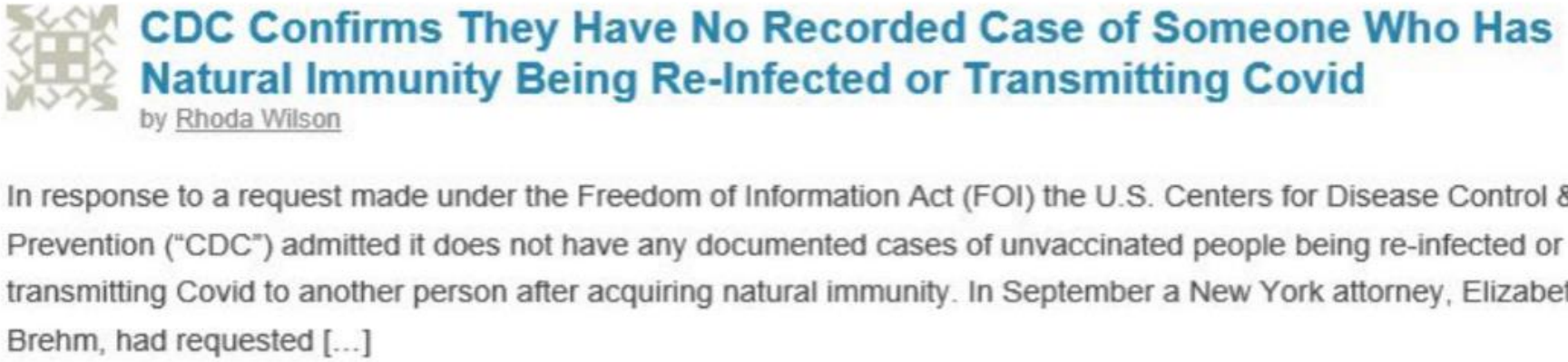
- US COVID-19 Vaccines Proven to Cause More Harm than Good Based on Pivotal Clinical Trial Data Analyzed Using the Proper Scientific Endpoint, "All Cause Severe Morbidity"
- **The author provides a proper explanation for the difference between using an all cause morbidity endpoint instead of a disease specific health endpoint in the PDF [12]**
- *"Results prove that none of the vaccines provide a health benefit and all pivotal trials show a statically significant increase in "all cause severe morbidity" in the vaccinated group compared to the placebo group. The Moderna immunized group suffered 3,042 more severe events than the control group (p=0.00001). The Pfizer data was grossly incomplete but data provided showed the vaccination group suffered 90 more severe events than the control group (p=0.000014), when only including "unsolicited" adverse events. The Janssen immunized group suffered 264 more severe events than the control group (p=0.00001). These findings contrast the manufacturers' inappropriate surrogate endpoints: Janssen claims that their vaccine prevents 6 cases of severe COVD-19 requiring medical attention out of 19,630 immunized; Pfizer claims their vaccine prevents 8 cases of severe COVID-19 out of 21,720 immunized; Moderna claims its vaccine prevents 30 cases of severe COVID-19 out of 15,210 immunized. Based on this data it is all but a certainty that mass COVID-19 immunization is hurting the health of the population in general. Scientific principles dictate that the mass immunization with COVID-19 vaccines must be halted immediately because we face a looming vaccine induced public health catastrophe."*

- **Singapore:**
- Johns Hopkins Medicine explains that breakthrough infection is "…an infection with a virus, bacterium or other germs after you have been vaccinated". The emerging concern about breakthrough infections was exacerbated by the situation in Singapore.
- *Mass COVID-19 vaccination has essentially failed in Singapore—at least up to this point. With about 83% of its population fully inoculated and a version of zero-tolerance COVID-19 policy in place for over a year—that is, tight border controls, frequent testing, proactive contact tracing, this wealthy city-state was one of the leaders in getting the entire population vaccinated. What happened? By September 2021, COVID-19 cases started doubling by the day, and the country reinstated restrictions on gathering and other events. While mass vaccination appears to have reduced severe cases involving hospitalization and death, the data indicate something different–that deaths are at an all-time high in this country despite overwhelming vaccination.*
- **Conclusion**
- The data behind this surge indicates that not only are the COVID-19 vaccines falling short in stopping viral transmission but also in alleviating the death rate, which has risen since the nation's population became overwhelmingly fully inoculated. The trend here follows many other heavily vaccinated nations such as Israel, Iceland, and others that, despite high vaccination rates, have experienced serious surges in cases. While data in other nations indicates the vaccines prevent more serious symptomatic infection, hospitalization and death, the vaccines are not stopping viral transmission. [9]

Natural Covid Immunity (Immunity from prior infection of Covid-19):

There are many such articles/publications on the efficacy of Natural Covid Immunity (94+ in the literature)

This represents only a small subset of publications attesting to the validity of Natural Covid Immunity:



CDC Confirms They Have No Recorded Case of Someone Who Has Natural Immunity Being Re-Infected or Transmitting Covid

by Rhoda Wilson

In response to a request made under the Freedom of Information Act (FOI) the U.S. Centers for Disease Control & Prevention ("CDC") admitted it does not have any documented cases of unvaccinated people being re-infected or transmitting Covid to another person after acquiring natural immunity. In September a New York attorney, Elizabeth Brehm, had requested [...]

"A total of 2,653 individuals fully vaccinated by two doses of vaccine during the study period and 4,361 convalescent patients were included. Higher SARS-CoV-2 IgG antibody titers were observed in vaccinated individuals (median 1581 AU/mL IQR [533.8-5644.6]) after the second vaccination, than in convalescent individuals (median 355.3 AU/mL IQR [141.2-998.7]; $p<0.001$). In vaccinated subjects, antibody titers decreased by up to 40% each subsequent month while in convalescents they decreased by less than 5% per month…this study demonstrates individuals who received the Pfizer-BioNTech mRNA vaccine have different kinetics of antibody levels compared to patients who had been infected with the SARS-CoV-2 virus, with higher initial levels but a much faster exponential decrease in the first group".

Large-scale study of antibody titer decay following BNT162b2 mRNA vaccine or SARS-CoV-2 infection

Natural Covid Immunity:

"Cumulative incidence of COVID-19 was examined among 52,238 employees in an American healthcare system. The cumulative incidence of SARS-CoV-2 infection remained almost zero among previously infected unvaccinated subjects, previously infected subjects who were vaccinated, and previously uninfected subjects who were vaccinated, compared with a steady increase in cumulative incidence among previously uninfected subjects who remained unvaccinated. Not one of the 1359 previously infected subjects who remained unvaccinated had a SARS-CoV-2 infection over the duration of the study. Individuals who have had SARS-CoV-2 infection are unlikely to benefit from COVID-19 vaccination…"

Necessity of COVID-19 vaccination in previously infected individuals

Reports of waning vaccine-induced immunity against COVID-19 have begun to surface. With that, the comparable long-term protection conferred by previous infection with SARS-CoV-2 remains unclear.

"A retrospective observational study comparing three groups: (1) SARS-CoV-2-naïve individuals who received a two-dose regimen of the BioNTech/Pfizer mRNA BNT162b2 vaccine, (2) previously infected individuals who have not been vaccinated, and (3) previously infected *and* single dose vaccinated individuals found para a 13 fold increased risk of breakthrough Delta infections in double vaccinated persons, and a 27 fold increased risk for symptomatic breakthrough infection in the double vaccinated relative to the natural immunity recovered persons…the risk of hospitalization was 8 times higher in the double vaccinated (para)…this analysis demonstrated that natural immunity affords longer lasting and stronger protection against infection, symptomatic disease and hospitalization due to the Delta variant of SARS-CoV-2, compared to the BNT162b2 two-dose vaccine-induced immunity."

Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections

"203 recovered SARS-CoV-2 infected patients in Denmark between April 3rd and July 9th 2020, at least 14 days after COVID-19 symptom recovery… report broad serological profiles within the cohort, detecting antibody binding to other human coronaviruses… the viral surface spike protein was identified as the dominant target for both neutralizing antibodies and $CD8^+$ T-cell responses. Overall, the majority of patients had robust adaptive immune responses, regardless of their disease severity."

SARS-CoV-2 elicits robust adaptive immune responses regardless of disease severity

Natural Covid Immunity:

"Performed multimodal single-cell sequencing on peripheral blood of patients with acute COVID-19 and healthy volunteers before and after receiving the SARS-CoV-2 BNT162b2 mRNA vaccine to compare the immune responses elicited by the virus and by this vaccine…both infection and vaccination induced robust innate and adaptive immune responses, our analysis revealed significant qualitative differences between the two types of immune challenges. In COVID-19 patients, immune responses were characterized by a highly augmented interferon response which was largely absent in vaccine recipients. Increased interferon signaling likely contributed to the observed dramatic upregulation of cytotoxic genes in the peripheral T cells and innate-like lymphocytes in patients but not in immunized subjects. Analysis of B and T cell receptor repertoires revealed that while the majority of clonal B and T cells in COVID-19 patients were effector cells, in vaccine recipients clonally expanded cells were primarily circulating memory cells…we observed the presence of cytotoxic CD4 T cells in COVID-19 patients that were largely absent in healthy volunteers following immunization. While hyper-activation of inflammatory responses and cytotoxic cells may contribute to immunopathology in severe illness, in mild and moderate disease, these features are indicative of protective immune responses and resolution of infection."

Discrete Immune Response Signature to SARS-CoV-2 mRNA Vaccination Versus Infection, Ivanova, 2021

"The SARS-CoV-2 Immunity and Reinfection Evaluation study… 30 625 participants were enrolled into the study… a previous history of SARS-CoV-2 infection was associated with an 84% lower risk of infection, with median protective effect observed 7 months following primary infection. This time period is the minimum probable effect because seroconversions were not included. This study shows that previous infection with SARS-CoV-2 induces effective immunity to future infections in most individuals."

SARS-CoV-2 infection rates of antibody-positive compared with antibody-negative health-care workers in England: a large, multicentre, prospective cohort study (SIREN), Jane Hall, 2021

Natural Covid Immunity:

"Studied SARS-CoV-2–specific T cells in a cohort of asymptomatic (*n* = 85) and symptomatic (*n* = 75) COVID-19 patients after seroconversion…thus, asymptomatic SARS-CoV-2–infected individuals are not characterized by weak antiviral immunity; on the contrary, they mount a highly functional virus-specific cellular immune response."

Highly functional virus-specific cellular immune response in asymptomatic SARS-CoV-2 infection

"Months after recovering from mild cases of COVID-19, people still have immune cells in their body pumping out antibodies against the virus that causes COVID-19, according to a study from researchers at Washington University School of Medicine in St. Louis. Such cells could persist for a lifetime, churning out antibodies all the while. The findings, published May 24 in the journal Nature, suggest that mild cases of COVID-19 leave those infected with lasting antibody protection and that repeated bouts of illness are likely to be uncommon."

Good news: Mild COVID-19 induces lasting antibody protection

A Majority of Adults Have Pre-Existing Antibody Reactivity to SARS-CoV-2: Study

https://www.canadiancovidcarealliance.org/media-resources/a-majority-of-adults-have-pre-existing-antibody-reactivity-to-sars-cov-2-study/

Natural Covid Immunity:

“12,541 health care workers participated and had anti-spike IgG measured; 11,364 were followed up after negative antibody results and 1265 after positive results, including 88 in whom seroconversion occurred during follow-up…a total of 223 anti-spike–seronegative health care workers had a positive PCR test (1.09 per 10,000 days at risk), 100 during screening while they were asymptomatic and 123 while symptomatic, whereas 2 anti-spike–seropositive health care workers had a positive PCR test… the presence of anti-spike or anti-nucleocapsid IgG antibodies was associated with a substantially reduced risk of SARS-CoV-2 reinfection in the ensuing 6 months.”

Antibody Status and Incidence of SARS-CoV-2 Infection in Health Care Workers, Lumley, 2021

“No significant difference was observed between the 20B and 19A isolates for HCWs with mild COVID-19 and critical patients. However, a significant decrease in neutralization ability was found for 20I/501Y.V1 in comparison with 19A isolate for critical patients and HCWs 6-months post infection. Concerning 20H/501Y.V2, all populations had a significant reduction in neutralizing antibody titres in comparison with the 19A isolate. Interestingly, a significant difference in neutralization capacity was observed for vaccinated HCWs between the two variants whereas it was not significant for the convalescent groups…the reduced neutralizing response observed towards the 20H/501Y.V2 in comparison with the 19A and 20I/501Y.V1 isolates in fully immunized subjects with the BNT162b2 vaccine is a striking finding of the study.”

Live virus neutralisation testing in convalescent patients and subjects vaccinated against 19A, 20B, 20I/501Y.V1 and 20H/501Y.V2 isolates of SARS-CoV-2, Gonzalez, 2021

Covid-19 Vaccines:

- UW personnel do not wish to take the Covid-19 vaccines for various reasons:
  - Some individuals had the first dose and soon had health related adverse effects
  - Doctors are unable to sign medical exemptions except in a very narrow range of exceptions.
  - Staff at UW with a history of heart problems were unable to get a vaccine exemption from their doctor.
  - Others have firmly held religious beliefs to not take the Covid-19 vaccines
  - Large majority of people understand the risks associated with Covid-19 vaccines are not minimal.
  - Staff and students have documented natural immunity which offers greater protection than waning vaccine immunity [46] [47].
  - Growing number of research scientists, physicians and experts have uncovered the underlying harms associated with Covid-19 vaccines [28][29][30][31].
  - Clinical trials, existing data and statistics also indicate the harms of Covid-19 vaccines do not outweigh the benefits.
  - In the end, this is a personal choice made by every individual.
  - Forced vaccination as a result of unjust ultimatums is medical tyranny

  - Total Covid Deaths in Ontario for 2 years: 10 000
  - Population of Ontario: 14,789,778
  - Rate of Covid Related Deaths for 2 years: 0.068 % of the population
  - Predominantly death occurs in the elderly or individuals with an average of 4 comorbidities

Safety of Covid-19 Vaccines

Epidemiology of myocarditis and pericarditis following mRNA vaccines in Ontario, Canada: by vaccine product, schedule and interval [27]

- Rates per 1 million doses based on **passive surveillance system**
- Rates of Myocarditis and pericarditis are very high
- Males Ages 18-24)
  - 2 Pfizer doses: 46 per million: ~1 in 10000
  - 2 Moderna doses: 376 per million: ~1 in 3-4000
  - Moderna followed by Pfizer: Lowest rates (under 1 in 100 000)
  - Pfizer followed Moderna: 777 per million: **~1 in 1200**
    - Highest Rate Globally

- "Underreporting" is one of the main limitations of passive surveillance systems, including VAERS.

MYOCARDITIS

"Myocarditis is an inflammatory process of the myocardium. (Heart muscle.) **Severe myocarditis weakens your heart** so that the rest of your body doesn't get enough blood. Clots can form in your heart, **leading to a stroke or heart attack."**

THE US NATIONAL CENTRE FOR BIOTECHNOLOGY INFORMATION

"The mortality rate is up to 20% at 6.5 years."

https://jcmr-online.biomedcentral.com/articles/10.1186/1532-429X-13-S1-M7

- Long-term follow-up after viral myocarditis established by endomyocardical biopsy: Predictors of mortality
- Viral Myocarditis

THE PFIZER INOCULATIONS FOR COVID-19

MORE HARM THAN GOOD

WHO WE ARE

Our alliance of **over 500 independent Canadian doctors, scientists, and health care practitioners** is committed to providing quality, balanced, evidence-based information to the Canadian public about COVID-19 so that hospitalizations can be reduced, lives saved, and our country safely restored to normal as quickly as possible.

Detailed Report
https://www.canadiancovidcarealliance.org

Excerpt: **Declaration of the Canadian Covid Care Alliance**
Joint Association of over 500 Canadian Doctors/Medical Professionals

APPENDIX C

Recently published in the journal Science, Public Health Policy and the Law, Canadian Jessica Rose, PhD, MSc, BSc, authored a report titled, "A Report on the U.S. Vaccine Adverse Events Reporting System (VAERS) of the COVID-19 Messenger Ribonucleic Acid (mRNA) Biologicals,"[157]

This article[158] entitled New study: Vaccines are the likely cause of adverse effects and deaths following vaccination summarizes the results:

- 57% of reported deaths following vaccination occurred within 48 hours of inoculation.
- 66% of emergency room (ER) visits following vaccination occurred within 48 hours of inoculation.
- 63% of hospitalizations following vaccination occurred within 48 hours of inoculation.
- 70% of individuals developed symptoms within 48 hours following first or second doses.
- 79% of all VAERS reports were made after recipients received the first dose.
- 18% of all Adverse Events (AE) reports were cardiovascular, 12% were neurological, and 35% were immunological.
- Immunological AEs continue to rise with time even as other AEs have remained stable.
- Those aged 30 to 40 years old comprise the largest subset of reports overall.
- Higher absolute numbers of VAERS deaths and hospitalization are associated with the elderly aged 65 and above. 84% of deaths following vaccination belonged to those aged 70 to 90 years old.
- The highest frequency of cardiovascular AEs was by individuals aged 20 to 30 years of age.
- Spontaneous abortions recorded among women aged 20 to 40 years. 65% of these miscarriages happened after the first dose.

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[157] Covid Strategies. (2021, Jul 2) *Canadian researcher analyzes CDC VAERS data for COVID-19 vaccine safety POV – But is the other side of risk calculated.* https://www.covidstrategies.org/canadian-researcher-analyzes-cdc-vaers-data-for-covid-19-vaccine-safety-pov-but-is-the-other-side-of-risk-calculated/

[158] Covid call to humanity. (2021, May 24) *New study: Vaccines are the likely cause of adverse effects and deaths following vaccination.* https://covidcalltohumanity.org/2021/05/24/new-study-vaccines-are-the-likely-cause-of-adverse-effects-and-deaths-following-vaccination/

Safety of Covid-19 Vaccines

- Covid-19 vaccines: In the rush for regulatory approval, do we need more data?
- Why are we vaccinating children against COVID-19?
- Critical Appraisal of VAERS Pharmacovigilance: Is the U.S. Vaccine Adverse Events Reporting System (VAERS) a Functioning Pharmacovigilance System?
- A study at Mass General Brigham (MGM) that assessed anaphylaxis in a clinical setting after the administration of COVID-19 vaccines published in JAMA on March 8, 2021, found "severe reactions consistent with anaphylaxis occurred at a rate of 2.47 per 10,000 vaccinations." This rate is based on reactions occurring within 2 hours of vaccination, the mean time was 17 minutes after vaccination. This study used "active" surveillance and tried not to miss any cases.
- SARS-CoV-2 spike protein S1 subunit induces pro-inflammatory responses via toll-like receptor 4 signaling in murine and human macrophages
- SARS-CoV-2 spike protein S1 induces fibrin(ogen) resistant to fibrinolysis: implications for microclot formation in COVID-19
- Estimating the number of COVID vaccine deaths in America
- SARS-CoV-2 Spike Protein Impairs Endothelial Function via Downregulation of ACE 2
- Thrombocytopenia following Pfizer and Moderna SARS-CoV-2 vaccination
- Risk benefit by age of the COVID vaccines

- A study into VAERS underreporting factor (URF):
- "This suggests that the VAERS under-reporting factor (URF) is 41X." [35]

Safety of Covid-19 Vaccines

- “Just as the research is showing the vaccine mandates are not keeping students from harm (and are thus scientifically invalid), a growing mountain of scientific evidence shows that the vaccines themselves are doing significant physical harm to young people and, in particular, young, university-aged men. The prima facie evidence that physical harm is occurring to young people can be seen in the banning of the Moderna vaccine for youth by governments around the world. Let us keep in mind, this is the third vaccine to be approved as safe, and then banned completely or partially. Even Ontario’s government, via the Chief Medical Officer, ordered a “pause” of the Moderna vaccine for young men—tacitly admitting it is doing harm.”
- “Apart from this prima facie evidence, again, at the end of this letter, I list several recent studies showing that the Covid vaccines are directly linked to significant increase in negative cardiac events, especially in youth. I would note that in some of the studies listed the Pfzier vaccine, which is most heavily used in the vaccination of Canadian youth, is shown to be equally harmful as others. Related to harm, epidemiologist Dr. Tracey Hoeg, at the University of California has published research data showing that among university age youth and younger the risk of harm from the vaccine is greater than the risk of the Covid-19 disease. Others have as well.”
- “Another of my contacts with whom I can put you in touch is Dr. Donald Welsh. Dr. Welsh is Chair in Molecular Neuroscience and Vascular Biology, at the Schulich School of Medicine & Dentistry, Western University. Given his expertise in the vascular system, his grasp of the research related to the negative cardiac events spawned by the Covid-19 vaccines is excellent; he could walk you through the published data. These studies that I am citing are not fringe publications. The experts who agree with my assessment— and, again, there are many I am happy to introduce you to—are world-class researchers.”

Dr. David Haskell
Wilfrid Laurier University [22]

Safety of Covid-19 Vaccines

- Select research studies showing that the Covid-19 vaccines are solidly linked to elevated rates of negative cardiac/vascular events; in some cases the vaccines have been proven more harmful to younger people than the virus itself.
- https://www.medrxiv.org/content/10.1101/2021.08.30.21262866v1
- https://www.sciencedirect.com/science/article/pii/S221475002100161X
- https://int.artloft.co/wp-content/uploads/2021/10/pdf3-1.pdf
- https://www.ahajournals.org/doi/10.1161/circ.144.suppl_1.10712
- https://retractionwatch.com/2021/10/25/covid-19-vaccine-myocarditis-paper-to-bepermanently-removed-elsevier/
  - (NOTE: this final study showing that the Covid vaccine harms young people passed peer-review BUT was removed WITHOUT REASON by the journal editor)

Dr. David Haskell
Wilfrid Laurier University [22]

APPENDIX A

Slide #16 - FDA Safety Surveillance of COVID-19 Vaccines October 22, 2020 before EUA (Emergency Use Authorization): [156]

- Guillain-Barré syndrome
- Acute disseminated encephalomyelitis
- Encephalitis / myelitis / encephalomyelitis / meningoencephalitis / meningitis / encephalopathy
- Convulsions / seizures
- Stroke
- Narcolepsy and cataplexy
- Acute myocardial infarction
- Myocarditis / pericarditis
- Autoimmune disease
- Deaths
- Pregnancy and birth outcomes
- Transverse myelitis
- Other acute demyelinating diseases
- Anaphylaxis and non-anaphylactic allergic reactions
- Thrombocytopenia
- Disseminated intravascular coagulation
- Venous thromboembolism
- Arthritis and arthralgia/joint pain
- Kawasaki disease
- Multi-system Inflammatory Syndrome in Children
- Vaccine enhanced disease

All of these syndromes and more have been reported to the VAERS reporting system in the USA.

PFIZER TRIALS DID NOT PROVE SAFETY
THEY PROVED HARM

ILLNESS

	BNT162b2	Placebo	Risk Change
Efficacy (Meaning number of people diagnosed with COVID-19.)	77	850	**-91%**
Related Adverse Event (Meaning an investigator has assessed it as related to the BNT162b2 injection.)	5,241	1,311	**+300%**
Any Severe Adverse Event (Interferes significantly with normal function.)	262	150	**+75%**
Any Serious Adverse Event (Involves visit to ER or hospitalization.)	127	116	**+10%**

DEATHS

BNT162b2	Placebo
20	14

These are the results of Pfizer's own randomized control trial.

LEVEL 1 EVIDENCE OF HARM.

[32]

33

- (BMJ) Covid-19: Researcher blows the whistle on data integrity issues in Pfizer's vaccine trial

Covid Early Treatment:

- These talks are essential in order to better understand why **Covid Early Treatment** has not been offered at hospitals in Canada and the U.S.A.
- The data is indisputable. Covid Treatment exists and is preventative for outpatient/inpatient care.
- A subset of the research on Covid Treatment is linked in the slides below.

- **Why are hospitals in the U.S.A and Canada not administering Covid Treatment**
- **Answered: Interview** Joe Rogan & Peter McCullough

- **Dr. Pierre Kory:**
- Disinformation Campaign

Covid Early Treatment: Practiced Globally

- **Early Ambulatory Multidrug Therapy**, McCullough et al:
- https://rcm.imrpress.com/article/2020/2153-8174/RCM2020264.shtml (related interview and webinar)
- **The I-MASK+** Early Outpatient Treatment Protocol for COVID-19: https://covid19criticalcare.com/i-mask-prophylaxis-treatment-protocol/i-mask-protocol-translations/
- **Zelenko** Early Treatment Protocol: https://vladimirzelenkomd.com/treatment-protocol/
- Top Yale Doctor/Researcher: 'Ivermectin works,' including for long-haul COVID – https://trialsitenews.com/top-yale-doctor-researcher-ivermectin-works-including-for-long-haul-covid/
- The following is the protocol **Drs. Fareed and Tyson** have jointly developed as most effective for their COVID-19 patients: https://www.thedesertreview.com/health/drs-george-fareed-and-brian-tyson-update-treatment-for-delta-variant/article_33835a28-472d-11ec-b838-07d39a4e8d01.html
- **IppocrateOrg** "At Home Therapy" Protocol: https://ippocrateorg.org/en/2020/12/15/how-to-treat-covid-19/
- **The Fleming Directed CoVid-19** Treatment Protocol (FMTVDM): http://c19protocols.com/wp-content/uploads/2021/01/fleming-protocol.pdf
- **MATH+ Hospital Treatment** Protocol
- **Budesonide (Pulmicort) dosing for outpatient COVID** per the Oxford RCT: http://c19protocols.com/wp-content/uploads/2021/03/COVID_Budesonide_Oxford-Based_Dosing_Guidance.pdf
- **Budesonide-focused** Treatment Protocol: https://secureservercdn.net/45.40.145.151/umz.e26.myftpupload.com/wp-content/uploads/2020/11/Full-Protocol_withOTC.pdf from https://budesonideworks.com/

Covid Early Treatment: Practiced Globally

- Prophylaxis and Treatment for **COVID-19 in Nursing Homes** https://covexit.com/prophylaxis-and-treatment-for-covid-19-in-nursing-homes-video-highlights/
- Government of India Ministry of Health & Family Welfare Revised guidelines for Home Isolation of mild /asymptomatic COVID-19 cases: https://www.mohfw.gov.in/pdf/RevisedguidelinesforHomeIsolationofmildasymptomaticCOVID19cases.pdf
- COVID-19:THERAPEUTIC PLAN AND POTENTIAL THERAPIES. Aguirre-Chang, Gustavo; Trujillo F,Aurora; Córdova M, José Aníbal. February 2021 – https://www.researchgate.net/publication/348268812_TABLE_2021_COVID-19_THERAPEUTIC_PLAN_AND_POTENTIAL_THERAPIES_January_2021
- The following is the protocol **Drs. Fareed and Tyson** have jointly developed as most effective for their COVID-19 patients: https://www.thedesertreview.com/health/drs-george-fareed-and-brian-tyson-update-treatment-for-delta-variant/article_33835a28-472d-11ec-b838-07d39a4e8d01.html
- Early ambulatory outpatient sequenced antiviral multidrug COVID-19 treatment (including for Delta or similar variants) for high-risk children and adolescents – https://earlycovidcare.org/wp-content/uploads/2021/09/Early-Child-Treatment.pdf

Covid Early Treatment: Covid Early Treatment Fund

- Promising Drugs:
- Chetty protocol: Described in this paper, it has over 99% risk reduction.
- Italy protocol: This is extremely effective. Reportedly, only 4 out of 66,000 people died in Italy. This is an HCQ-based protocol because ivermectin is prohibited in Italy.

- **Why are hospitals in the US and Canada not administering Covid Treatment**
- **Answered: Interview** Joe Rogan & Peter McCullough

- **Pierre Kory:**
- Disinformation Campaign

Covid Early Treatment: Canada

- Summary of the Evidence for Ivermectin in COVID-19
- A Guide to the Management of COVID-19
- I-Recover Management Protocol for Long Haul COVID-19 Syndrome
- https://covid19criticalcare.com/covid-19-protocols/i-recover-protocol/
- Canadian Covid Care Alliance: Declaration
- World Council for Health: Practical Guide to Treatment

[42]

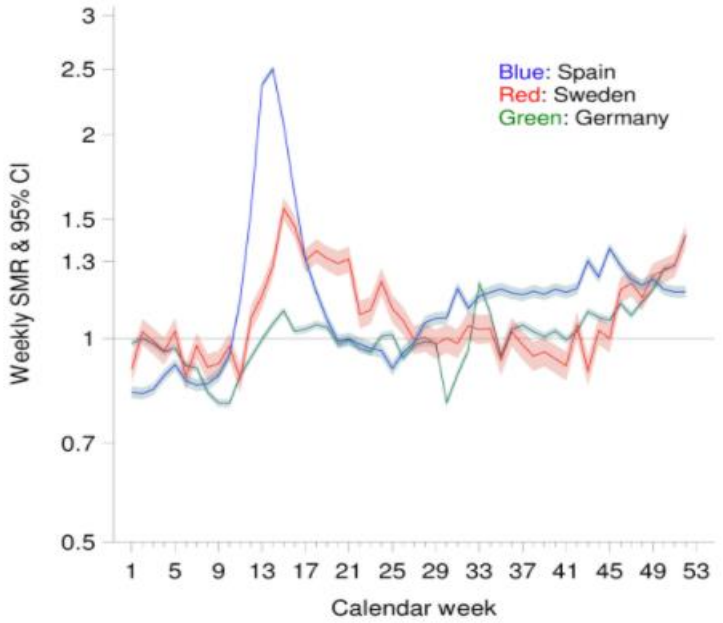
Covid Early Treatment: Research Studies

- The following websites have dynamically updated databases on the current research studies on several therapeutic options
- Research studies on hydroxychloroquine
- Research studies on Ivermectin
- Research studies on Vitamin D
- Research studies on Zinc
- Research studies on REGN-COV2
- Research studies on LY-COV
- Research studies on Remdesivir

More on Covid Early Treatment End of this document [55]

Sweden

- Expert statement regarding the need for lock-downs and other measures to ‘fight the pandemic’ and on their effects on children: Michael Palmer MD and Sucharit Bhakdi MD



- Excess mortality due to Covid-19? A comparison of total mortality in 2020 with total mortality in 2016 to 2019 in Germany, Sweden and Spain
- Coronavirus: Sweden's economy hit less hard by pandemic

Waning Vaccine Immunity

- ***"Overall, this study determines any benefit beyond six months isn't certain—and appears to dissipate. And what could be considered a bombshell of a story, is that the Umeå -based authors determine that the Pfizer-BioNTech vaccine known as BNT162b2 or "Comirnaty," the only vaccine formally approved in the United States, shows notable waning efficacy, particularly among men, the elderly, and people with comorbidities."***
- National Swedish Study Finds COVID-19 Vaccines Not Effective After Six Months

- "Interestingly and of concern, individuals who were previously infected with SARS-CoV-2—or even just exposed—then vaccinated experienced an expedited decline in antibodies."
- Total Anti-SARS-CoV-2 Antibodies Measured 6 Months After Pfizer-BioNTech COVID-19 Vaccination in Healthcare Workers

- Resurgence of SARS-CoV-2 Infection in a Highly Vaccinated Health System Workforce

Waning Vaccine Immunity

- **Correlation of SARS-CoV-2-breakthrough infections to time-from-vaccine**

- ***"A recent study led by Leumit Health Services and the Shamir Medical Center Institutional Review Board in Israel led to some concerning results. The study authors recently uploaded the manuscript to the preprint server medRxiv. Involving 33,943 fully vaccinated adults administered the Pfizer-BioNTech vaccine, three cohorts based on age were studied, including 1) 60 and up, 2) 40 to 59, and 3) 18 to 29. The study authors found concerning risk of breakthrough infection in those vaccinated at least 146 days (4.8 months) before reinfection—the risk further escalates for people older than 60."*** [49]
- **Elapsed time since BNT162b2 vaccine and risk of SARS-CoV-2 infection in a large cohort**

Dalinda Reese
dreesetotal@yahoo.com

October 28, 2021

Urgent: unacknowledged ethical concerns regarding your policy to mandate COVID-19 vaccines

To: University Senate leadership of the Universities of Laurier, Waterloo, and Guelph

Please note: I am entrusting individuals I know to convey this communication to you. These opinions are my own and are not meant to suggest anything about the opinions of the conveyers.

I am asking your serious consideration of the ethical concerns noted below that made it *impossible for me to comply with a policy that would legitimize stigmatization and segregation.* At the end of August, I received instruction to submit proof of vaccination or accommodation by September 7, 2021. Matters of deepest conscience informed my intention to non-comply even knowing that doing so would prevent my teaching at one of your universities this fall. While I have been disappointed, I have not suffered the major disruptions and impossible choices that some of your staff and students have faced.

To offer context, I note that I am an American-Canadian and a US physician who retired in 2019 just prior to the pandemic in order to complete work on a Masters in Spiritual Care and Psychotherapy. During the pandemic, I completed training in the Spiritual Care department of an Ontario hospital and a Withdrawal Management Center. In that work I saw how job loss, lockdowns, and isolation made lives and health outcomes worse – especially for those already socioeconomically disadvantaged and for those struggling with mental health issues and/or substance use disorders. I have seen the underside of this beast!

Policy decisions with such far-reaching ethical and human rights implications require impeccable consideration especially when implemented by institutions that represent higher learning, critical thinking, diversity, and/ or faith-based values. The rare responses I have received from leaders of academic institutions in ON, NY, and VA regarding the vaccine mandates have been along the lines of "just following (public health) orders."

Vaccine mandates can and have been used to legitimize other forms of human rights abuses. In the US, the 1905 Supreme Court decision to uphold compulsory vaccine (a vaccine mandate) was used to justify eugenics public policy programs in at least 30 states that instituted compulsory sterilization. Those policies persisted into the 1960s and 1970s.[1]

We can keep each other safe without mandates or vax passports. Based on the available science, if we were really concerned about asymptomatic spread of the virus, we would be doing rapid antigen testing on everyone regardless of vax status.[2]

Vaccine exemptions (medical, religious, or human rights) are legal maneuverings to get everyone to take a non-negotiable, non-individualized medical intervention regardless of medical risk or matters of conscience.[3] In medical ethics that used to be known as "assault."

Offering and denying these exemptions are designed to abrogate anyone mandating the vaccination from any responsibility or liability for harms. Please be aware that as a precondition to providing vaccines, pharmaceutical companies demand to be shielded from any liability. To be clear: the unabashed push for these COVID-19 biologic injectables (now referred to as "vaccines") *bypasses free and fully informed consent, violates the AMA code of ethics*[4]*, and abrogates those who mandate the vaccine from any fiduciary duty to those who receive it.*

A frenzied vaccination push and single narrative that disallows any room for dissenting voices ***should alarm*** *any thoughtful, conscientious citizen*. The political and regulatory responses have relied on media and public messaging to effectively silence any voices that have concerns or have offered expanded understandings and responses to the only allowable narrative. You must be aware that those censored voices include now vilified academics within your own ranks. *The prolonged and restrictive pandemic control measures increase harms.* They undermine every social determinate of health.[5] Ongoing harms include increasing disparities, worse health outcomes for those already vulnerable, excessive numbers of deaths from overdoses and substance use disorders, burgeoning mental health issues, and more. Isolating, separating, segregating, and disempowering us has to be the most devastating aspect of pandemic management. The way we have been torn apart and pitted against each other is sinister. *The censorship, vilification, and persecution of physicians (by political and regulatory agencies) who challenge the only allowable pandemic narrative is unconscionable.*[6]
Vaccine mandates and vaccine passports are a forced coercive medical intervention that is an assault on human dignity and bodily autonomy. Intended or not, the mandates and vax passes segregate and stigmatize.[7] This necessarily disadvantages specific groups and worsens health outcomes. The mandates, vax passes, and the rhetoric around them continue to fuel divisiveness, discrimination, and an "us vs. them" hostility that threatens the safety and health of all.

I don't know what you know, nor am I privy to your deliberations on this policy matter. I do know that you have a challenging task. I would like to know that you appreciate the gravity of these fundamental human rights concerns. All who are affected by your policy decision to make the COVID-19 vaccine compulsory with no realistic recourse deserve to know how these ethical concerns are addressed in your considerations.

I respectfully request acknowledgement that you have received this communication.

Thank you,

Dalinda Reese, Fellow Human Being
MD (USA, U Michigan, 1981, retired 2019), MTS (Grebel, U Waterloo, 2008)
MA Spiritual Care and Psychotherapy (Luther, Laurier University, 2021)

Although this background (and more) profoundly influences my thinking and ways of being, the views expressed here are my own and are not meant to represent the views of the medical profession or any of the institutions with which I have been associated.

"Those who have the privilege to know, have the duty to act." [8] (Tyrone Hayes, PhD)

References:

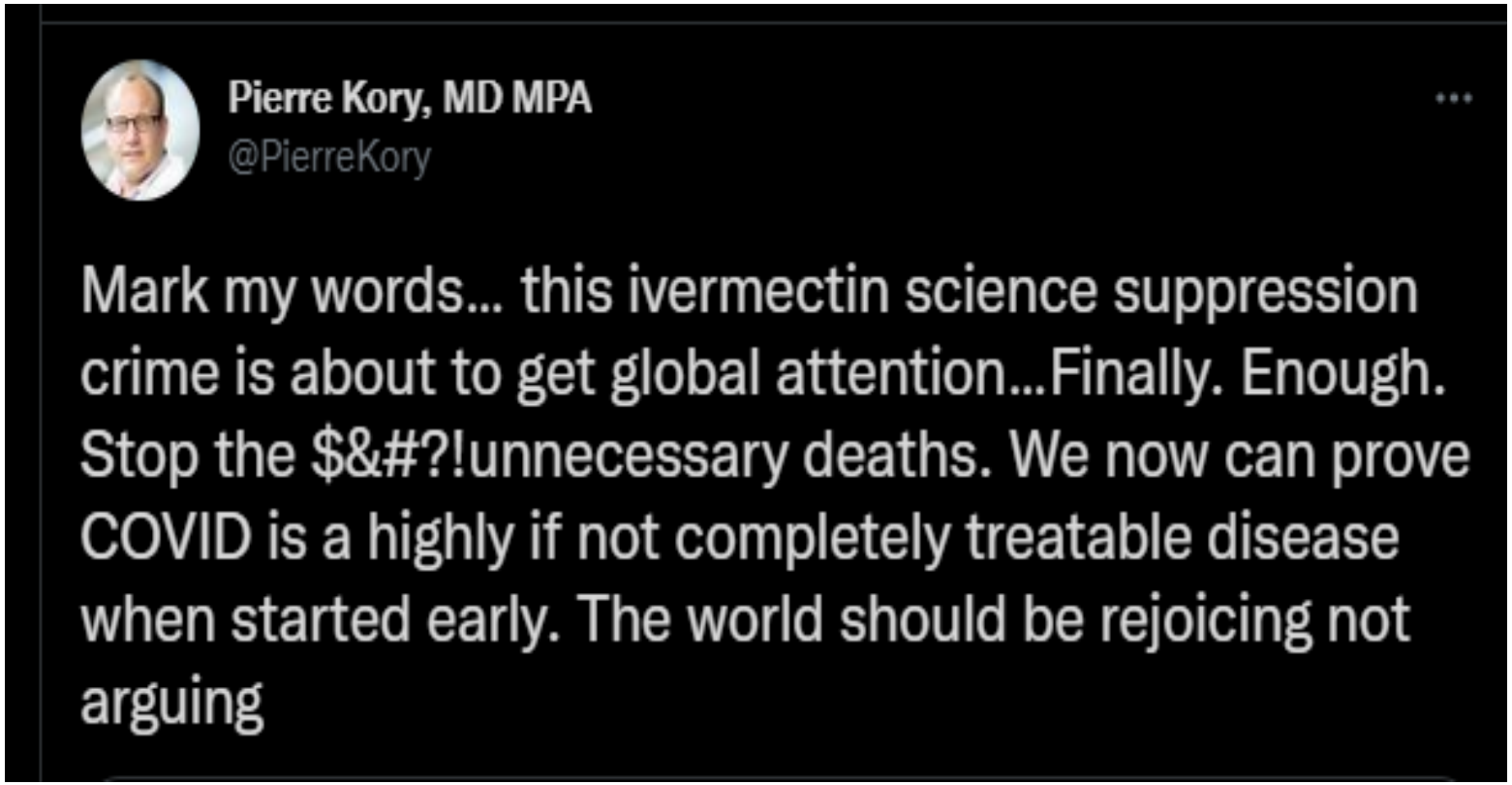
1. Erina Kim-Eubanks, “When Medicine is Violent: The Harmful Legacy of Eugenics and Medical Racism,” (September 17.2020) https://medium.com/firstpres/when-medicine-is-violent-the-harmful-legacy-of-eugenics-and-medical-racismf8dd02ab94a7
2. ***Even the CDC has acknowledged that vaccinated people can become infected, carry equal nasal viral loads, and transmit the virus at least as much as the unvaccinated.*** (https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7031e2-H.pdf)
3. Although routinely downplayed, evidence of serious harms following COVID-19 vaccinations continues to grow – especially for younger healthy people. The sudden unexplained deaths of young people in Ontario following COVID-19 injections are alarming and deserve investigation (https://ocla.ca/list-of-sudden-deaths-in-ontario/).

- Vaccine Adverse Reactions: https://nomoresilence.world/no-more-silence/we-want-to-be-heard/
- Apart from the personal risks of harm, there is also accumulating evidence that **these COVID-19 vaccinations fail to stop the pandemic** (Subramanian, S.V., Kumar, A. Increases in COVID-19 are unrelated to levels of vaccination across 68 countries and 2947 counties in the United States. *Eur J Epidemiol* (2021).
- **Adverse Reactions from Covid Vaccines**

4. While they may offer personal health protection they don’t protect public health (https://fee.org/articles/stanford-epidemiologistsays-covid-vaccination-is-primarily-a-matter-of-personal-health-not-public-health/) and Why Covid-19 Vaccines should not be required for all Americans

5. Social determinants of health include food and shelter security, human connection and community, meaningful employment, and access to quality education and healthcare.
6. These are committed and competent physicians who are asking questions, who are actively providing early treatment of COVID-19, who are keeping patients out of the hospital, who are requesting more robust evidence of stratified safety/ efficacy/ necessity/ and long-term health impacts of this gene immunotherapy vaccine (that has been approved despite astronomic increases in VAERS and before the studies are even due for completion), who are seeing and treating harms following the COVID-19 inoculations, and who are examining the convoluted and unnecessarily chaotic evidence for themselves.
7. Open letter to RCMP Commissioner Brenda Lucki, October 21, 2021. https://web.archive.org/web/20211023130926/https://mounties4freedom.ca/
8. Tyrone Hayes, PhD, "From Silent Spring to Silent Night," lecture at online Environmental Health Symposium, April 4, 2020. A salient perspective about Tyrone Hayes' courage and life's work can be found at https://www.newyorker.com/culture/culture-desk/the-biologist-who-challenged-agribusiness

- June 2021



- Must See:
- [Disinformation Campaign]

Italy: Feb 2021

Crying wolf in time of Corona: the strange case of ivermectin and hydroxychloroquine. Is the fear of failure withholding potential life-saving treatment from clinical use?

Pasquale Nardelli[1] Alberto Zangrillo[1,2] Gabriele Sanchini[1] Valery V Likhvantsev[3,4] Andrey G Yavorovskiy[4] Carolina Soledad Romero Garcia[5] Giovanni Landoni[1,2]✉

[1]Department of Anesthesia and Intensive Care, IRCCS San Raffaele Scientific Institute, Milan, Italy

[2]Vita-Salute San Raffaele University, Milan, Italy

[3]Federal Research and Clinical Center of Resuscitation and Rehabilitation, Moscow, Russia

[4]IM Sechenov First Moscow State Medical University of the Ministry of Health of the Russian Federation (Sechenov University), Moscow, Russia

[5]Department of Anaesthesia and Critical Care, Consorcio Hospital General Universitario de Valencia, Valencia, Spain

DOI: 10.22514/sv.2021.043 Vol.17,Issue 3,May 2021 pp.3-4

Submitted: 25 February 2021 **Accepted:** 28 February 2021

Published: 07 May 2021

***Corresponding Author(s):** Giovanni Landoni **E-mail:** landoni.giovanni@hsr.it

U.S.A:

Spain: Feb 2021

Potential use of ivermectin for the treatment and prophylaxis of SARS-CoV-2 infection

R Cobos-Campos,[a,*] A Apiñaniz,[a,b,c] N Parraza,[a] J Cordero,[a] S García,[a] and E Orruño[a]

▸ Author information ▸ Article notes ▸ Copyright and License information Disclaimer

Abstract

Go to:

Purpose of the study

Currently no treatment has been proven to be efficacious for patients with early symptoms of COVID-19. Although most patients present mild or moderate symptoms, up to 5-10% may have a poor disease progression, so there is an urgent need for effective drugs, which can be administered even before the onset of severe symptoms, i.e. when the course of the disease is modifiable. Recently, promising results of several studies on oral ivermectin have been published, which has prompted us to conduct the present review of the scientific literature.

Methods

A narrative review has been carried out, focusing on the following four main topics: a) short-term efficacy in the treatment of the disease, b) long-term efficacy in the treatment of patients with post-acute symptoms of COVID-19, c) efficacy in the prophylaxis of the disease, and c) safety of ivermectin.

Results

The reviewed literature suggests that there seems to be sufficient evidence about the safety of oral ivermectin, as well as the efficacy of the drug in the early-treatment and the prophylaxis of COVID-19.

Japan: March 2021

Global trends in clinical studies of ivermectin in COVID-19

Morimasa Yagisawa, Ph.D.[1,2], Patrick J. Foster, M.D.[2], Hideaki Hanaki, Ph.D.[1] and Satoshi Ōmura, Ph.D.[1]

[1] Kitasato University Ōmura Satoshi Memorial Institute
[2] Keio University Faculty of Pharmacy

(Received for publication March 10, 2021)

Response to the initial alarm bells of the Coronavirus infection, which occurred in Wuhan City, Hubei Province, China in November 2019, was delayed as it was announced to be a type of pneumonia of unknown cause. The WHO warned about traveling to China in January 2020. After much urging, the world was finally properly warned, but the Chinese government did not accurately announce the outbreak situation. Consequently, the delaying of the construction of an epidemic prevention system worldwide has resulted in the direst infection circumstances facing the world today. One year has passed since the WHO named the new coronavirus SARS-CoV-2 infection, COVID-19, and it was declared a pandemic on the 11th of March 2020, based on the judgment that it corresponds to "an internationally concerned public health emergency". Suppression of virus transmission by vaccine has finally begun. To date, the pandemic has affected more than 115 million people and killed more than 2.5 million people in 220 countries/ regions around the world. There appears to a potential for control in the near future. However, there is a limit to the supply of vaccines and developed countries are competing to obtain the required amount of vaccination necessary for their own citizens. Although the WHO is trying to secure a certain amount for developing countries, it is predicted that a considerable period of time will be required before

UK: Feb 2021

The BIRD Recommendation on the Use of Ivermectin for Covid-19

B/RD

British
Ivermectin
Recommendation
Development

Proceedings and conclusions of the British Ivermectin Recommendation Development meeting held on the 20th February 2021 in Bath, United Kingdom.

I-MASK+ Prevention & Early Outpatient Treatment Protocol for COVID-19

I-MASK+
PREVENTION & EARLY OUTPATIENT TREATMENT PROTOCOL FOR COVID-19

Below you can download the **I-MASK+ Prevention & Early Outpatient Treatment Protocol for COVID-19** with guidance on the timing and doses of each component medication. Further below please find more information on the I-MASK+ Protocol.

The I-MASK+ Protocol complements our > **MATH+ Hospital Treatment Protocol for Covid-19** from March 2020, which is intended for hospitalized patients. Both are physiologic-based combination treatment regimens developed by leaders in critical care medicine. All component medicines are FDA-approved, inexpensive, readily available and have been used for decades with well-established safety profiles. **In October 2020, we added > ivermectin as a core medication** in the prevention and treatment of COVID-19.

The protocol document is available in several languages (see below) – more translations are available > **here**. This is not a medical advice, but a recommendation – please consult your doctor, share the information on this website with her/him, and listen. Please review our > **Disclaimers**!

Please check this page regularly for updates – new medications may be added and/or dose changes to existing medications may be made as further scientific studies emerge.

Current I-MASK+ protocol: version 16, updated on September 1, 2021 (English version, translation updates follow).

Prevention & early outpatient treatment for COVID-19

Prophylaxie et traitement ambulatoire précoce COVID-19

Profilaxis y tratamiento ambulatorio temprano para COVID-19

Profilassi e trattamento ambulatorio precoce per COVID-19

Profilaxia e tratamento ambulatorial precoce para COVID-19

Prophylaxe & frühe ambulante Behandlung von COVID-19

I-RECOVER Management Protocol for Long Haul COVID-19 Syndrome (LHCS)

I-RECOVER
MANAGEMENT PROTOCOL FOR
LONG HAUL COVID-19 SYNDROME

The Long Haul COVID-19 Syndrome (LHCS) is an often debilitating syndrome characterized by a multitude of symptoms such as prolonged malaise, headaches, generalized fatigue, sleep difficulties, smell disorder, decreased appetite, painful joints, dyspnea, chest pain and cognitive dysfunction. The incidence of symptoms after COVID-19 varies from as low as 10% to as high as 80%. LHCS is not only seen after the COVID-19 infection but it is being observed in some people that have received vaccines (likely due to monocyte activation by the spike protein from the vaccine). A puzzling feature of the LHCS syndrome is that it is not predicted by initial disease severity; post-COVID-19 frequently affects mild-to-moderate cases and younger adults that did not require respiratory support or intensive care.

The symptom set of LHCS in the majority of cases is very similar to the chronic inflammatory response syndrome (CIRS)/myalgic encephalomyelitis/chronic fatigue syndrome, although in LHCS, symptoms tend to improve slowly in the majority of the cases. Furthermore, the similarity between the mast cell activation syndrome and LHCS has been observed, and many consider post-COVID-19 to be a variant of the mast cell activation syndrome. LHCS is highly heterogenous and likely results from a variety of pathogenetic mechanisms. Furthermore, it is likely that delayed treatment (with ivermectin) in the early symptomatic phase will result in a high viral load, which increases the risk and severity of LHCS.

Although numerous reports describe the epidemiology and clinical features of LHCS, studies evaluating treatment options are glaringly sparse. Indeed, the NICE guideline for managing the long-term effects of COVID-19 provide no specific pharmacologic treatment recommendations.

Given the lack of available treatment recommendations in the setting of large numbers of patients suffering with this disorder globally, the FLCCC developed the I-RECOVER protocol in collaboration with a number of expert clinicians including Dr. Mobeen Syed, Dr. Ram Yogendra, Dr. Bruce Patterson, and Dr. Tina Peers. Although our varied yet often overlapping treatment approaches were initially empiric, while based on both preliminary investigations into and prevailing theoretical pathophysiologic mechanisms of LHCS, the consistently positive clinical responses observed, often profound and sustained, led the collaboration to form the consensus protocol below. As with all FLCCC protocols, we must emphasize that multiple aspects of the protocol may change as scientific data and clinical experience in this condition evolve, thus it is important to check back frequently or join the FLCCC Alliance to receive notification of any protocol changes.

Numerous Research Papers
Published Clinical Trials in Peer-reviewed Journals.
Evidence is Undeniable

Review of the Emerging Evidence Demonstrating the Efficacy of Ivermectin in the Prophylaxis and Treatment of COVID-19

Pierre Kory, MD[1*], G. Umberto Meduri, MD[2†], Jose Iglesias, DO[3], Joseph Varon, MD[4], Keith Berkowitz, MD[5], Howard Kornfeld, MD[6], Eivind Vinjevoll, MD[7], Scott Mitchell, MBChB[8], Fred Wagshul, MD[9], Paul E. Marik, MD[10]

1 Front-Line Covid-19 Critical Care Alliance
2 Memphis VA Medical Center, Univ. of Tennessee Health Science Center, Memphis, TN
3 Hackensack School of Medicine, Seton Hall, NJ.
4 Chief of Critical Care at United Memorial Medical Center in Houston, TX
5 Center for Balanced Health, New York
6 Recovery Without Walls
7 Volda Hospital, Volda, Norway
8 Princess Elizabeth Hospital, Guernsey, UK
9 Lung Center of America, Dayton, Ohio
10 Eastern Virginia Medical School

* **Correspondence:**
Corresponding Author: Pierre Kory, MD, MPA
pkory@flccc.net
1 These authors have contributed equally to this work
† Dr. Meduri's contribution is the result of work supported with the resources and use of facilities at the Memphis VA Medical Center. The contents of this commentary do not represent the views of the U.S. Department of Veterans Affairs or the United States Government

Numerous Research Papers
Published Clinical Trials in Peer-reviewed Journals.
Evidence is Undeniable

ACCEPTED MANUSCRIPT

Meta-analysis of randomized trials of ivermectin to treat SARS-CoV-2 infection

Andrew Hill ✉, Anna Garratt, Jacob Levi, Jonathan Falconer, Leah Ellis, Kaitlyn McCann, Victoria Pilkington, Ambar Qavi, Junzheng Wang, Hannah Wentzel

Open Forum Infectious Diseases, ofab358, https://doi.org/10.1093/ofid/ofab358
Published: 06 July 2021 **Article history** ▾

A correction has been published:
Open Forum Infectious Diseases, Volume 8, Issue 8, August 2021, ofab394, https://doi.org/10.1093/ofid/ofab394

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Abstract

Ivermectin is an antiparasitic drug being investigated for repurposing against

Numerous Research Papers
Published Clinical Trials in Peer-reviewed Journals.
Evidence is Undeniable

Meta-Analysis › Am J Ther. 2021 Jun 21;28(4):e434-e460. doi: 10.1097/MJT.0000000000001402.

Ivermectin for Prevention and Treatment of COVID-19 Infection: A Systematic Review, Meta-analysis, and Trial Sequential Analysis to Inform Clinical Guidelines

Andrew Bryant [1], Theresa A Lawrie [2], Therese Dowswell [2], Edmund J Fordham [2], Scott Mitchell [3], Sarah R Hill [1], Tony C Tham [4]

Affiliations + expand

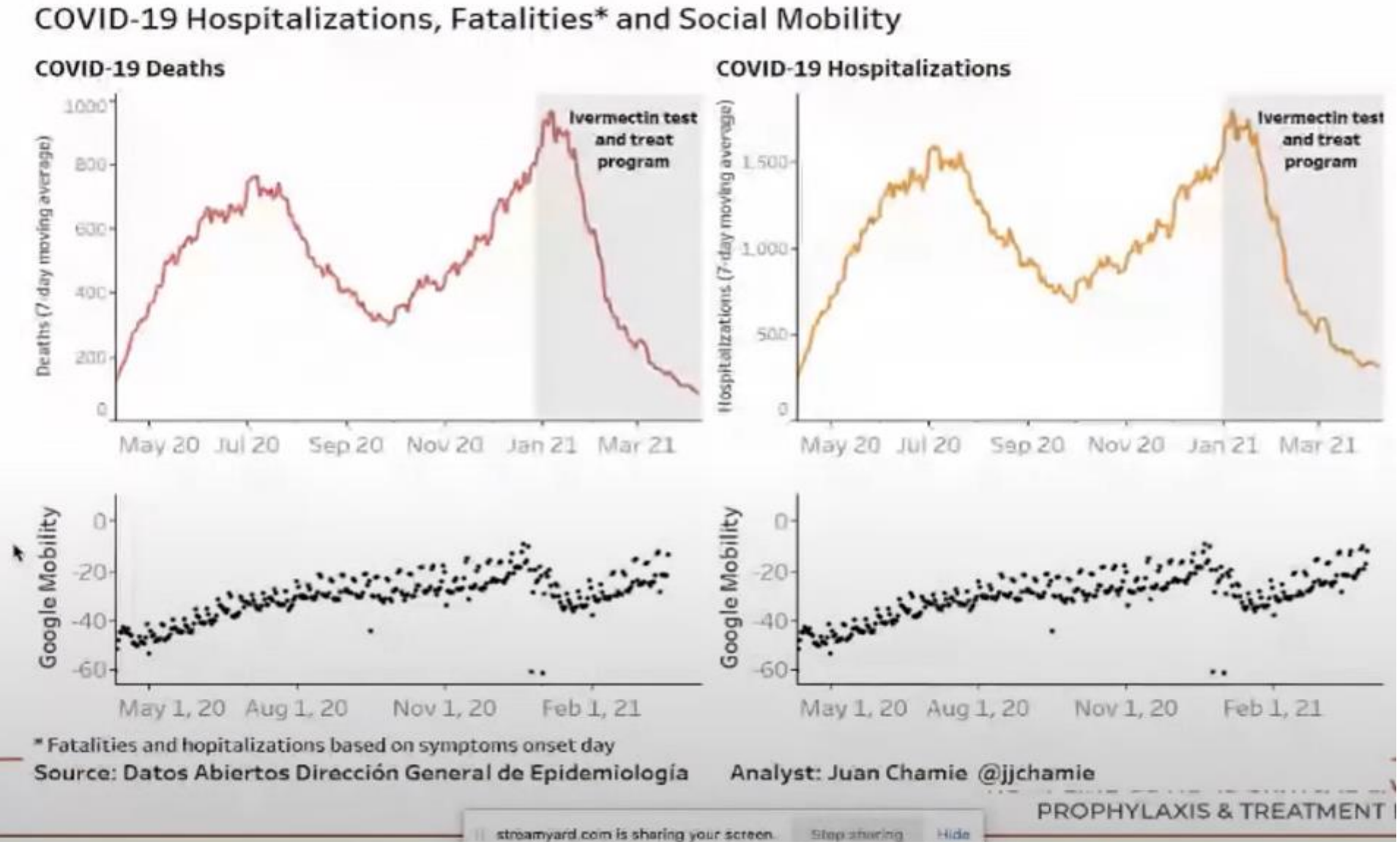
PMID: 34145166 PMCID: PMC8248252 DOI: 10.1097/MJT.0000000000001402

Free PMC article

Abstract

Background: Repurposed medicines may have a role against the SARS-CoV-2 virus. The antiparasitic ivermectin, with antiviral and anti-inflammatory properties, has now been tested in numerous clinical

MEXICO



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PROPHYLAXIS & TREATMENT

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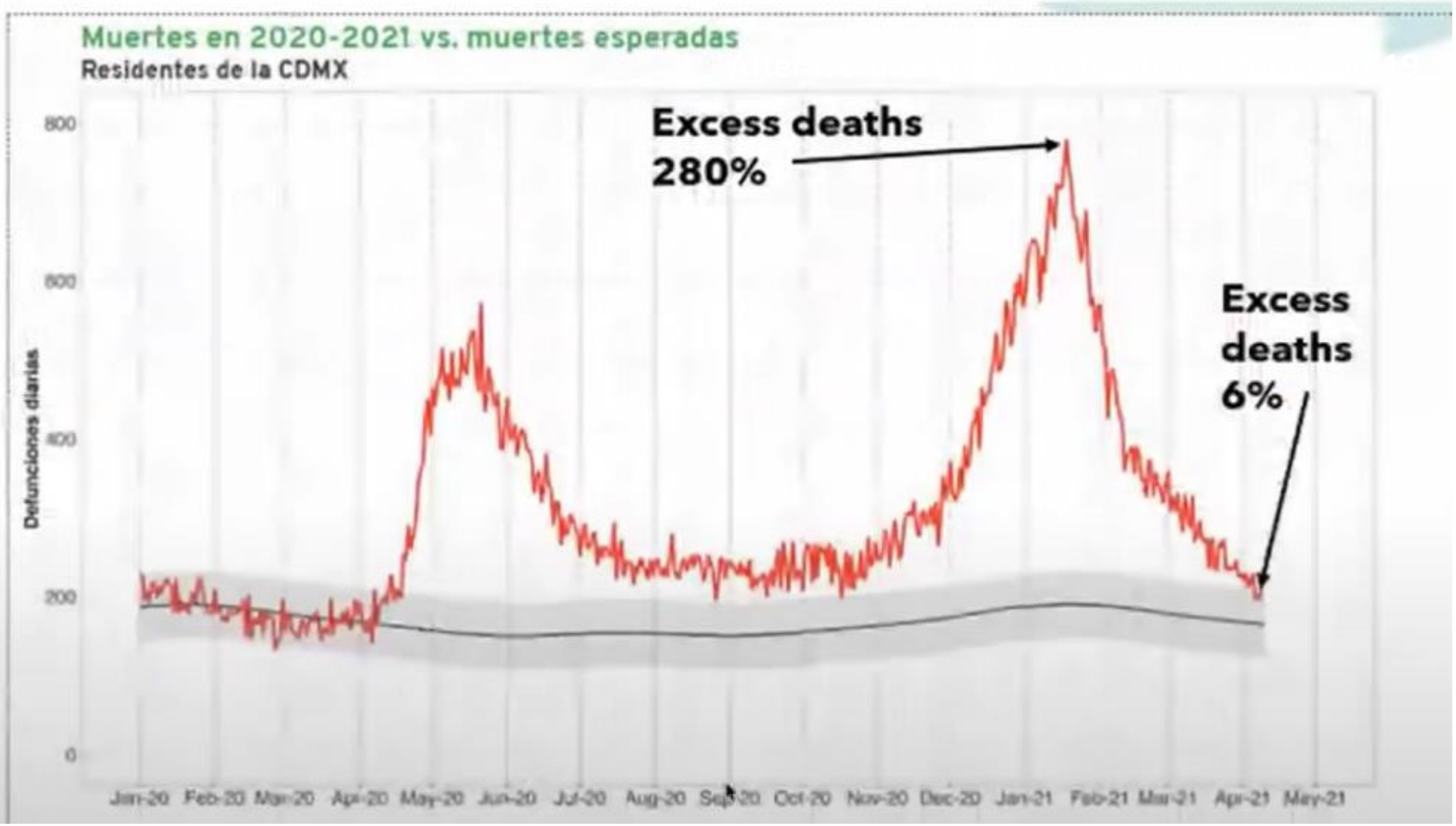

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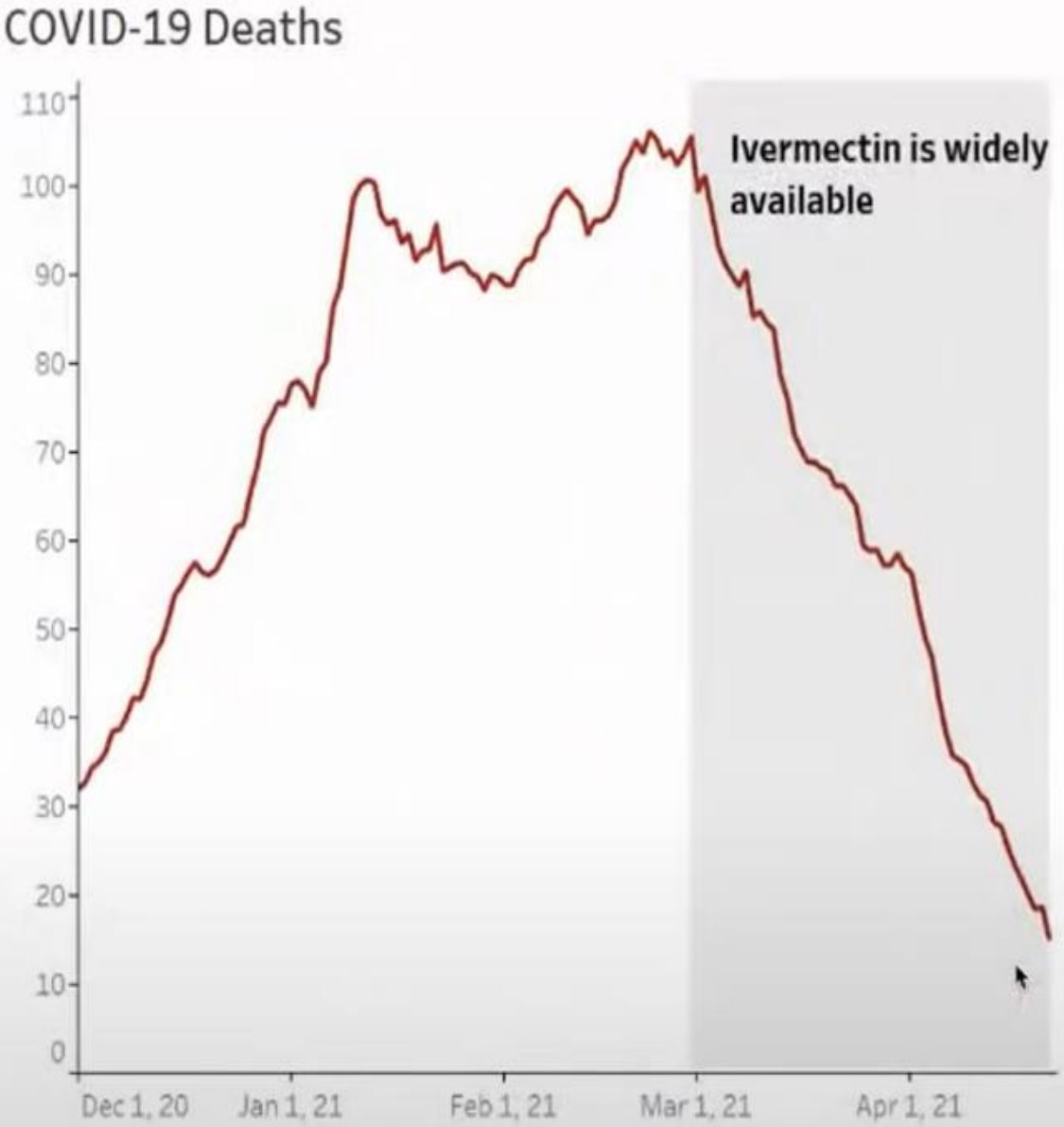

Analyst: Juan Chamie @jjchamie
Source: Inštitút Zdravotných Analýz Slovakia

Rate of Infection per 100 000 Calculation:

1. Population of Ontario: 14,789,778
2. Total Fully Vaccinated in Ontario Jan 1st: 11,469,856
3. Partially Vaccinated in Ontario Jan 1st : 812,651
4. Total Unvaccinated in Ontario Jan 1st (#1 -#2 -#3): 2,507,271
5. Total Cases Fully Vaccinated Jan 1st: 14,703
6. Total Cases Unvaccinated Jan 1st: 2,679
7. Rate of Infection Fully Vaccinated:
   - 14,703/11,469,856 x 100 000 = **128.19**
8. Rate of Infection Unvaccinated:
   - 2,679/2,507,271 x 100 000 = **106.85**

Rate of Infection per 100 000 Calculation:

1. Population of Ontario: 14,789,778
2. Total Fully Vaccinated in Ontario Dec 31st: 11,410,550
3. Partially Vaccinated in Ontario Dec 31st : 798,186
4. Total Unvaccinated in Ontario Dec 31st (#1 -#2 -#3): 2,581,042
5. Total Cases Fully Vaccinated Dec 31st: 13,436
6. Total Cases Unvaccinated Dec 31st: 2,278
7. Rate of Infection Fully Vaccinated:
   - 13,436/11,410,550 x 100 000 = **117.75**
8. Rate of Infection Unvaccinated:
   - 2,278/2,581,042 x 100 000 = **88.26**

Covid Hospitalization Process In Ontario

- **Hospitalizations of Covid Patients**
  - Patient arrives at the hospital for any condition (broken bone, illness of any sort)
  - Patient is tested for Covid and is positive (symptomatic or asymptomatic)
  - Province-wide data adds this patient to the count of Covid Hospitalizations.
    - Patient may enter ICU for any reason (comorbidities)
    - Patient is added to the Covid Positive ICU data
- **Single Dose vaccinated person arrives at the hospital < 14 days of 1st dose**
  - The person is listed as unvaccinated
  - Testing Positive for Covid (because they just had the vaccine)
  - Patient is listed as **Covid Positive – Unvaccinated**
  - Patient is added to the provide-wide hospitalization data
  - There is no data in hospital chart for *"Vaccine Adverse Event"*
- **Double Dose vaccinated person arrives at the hospital < 14 days of 2nd dose**
  - Patient arrived at the hospital based on a vaccine adverse event
  - The person is listed as **unvaccinated** in most Ontario hospitals as it is less 14 days of the 2nd dose
    - Only a subset of hospitals list the patient as partially vaccinated
    - This is one reason the partially vaccinated cases are low in the counts
  - Testing Positive for Covid (because they just had the vaccine)
  - Patient is listed as **Covid Positive – Unvaccinated**
  - Patient is added to the provide-wide hospitalization data

- *Ontario Emergency Doctors/Nurses have explained this process.*

- ***You cannot understand what you do not look for:***
- ***At Ontario Hospitals, charts and data on Vaccine Adverse Events have not been collected for the majority of the pandemic***
- ***Ask an ER doctor***
- *Doctor Kilian: ER Doctor Owen Sound*

- *Call your local Hospital and verify the data collection process.*

Rate of Infection per 100 000 Calculation:

1. Population of Ontario: 14,789,778
2. Total Fully Vaccinated in Ontario Dec 29th: 11,400,095
3. Partially Vaccinated in Ontario Dec 29th : 786,307
4. Total Unvaccinated in Ontario Dec 29th (#1 -#2 -#3): 2,603,376
5. Total Cases Fully Vaccinated Dec 29th: 8221
6. Total Cases Unvaccinated Dec 29th: 1514
7. Rate of Infection Fully Vaccinated:
   - 8221/11,400,095 x 100 000 = **72.11**
8. Rate of Infection Unvaccinated:
   - 1514/2,603,376 x 100 000 = **58.16**

Rate of Infection per 100 000 Calculation:

1. Population of Ontario: 14,789,778
2. Total Fully Vaccinated in Ontario Dec 24th: **11,383,811**
3. Partially Vaccinated in Ontario Dec 24th : 776,678
4. Total Unvaccinated in Ontario Dec 24th (#1 -#2 -#3): 2,629,289
5. Total Cases Fully Vaccinated Dec 24th: 7425
6. Total Cases Unvaccinated Dec 24th: 1536
7. Rate of Infection Fully Vaccinated:
   - 7425/11383811 x 100 000 = **65.22**
8. Rate of Infection Unvaccinated:
   - 1536/2629289 x100 000 = **58.42**

Rate of Infection per 100 000 Calculation:

1. Population of Ontario: 14,789,778
2. Total Fully Vaccinated in Ontario Dec 22nd: 11,373,519
3. Partially Vaccinated in Ontario Dec 22nd : 761,473
4. Total Unvaccinated in Ontario Dec 22nd (#1 -#2 -#3): 2,654,786
5. Total Cases Fully Vaccinated Dec 22nd: 3243
6. Total Cases Unvaccinated Dec 22nd: 746
7. Rate of Infection Fully Vaccinated:
   - 3243/11373519 x 100 000 = **28.51**
8. Rate of Infection Unvaccinated:
   - 746/2654786 x100 000 = **28.10**