November 10, 2021

Dear parents,

I am a Canadian pediatrician who is deeply concerned about the forthcoming approval of the COVID-19 shot for 5-11 year olds. I have no political agenda. However, in full disclosure, I do place my own children and all the children I care for ahead of the pharmaceutical industry and ahead of our governments' interests. I believe in public health measures aimed at reducing the burden of COVID-19 on our health care system and on the population at large, but I am strongly opposed to the approval of these mRNA vaccines in children for 5 principal reasons:

1- The mRNA vaccines are NOT as effective as we have been told, often falling below 50% effectiveness
2- The mRNA vaccines have evolving safety data, much of which has come out after many have already received their shots, and there is no long-term safety data which is obviously most important when dealing with children
3- The pediatric population, in general, clearly and consistently do NOT suffer significant disease from COVID-19
4- Children are only minimally responsible for community transmission when compared with adults
5- Children acquiring natural immunity protects them best against COVID-19 now and against future variants

We have heard the general population be told that this shot is “safe and effective” throughout the pandemic. This is more of a marketing slogan and less of a public health message based in science. I will show below that these mRNA vaccines are neither as safe, nor as effective, as what we are all being led to believe. We have heard our teenagers be told that they require this shot to participate in society, to play the sports they love, to learn in many post-secondary institutions, to go to restaurants or concerts or museums or professional sports games, etc., etc. The list of their restrictions is obviously too long to itemize. Many adults and parents, and most recently teenagers, have already had their shots for a multitude of reasons:

- because of the fear instilled in them at the outset of the pandemic
- because they thought they were doing the right thing in protecting themselves or their loved ones
- because they were threatened with losing their job and thus, their ability to earn a living and provide for their families
- because they were threatened with being excluded from many aspects of society
- because they were told that the vaccine was a way back to society as we knew it pre-COVID-19

I am certainly not opposed to those who understand the risks and benefits and decide to get the vaccine for themselves. I fully endorse the freedom to choose. In some instances, the

benefits of these vaccines outweigh the risks, especially in the elderly and in those who are obese or have other comorbidities. Some have simply decided to get the shot because they want it. That is also completely fine and should be each individual's personal decision.

Getting back to the society we knew pre-COVID-19

I will start by stating the obvious: the COVID-19 mRNA vaccines are not getting us back to the society we once knew. If anything, these shots are bringing us back to some of the worst times from the last century, those of discrimination and hatred of a society's subgroup (the unvaccinated) and those of taking away our freedom to choose. These vaccines and the policies surrounding them are violating many of our most preciously held ethos, specifically **Informed Consent**, which previously ***was*** so sacred to us all. And it was precisely this issue of Informed Consent that was terrifyingly disregarded in Germany from the 1920's through the Nazi regime that the globally recognized Nuremberg Code was written. The very first words of that Code are: **THE VOLUNTARY CONSENT OF THE HUMAN SUBJECT IS ABSOLUTELY ESSENTIAL.**[1] That Code is currently being completely disregarded again, and the significance of this cannot be overstated. One can make the argument that these shots are not mandatory and consent is still voluntary, but once someone's ability to earn a living is threatened, or once someone is removed from participating in society, any voluntary aspect from this consent has been removed. It then becomes, by definition, coercion.

Furthermore, the notion that the unvaccinated are dirty, selfish, ignorant, or conspiracy theorists has been perpetuated by many of our respected governments for the purpose of further dividing our society and promoting hate, all for the purpose of getting more vaccines into people. President Biden referred to this as the "pandemic of the unvaccinated"[2] and many other world leaders have similarly expressed contempt or outright disdain for the unvaccinated, despite science not supporting any of those claims. The society of inclusion and equality that we have fought so hard to achieve is being eroded and we are all witnesses to another group being marginalized: this time, those who have made the educated decision to not be vaccinated for COVID-19.

If we look at this from the most basic perspective, why are those who are vaccinated with this "safe and effective" vaccine worried about the risk that the unvaccinated pose? There are two main reasons. First, it is because they are listening to the message being delivered by the media and governments that the unvaccinated are dangerous, and that they are to blame for society not getting back to the pre-pandemic ways, and thus, they should be marginalized. Secondly, and no less important or relevant is that many are starting to realize that these vaccines are not so effective after all.

Effectiveness

We were told repeatedly as the vaccines were going through trials and being approved, that both mRNA vaccines had 95% efficacy. These were studies straight from the pharmaceutical companies themselves, who obviously stood to profit a tremendous amount

from an efficacious vaccine. We have seen this happen. In May 2021, Pfizer announced that global sales of its mRNA vaccine eclipsed **$26 billion**[3], and in July, raised its 2021 sales forecast of the vaccine to **$33.5 billion**[4]. Moderna, interestingly, had never made a profit before 2021, and in the first quarter of 2021, had mRNA vaccine sales of **$1.7 billion**[5], with expected 2021 revenue from its vaccine to be at least **$20 billion**[6]. Clearly, we need to be aware of the conflict of interest that their own studies demonstrate, and at the very least, remain skeptical until there is independently peer-reviewed data that is **NOT** done by scientists who receive funding from these very companies.

All of us were excited about this return to normalcy that was promised to us with the roll-out of these vaccines. But we should all be aware of the inherent bias of Pfizer's and Moderna's own studies, especially as their financial interests were inarguably linked to the success of the mRNA vaccines. When we look at real-world effectiveness, the efficacy of the vaccines is much less than the 95% that was claimed by both pharmaceutical companies. In Israel, between June 20 and July 7, 2021, the Pfizer vaccine was found to be 39% effective at preventing any infection, and 40.5% against symptomatic infection.[7] When broken down by month of 2nd dose, it becomes even more shocking: for those fully vaccinated in January 2021, the vaccine was only 16% effective at preventing any infection and also 16% effective against symptomatic infection: **16%!!!**[7]

In Qatar, the effectiveness of the Pfizer vaccine against the Delta variant specifically, as demonstrated at >14 days after the 2nd dose, thus fully vaccinated, was only 53.5% in a study population of 877,000. [8]

A U.S. nursing home study found Pfizer to be only 52.2% effective among its 3.2 million residents, and Moderna 48.4% effective among its 1.8 million residents, when reviewing vaccine effectiveness against the Delta variant from August 2021.[9]

A large Mayo clinic study also demonstrated waning effectiveness from both mRNA vaccines. With over 25,000 vaccinated patients, Pfizer went from 76% effectiveness in January 2021 to 42% effectiveness in July. Similarly, Moderna went from 86% to 76% effective over the same time period.[10]

Recently, a study of 620,000 U.S. Veterans investigated effectiveness from 1 month after their second shot (mid-March 2021), thus fully vaccinated, and compared this to 7 months later. Over this time period, Janssen effectiveness went from 86.4% to 13.1%, Moderna from 89.2% to 58%, and Pfizer from 86.9% to 43.3%.[11]

The Lancet published a study looking into Pfizer's effectiveness among over 3.4 million Southern California residents from December 2020 to August 2021. As expected, effectiveness was high during the first month, at 88%, but only 47% after 5 months.[12] When the authors looked at effectiveness against Delta specifically, the same pattern emerged, with 93% effectiveness during the first month but only 53% after 4 months. [12] It is important to note that ***this study showing waning effectiveness was funded by Pfizer itself,*** and concluded that

although the effectiveness waned over time, these findings "suggest that booster doses might eventually be needed to restore high levels of protection". [12] It cannot be overlooked that vaccine effectiveness has dropped to 50% at best, and far below 50% at worst. As a result, the emergency approval of these vaccines based on their 95% efficacy must be re-evaluated and it could be argued, rescinded entirely. At the very least, we should not be seeing new mandates for populations like teenagers and potentially the 5-11 year old group next. Nevertheless, the pharmaceutical companies are not disturbed by evidence of their product's ineffectiveness. They rather see this as an opportunity to increase their sales and profits, and are now actively funding studies to fully demonstrate their ineffectiveness in order to promote the need for booster doses.

Lastly, there is an excellent article in the *European Journal of Epidemiology* investigating the relationship between the percentage of the population fully vaccinated and new COVID-19 cases across 68 countries and 2947 U.S. counties. This data, and the summary graph in particular, is quite striking in that we would presume, based on all that we are told from media and government, that the most highly vaccinated countries and U.S. counties would have the fewest new COVID-19 cases, but that is **NOT** the case. In fact, there is a marginally positive association showing that countries with highest vaccination rates actually had more new COVID-19 cases. Notably, Israel, with >60% of their population fully vaccinated, had the most new COVID-19 cases in the last 7 days.[13] Additionally, Portugal and Iceland, with over 75% of their population fully vaccinated, have more new COVID-19 cases than Vietnam and South Africa, where only around 10% of their population are fully vaccinated.[13] Interestingly, even within U.S. county data, this phenomenon is seen. Of the top 5 counties with the highest percentage of population fully vaccinated, the CDC lists 4 of them as "High" transmission counties whereas over 50 of the "Low" transmission counties have less than 20% of their population fully vaccinated.[13]

Outbreaks

Outbreaks among largely fully vaccinated populations also help us understand the effectiveness, or lack thereof, of these mRNA vaccines. In Provincetown, Massachusetts, there were 1,098 known outbreak cases of COVID-19 after the July 4th weekend. The county encompassing Provincetown has a 68% full vaccination rate,[14] and yet, 74% of cases were in fully vaccinated individuals, of whom 79% were symptomatic.[15] Most importantly, when genetic sequencing was performed, it was found that 84% of the transmission came from fully vaccinated individuals.[15]

In May 2021, there was an outbreak from an index patient with COVID-19 causing infection among healthcare workers in Finland. Only 3% of those who acquired COVID-19 from this index patient were unvaccinated, whereas 83% of them were fully vaccinated and that percentage goes up to 90% when including those with previous infection who had 1 dose of vaccine after their infection.[16]

In July 2021, a fully vaccinated patient was the index case of another COVID-19 outbreak. This patient's symptoms were mistaken for a potential bloodstream infection given their full vaccination status, demonstrating the concern of being falsely reassured with fully vaccinated status. In this instance, the attack rate among all exposed patients and staff was 10.6% for staff and 23.7% for other patients, in a population with a 96.2% full vaccination rate.[17]

In July 2021, there was a COVID-19 outbreak in a federal prison in Texas where 74% of the prisoners were infected (172 of 233). In this instance, there was significant transmission among those who were fully vaccinated with an attack rate of 70% (129 out of 185).[18]

The FDA requires a minimum of 50% efficacy for a vaccine to be approved.[19] I have shown that they are not the effective vaccines we were promised. Most of us already knew this. But are they safe?

Safety

They are certainly not as safe as we were initially led to believe. We were told all the vaccines were **safe** and **effective** at the outset. Then, in May, after many had received the Astra-Zeneca shot, it was discovered that there was a significant clotting risk so it was no longer used. Similarly, we were told that both Pfizer and Moderna mRNA vaccines were safe and effective. As time went on, we were told that those 12 years and over needed them to participate in society. But it was only after these mandates, and vaccination of so many Canadian teenagers, that studies started coming out demonstrating the clear risk of myocarditis. The lack of knowledge of adverse events can be attributed to the study designs that were entirely up to each pharmaceutical company. A critical mind would see that it clearly serves the pharmaceutical companies' own interests, and certainly their bottom line, to design studies that are purposefully undersized so as to limit the observation and identification of possible adverse effects.

The COVID-19 vaccine Phase 3 trials for adolescents were quite small with a short duration of follow-up regarding safety. For Pfizer, less than 1,200 received the vaccine, the follow-up was for 7 days after each dose, after which any adverse events were recorded only if the participants reported them without any prompting at 1 and 6 months post-dose, and it was, of course, funded by Biotech.[20] For Moderna, less than 2,500 patients received the vaccine, the follow-up was again for 7 days after each shot, adverse events were recorded only if the participants reported them without any prompting up to 28 days after each shot, and again was funded by Moderna itself.[21] For the 5-11 year old group specifically, the Phase 2/3 study only had 1,518 vaccine and 750 placebo recipients before the FDA required another 1,591 vaccine recipients for more robust safety assessment, but that is still only 3,109 children and there were no severe COVID-19 cases.[22] The effectiveness against mild disease is much less relevant than the high efficacy percentage suggests as we should be most concerned with severe outcomes like hospitalizations, not asymptomatic or mild infection prevention. As for the safety

data, the first cohort were followed for 2 months, but only 2.4 weeks for the 2nd cohort, and 4.9% of the study population was lost to follow-up.[22]

A study from Ontario showed the myocarditis risk in young men aged 18-24 years to be 1 in 5,000 for Moderna and 1 in 28,000 in Pfizer.[23,24] U.K. data in 12-15 year olds with no underlying health condition show myocarditis risk to be 0.3-1.7 per 100,000 after the first Pfizer dose and another 1.2-3.4 per 100,000 after the second Pfizer dose.[25] I will elaborate on myocarditis data in its own section below.

Please note that the risk of death for the pediatric population dying ***with*** COVID-19, ***not even because of*** COVID-19, is **1.33 per 10 million per week**, as I will show below. The risk of hospitalization in the pediatric population is **1.1 per 100,000 per week**. If you see nothing else from this letter, please compare those numbers: the risk of serious disease from COVID-19 in kids compared to their risk of adverse effects from the vaccines. And please weigh that balance in your own children.

Myocarditis Data

I have gathered as much data on myocarditis post-vaccine as possible. But it would be very important to remember that this is not the only adverse effect from the vaccine, it is simply one of many, and the most discussed at present. As you will see below, there is a significant risk of myocarditis post-vaccine and this risk varies with age and gender.

In a large Israeli study of over 5 million residents, the incidence of myocarditis in 16-19 year-olds, within 21 days after the second vaccine dose occurred in approximately 1 of 6,637 male recipients and in 1 of 99,853 female recipients.[26] For the overall population studied (ages 16 to >50 years), it was estimated that the rate of post-vaccine myocarditis is approximately 1 per 26,000 males and 1 per 218,000 females after the second vaccine dose, with the highest risk again among young male recipients.[26] Of note, the Phase 3 vaccine trials only included 15,000 people of all ages, and this is why it failed to show any cases of myocarditis.[27]

Another large Israeli study examining over 2.4 million fully vaccinated individuals looked at the incidence of myocarditis after the first dose of vaccine, which will substantially underestimate the true incidence considering it has been well established that the incidence of myocarditis is higher with the second dose.[26] Nevertheless, they still found the incidence of myocarditis to be 2.13 per 100,000 after the first dose of Pfizer and when broken down further, the incidence among male patients was 4.12 (1 in 24,272) and female patients 0.23 per 100,000 (1 in 434,783).[28] Among those between 16-19 years, the incidence is 5.49 per 100,000 (1 in 18,215), while the highest incidence observed was among male patients between the ages of 16 and 29 years at 10.69 per 100,000 (1 in 9,355).[28]

On August 23rd, the FDA released a Pfizer-BioNTech vaccine report which outlines an "excess risk of myocarditis approaching 200 cases/million" or 1 in 5,000 in 16–17 year old boys.[29]

Hoeg et al found the rates of cardiac adverse event to be 1 in 6,172 (162/million) for 12-15 year old boys and 1 in 10,638 (94/million) for 16-17 year old boys post-2nd Pfizer dose.[30] Of note, the authors concluded that based on current hospitalization rates **for teenage boys, this population has a greater than 4-fold increased risk of vaccine-associated myocarditis (162 per million) than hospitalization from COVID-19 (44 per million)**.[30]

The American Heart Association has described the incidence of post-vaccine myocarditis in the 12-17 year old group as 1 in 14,492-17,857 (56-69 per million) for males and between 1 in 100,000-125,000 (8-10 per million) for females.[31]

Even more concerning is the fact that while it is repeatedly described as ***mild***, 86% of these myocarditis cases required hospitalization.[30] The CDC reported a 94-96% hospitalization rate for VAERS-identified myocarditis.[32-33] Furthermore, historical mortality rates for pediatric myocarditis (prior to COVID-19) are not insignificant: 9%,[34] 15%,[35] 17%,[36] 20%,[37] and 25%[38].

Even if it is mild in presentation, and does not warrant ICU admission, vaccine-induced myocarditis can have a grave impact on competitive sports. The American College of Cardiology suggests that return to competitive sport can occur only after all lab and ECG changes have normalized AND an exercise ECG is performed 3-6 months after the initial acute event.[39] That is an eternity to not play competitive sports for a teenager and can lead to a multitude of mental health issues.

Myocarditis from COVID-19 infection does occur. This incidence was found to be 1 in 9,090 in Israel (11.0 events per 100,000 persons).[40] A large U.S. study found the risk of myocarditis from COVID-19 infection to be higher at 1 in 1,141 (6 in 6,846) in males 12-17 years and 1 in 2,453 (3 in 7,361) females of the same age group.[41]

The Canadian Pediatric Society has a position statement on the COVID-19 Vaccine for Children and within their statement, they explain that the risk of myocarditis from the virus is 450 per million, or 1 in 2,200.[42] The CDC describes the incidence of myocarditis post-COVID-19 to be 150 per 100,000 or 1 in 667 overall, and specifically 1 in 752 for <16 year olds and 1 in 1,020 for 16-24 year olds.[43]

At first glance, it certainly appears that the risk of COVID-19 infection induced myocarditis is higher than that of vaccine-induced myocarditis. However, we need to be careful when comparing the two. The vaccine-induced myocarditis risk is based on you getting the vaccine, so that once someone has received the vaccine, their risk is outlined by the above studies depending on your age and gender. In contrast, the infection-induced myocarditis requires that you acquire COVID-19, so the risk of acquiring COVID-19 must be taken into account before considering the risk of COVID-19 infection induced myocarditis. The risk of acquiring COVID-19 is obviously difficult to ascertain as it is so variable depending on a multitude of factors, including whether a person has already had COVID-19 infection, the current transmission and incidence within the community, individual behaviours, and so on.

To put all these numbers in perspective, the historical annual incidence of myocarditis from other causes in children and adolescents in the United States is estimated to be 1-2 per 100,000 pre-COVID-19.[44]

Suspension of vaccines in other countries

Based on the risk these vaccines pose, especially to the pediatric population, many countries have reviewed their stance on vaccinating with specific vaccines, or on vaccinating teenagers. On September 3, 2021 England suspended administration for 12-15 year olds, explaining: "The available data indicate that the clinical manifestations of myocarditis following vaccination are typically self-limiting and resolves within a short time. However, the clinical picture is atypical and the medium to long-term (months to years) prognosis, including the possibility of persistence of tissue damage resulting from inflammation, is **currently uncertain as sufficient follow-up time has not yet occurred**."[25] They went further to describe that "overall, the committee is of the opinion that the benefits from vaccination are ***marginally*** greater than the potential known harms (tables 1 to 4) but acknowledges that there is considerable **uncertainty** regarding the magnitude of the potential harms. The margin of benefit, based primarily on a health perspective, is considered too small to support advice on a universal programme of vaccination of otherwise healthy 12 to 15-year-old children at this time. As longer-term data on potential adverse reactions accrue, greater certainty may allow for a reconsideration of the benefits and harms. Such data may not be available for several months."[25]

On Sept 29, Slovenia suspended the Janssen COVID-19 vaccine following the unexplained death of a 20 year old woman.[45] On Oct 6, Sweden announced that they were no longer giving Moderna to anyone under 30.[46] The same day, Norway announced the same suspension of Moderna in the under 18 group, as well as males under 30.[47] The next day, Oct 7, Finland did the same, suspending Moderna for males under 30 years old.[48] Going even further, on Oct 8, Iceland stopped using Moderna vaccines altogether.[49] They all did so while citing the risk of myocarditis and pericarditis. Furthermore, on Nov 8, the High Authority of France advised against the use of Moderna in anyone under 30 years, citing myocarditis risk as 1 in 7,599 (131.6 per million) for Moderna and 1 in 37,453 (26.7 per million) for Pfizer, regardless of gender.[50]

These are not totalitarian regimes unconcerned with their population's well-being. They are universally regarded as some of the most people-centered countries in the world with respect to social determinants of health. They are less concerned with pharmaceutical companies profits and more concerned about their people, especially their children. We could certainly take a lesson from these countries that were very similar to Canada in many respects, before the pandemic. And yet, at the same time as there is pause for concerns due to safety, many parts of Canada push harder and marginalize more groups who are unvaccinated, preventing them from participating in many aspects of society.

What about receiving the vaccine after already having had COVID-19 infection?

The last safety issue to be discussed relates to receiving the vaccine after already having had COVID-19 infection. A U.K. study found an 8% increase in any side effect and a 56% increased risk of experiencing a severe side effect requiring hospitalization, when looking at recipients of a first dose of the vaccine who had previous COVID-19 infection compared to those who were COVID-19 infection naïve.[51] A similar study in the U.K. found that systemic side effects were nearly 3 times more common in the previously infected group who received the vaccine compared to vaccine receivers who never had COVID-19.[52] A study of healthcare workers in Italy also demonstrated a 3-fold higher risk of moderate to severe systemic side effects from the first dose of the vaccine if they had previously had COVID-19 infection.[53] Another U.K. study demonstrated similar findings with the previously COVID-19 + patients having 2.2-fold higher risk of having at least one moderate symptom while also being more likely to have a higher symptom number and more severe symptoms.[54]

Pediatric Data for New Cases Rates, Hospitalization, and Mortality

The American Academy of Pediatrics has prepared a joint report from the AAP and the Children's Hospital Association from publicly reported data from 49 states and New York City (NYC). This detailed report is the most comprehensive pediatric data collection that I could identify, and from a trusted and reputable source. The most recent version has data up to the week ending Oct 28, 2021.

Over the last week, there were 133.7 per 100,000 new pediatric COVID-19 cases in children throughout the U.S.[55] It is important to note that case rates have been decreasing every week for 8 consecutive weeks. The hospitalization rate among pediatric patients is currently 0.8% for children and has been decreasing consistently since the pandemic began: it was 3.8% back in May/20, declined rapidly to 2.4% in July/20 and has been declining ever since, 2.1% in Aug/20, 1.6% in Oct/20, 1.2% in Nov/20 and steadily 0.8-0.9% since Dec/20.[55] At the current hospitalization rate of 0.8%, that means that there are:

1.1 new hospitalizations per 100,000 children ***with*** COVID-19, not necessarily ***from*** COVID-19 in 1 week

The CDC has previously shown that from Jan-March 2021, only 54% of COVID-19 positive cases were considered COVID-**related**.[56] Other studies have shown that 39-40% of hospitalized patients ***with*** COVID-19, were asymptomatic, demonstrating that their admission was unrelated to COVID-19, but rather incidentally found.[57,58] So the actual number of COVID-19-**related** hospitalization from the above numbers is closer to **0.6 per 100,000**, just last week!

Interestingly, the CDC cumulative hospitalization rates (and average weekly rates, with 28 weeks in a reporting season) for influenza are:[59]
- 41.8 per 100,000 for the 2019-2020 season (1.5 per 100,000 average weekly rate)
- 33.8 per 100,000 for the 2018-2019 season (1.2 per 100,000 average weekly rate)

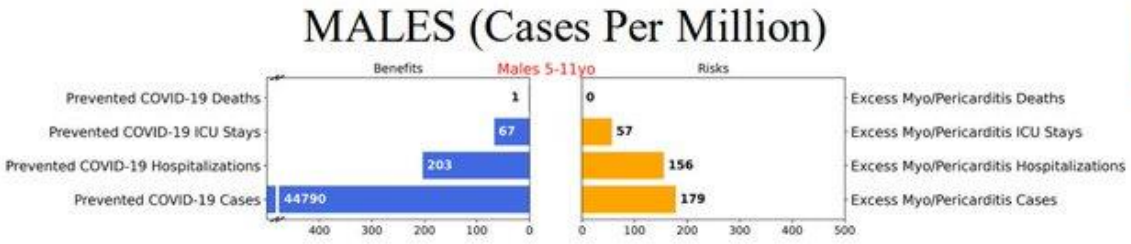
- 33.5 per 100,000 for the 2017-2018 season (1.2 per 100,000 average weekly rate)

*** Remember that this 3-year average of 1.3 per 100,000 is greater than the current hospitalization rate of patients who are COVID-19-positive and more than twice as much as the estimated hospitalization rate that is **from** COVID-19, not just **with** COVID-19***

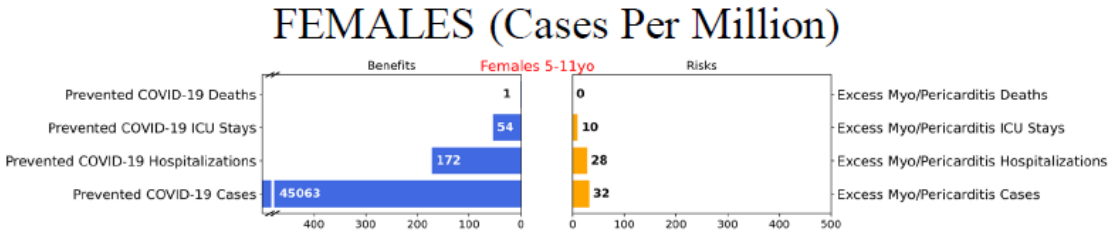
The most important statistic within this paper is in regards to mortality, and this rate is **1.33 deaths per 10,000,000 (i.e. 10 million!)** children per week (new cases at 133.7 per 100,000 x current mortality of 0.01%). This mortality data includes 45 States + NYC.[55] This is not a small sample size. Critically, U.K. data demonstrates that only 41% of deaths ***with*** COVID-19 are actually ***due*** to COVID-19 while the majority, at 59%, had COVID-19 positivity but that COVID-19 ***DID NOT*** contribute to death.[60]

When the FDA examined the risks and benefits of vaccinating 5-11 year olds using vaccine efficacy data from Pfizer itself,[61] with high COVID-19 incidence from mid-September 2021 and using myocarditis data without even considering other adverse events, there were a few interesting findings:

In males 5-11 years old, the vaccine would prevent 67 ICU stays and 203 hospitalizations per million compared to the 57 ICU stays and 156 hospitalizations per million that would be caused by vaccine-induced myocarditis.[62]

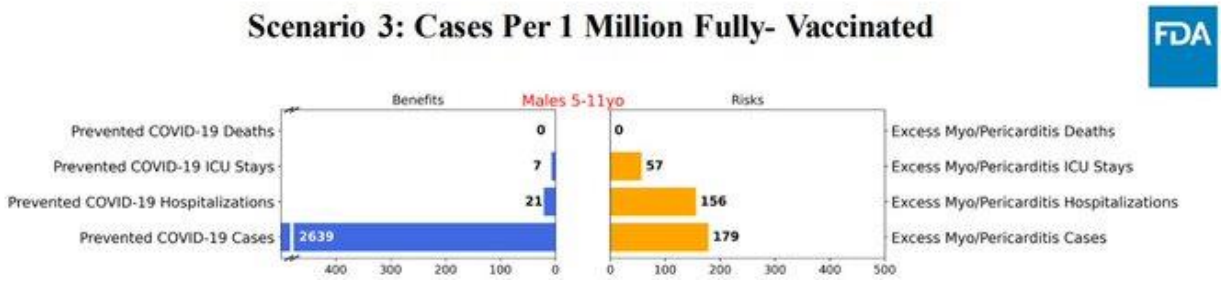


In females 5-11 years old, the difference is greater owing to the lower risk of myocarditis: the vaccine would prevent 54 ICU stays and 172 hospitalizations per million compared to the 10 ICU stays and 28 hospitalizations per million that would be caused by vaccine-induced myocarditis.[62]



However, when a different scenario was examined, looking at the lowest COVID-19 incidence, the results were startling.

In males 5-11 years old, the vaccine would prevent 7 ICU stays and 21 hospitalizations per million compared to the 57 ICU stays and 156 hospitalizations per million that would be caused by vaccine-induced myocarditis.[62]



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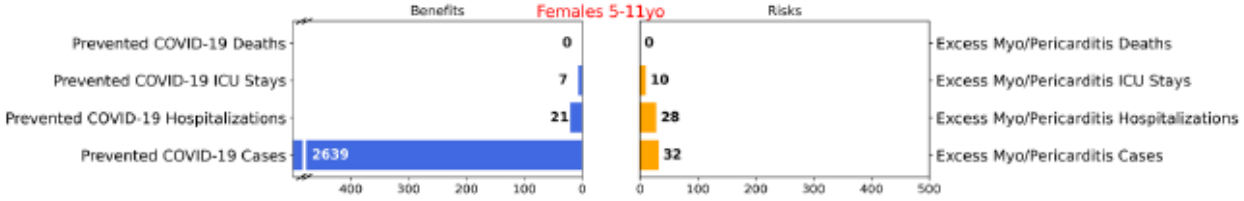

In times of higher incidence like mid-September, the benefit of a vaccine for girls 5-11 years old seems to outweigh the risk of myocarditis, but there are clearly other potential risks involved. However, for boys, in periods of higher incidence, the risks and benefits are very close, and at times of low COVID-19 incidence, the solitary risk of myocarditis clearly and drastically outweighs the benefit from the vaccine in both boys and girls. And this is from the FDA's own data on myocarditis. It has been consistently shown that vaccine adverse effects are shockingly underreported, as low as 1% of true adverse events.[63]

Comorbidities

Comorbidities also play a significant role within COVID-19 data. U.S. data demonstrates that 70.6% of adolescents who were hospitalized had $\geq$ 1 comorbidity.[56] Similarly, a U.K. study found that 53.9% of COVID-19 positive admissions had $\geq$ 1 comorbidity, and even more striking, 91% of ICU admissions had $\geq$ 1 comorbidity.[64] In the U.K., the incidence of ICU admissions ***with*** COVID-19 for healthy pediatric patients is 2 per million compared to 100 per million in those with $\geq$ 1 comorbidity.[64] Further examining the subsegment of comorbidities, one study found that the only single comorbidity to independently increase the risk of severe COVID-19 infection course was obesity,[65] whereas another found asthma, diabetes, epilepsy, and trisomy 21 to increase the risk of ICU admission and death.[64] Specifically, among 5-11 year olds, obesity, asthma, and diabetes were found to be risk factors for severe disease.[66]

Pediatric transmission

I have shown that the vaccines are not as safe, or as effective as we are being led to believe, and that the pediatric population very rarely experience severe disease from COVID-19. However, a very valid question is whether this population is driving transmission. Because if

they are AND the vaccines are shown to consistently reduce transmission, then that would alter the risk-benefit ratio.

No age correlation has been found with respect to viral load, indicating that infants through young adults can carry equally high levels of COVID-19 virus.[67,68] Furthermore, a larger study showed that nasopharyngeal viral loads are not statistically higher in younger age, demonstrating that Ct values were similar in the <5 year old age group when compared to the 5-17 year old group, or the adult groups.[69]

In Berlin, during a period of high infection prevalence, whereby 2.7% of the students studied were COVID-19 positive, the attack rate in households connected to positive cases was only 1.1% and even more importantly, no school-related infection of either students or staff was observed at re-testing, suggesting minimal to no in-school transmission with current infection prevention and control measures.[70] A similar study in the German state of Rhineland-Palatinate had a secondary attack rate of 1%.[71] The CDC showed that secondary attack rate from school contacts was only 0.7% and there were no school outbreaks in a population where the majority wore masks and the median distance between students was only 3 feet.[72] An Australian study similarly showed a secondary attack rate of only 0.5%.[73]

A large U.K. study showed that infection and outbreak rates were significantly higher in staff than in children and that staff-to-staff transmission was most common, whereas student-to-student transmission was rare.[74] The same was found in Australia where the secondary attack rate in schools was 4.7% during the period when Delta was most prevalent (up from 0.9% during previous variants) but again the most common transmission was from staff to staff.[75]

Another German study saw that only 3.3% of students who tested positive for COVID-19 had the school setting as their source of infection.[76]

Furthermore, children under 20 years old have been shown to acquire COVID-19 infection at nearly half the rate compared to adults after exposure.[77]

A case study of a child with a COVID-19 infection demonstrated that this child failed to transmit the virus to any other person, despite having visited 3 different schools and been in contact with over a hundred children.[78]

A meta-analysis examining the role of children in COVID-19 transmission demonstrated that only 3.8% of all transmission clusters had a pediatric index case compared to 96% of clusters having an adult index case.[79] Household contact studies from across the world illustrate the same thing: children are very rarely the index case driving transmission. Three Chinese studies show that household transmission is due to a child index case in only 4-5%.[80-82] Other Southeast Asian studies show the same thing, with a child index case in only 0.5-3% of household transmissions.[83-85] European and Canadian studies are also similar with 5-9% of all households having a pediatric index case.[86-89]

Transmission comparison between the Vaccinated and Unvaccinated

Although the pediatric population are clearly not driving community transmission as initially feared, and shown above, is it possible that vaccinating them could nevertheless reduce the infrequent transmission that does occur? Adult studies have compared transmission from vaccinated and unvaccinated groups.

There is no absolute single test that can determine transmissibility. However, Ct values have been universally used as there is inverse relationship to viral load, in that lower Ct values are associated with higher viral loads, and thus, greater likelihood of transmission. This is the best marker we have to estimate transmission.

In a large California study looking at 2 distinct populations when Delta was predominant, there was no statistically significant difference in mean Ct values of those fully vaccinated when compared to the unvaccinated. The UC Davis subgroup mean Ct values were 25.5 for the fully vaccinated and 25.4 for the unvaccinated, and in the Mission District of San Francisco subgroup, mean Ct values for the fully vaccinated was 23.1 compared to 23.4 for the unvaccinated.[90]

A large U.K. study examined Ct values in vaccinated vs unvaccinated after June 14, 2021 when Delta became predominant. Unvaccinated individuals had median Ct values of 25.7, while vaccinated individuals had median Ct values of 25.3.[91] The authors then went on to explain that viral load therefore now appears similar in infected vaccinated and unvaccinated individuals, with potential implications for onward transmission risk, given the strong association between peak Ct and infectivity.[92]

Another U.K. study examining healthcare workers (HCWs) showed that the highest viral loads (lowest Ct values) were found in unvaccinated and seronegative (no previous infection) HCWs at Ct=18.3, followed by vaccinated seronegative HCWs at Ct=19.7, and lastly that unvaccinated seropositive HCWs had the lowest viral loads with at Ct=27.2, demonstrating that previously infected patients have significantly less risk of transmitting COVID-19 than fully vaccinated patients.[92]

This is similar to what has been demonstrated in Massachusetts with median Ct values of 22.77 in those fully vaccinated compared to 21.54 in the unvaccinated, not meeting statistical significance.[15] Or in hospitalized patients in Singapore, with mean Ct values of 19.2 in fully vaccinated compared to 18.8 in the unvaccinated, again not statistically significant.[93]

A U.K. study showed similar secondary attack rates (25%) in household contacts exposed to fully vaccinated index cases as in those exposed to unvaccinated index cases (23%). This finding indicates that breakthrough infections in fully vaccinated people can efficiently transmit infection in the household setting.[94] These findings indicate continued risk of infection in household contacts despite full vaccination.[94]

Natural Immunity

According to the CDC's own data up until May 2021, it is estimated that 37% of all U.S. children have had a COVID-19 infection.[95,96] This data was taken 16 months into the pandemic so extrapolating for 6 months later, it is most likely that 51% (22/16 x 37%) of all U.S. children have now had COVID-19. Since half of all children are estimated to have had COVID-19 already, should we still be vaccinating them without consideration of natural immunity? How effective is this natural immunity?

The large U.K.-based *SIREN* study compared the Pfizer vaccine's effectiveness in protecting against any (symptomatic or asymptomatic) infection to be 70% after the first dose and 85% a week after the second dose,[97] whereas previous infection was 84% effective against any infection and 93% effective against symptomatic infection.[98]

In Qatar, it was found that the effectiveness of a previous natural infection at preventing re-infection was 95.2% at 7 months.[99]

In Israel, the level of protection from previous documented COVID-19 infection is 94·8% against re-infection, 94.1% against hospitalization, and 96.4% against severe illness, as tested from 3-9 months post-initial infection.[100]

In the U.S., the protective effectiveness of a previous infection was found to be 82% against any infection and 85% against symptomatic infection over a median of 4 months.[101]

In Israel, when comparing previously infected with vaccinated people and adjusting for comorbidities and matching for the timing of the first event (either infection or vaccine), there was a **13-fold** increased risk for any breakthrough (post-vaccine) infection as opposed to re-infection and **27-fold** increased risk for symptomatic breakthrough infection vs re-infection.[102] When comparing between the vaccinated and those who had previous infection and then received 1 dose of the vaccine, there was no significant difference in the risk of re-infection,[102] illustrating, at the very least, that the second dose of the vaccine after previous infection is unnecessary.

A study of U.S. Veterans found that during July and August, when Delta was prevalent, vaccination showed reduced protection in comparison to previous infection against breakthrough infection, although not statistically significant.[103]

A Cleveland study showed that not one of the 1,359 patients who previously had COVID-19 experienced reinfection over the 5 months studies.[104] A similar study among U.K. healthcare workers showed no re-infections over 5 months.[105] In Austria, only 0.27% of nearly 15,000 previously infected patients experienced re-infection up to 10 months.[106] In a Qatar study of 43,044 patients, the risk of re-infection was 0.1%. Also, 0.1% risk of re-infection over 10 months in Israel on nearly 150,000 studied.[107] In Denmark, the risk of re-infection was 0.005% over 3-6 months in over 1.3 million studied.[108]

Interestingly, in October 2020, CDC director Rochelle Walensky, among other authors, in their *Lancet* article, stated "there is no evidence for lasting protective immunity to SARS-CoV-2 following natural infection".[109] The NIH then demonstrated, just 2 months later, durable immune responses in the majority of people studied, whereby 98% of patients had antibodies against the SARS-CoV-2 spike protein at 1 month with levels that remained fairly stable over time, declining only modestly to a still robust 90% at 6 to 8 months after infection.[110,111]

When comparing IgG antibodies of those vaccinated to those who have experienced COVID-19 infection, the vaccinated group have higher initial antibody titers immediately after vaccination but the titers quickly drop, decreasing by 40% each passing month, whereas in the previously infected group, the initial titers are lower, but the titers decrease much more slowly, by ~4% every month.[112] Moreover, at 6 months, 16% of those vaccinated are below the seropositivity threshold of <50 AU/ml compared to 11% of those previously infected, at 9 months, demonstrating longer-lasting and better immunity in the previously infected group.[112]

MIS-C

MIS-C is the Multisystem Inflammatory Syndrome in Children. There is little doubt that this is a severe sequela of COVID-19 infection. It generally occurs 2-6 weeks after COVID-19 infection. It is similar to Kawasaki Disease in many respects but also has some unique features and as such, is a novel entity from COVID-19. For those who are not familiar, Kawasaki Disease is an acute febrile systemic childhood vasculitis and is one of the leading causes of acquired heart disease in industrialized countries. There is no specific test for it, but rather a set of internationally accepted clinical criteria, and most evidence points to a presumed viral trigger in individuals with some genetic predisposition. This has not been precisely identified but seasonal variation points to an infectious, presumed viral trigger, and the ethnic distribution would suggest an underlying genetic component.

MIS-C can certainly be severe, to the point of requiring ICU support for cardiac medications to support the contractility of the heart, as well as intubation. However, like anything else in medicine, we have to look at the data to fully understand the incidence and whether it warrants vaccinating our children.

The incidence of MIS-C has been reported in a large U.S. study, to be 316 per 1,000,000 COVID-19 infections (0.03%).[113] The CDC confirms the same thing, showing that only 0.03% of all COVID-19 infections result in MIS-C on their presentation to the FDA.[114]

- ➔ If you look at the risk of acquiring COVID-19 right now, in the U.S., in the pediatric population, up to Oct 28, 2021, it is:
  - ***133.7 per 100,000 per week***
- ➔ The risk of MIS-C then, right now, is:
  - 0.04 per 100,000 (133.7 per 100,000 at 0.03% MIS-C rate) per week, or
  - ***1 in 2.5 million per week***
- ➔ The risk of dying from MIS-C is:

- 0.00048 per 100,000 per week (0.04 @ 1.2% mortality), or
- ***1 in 208 million per week***

The cumulative incidence of MIS-C in <21 year olds since the start of the pandemic is 2.1 per 100,000[113] and also found to be 2 per 100,000 in another large U.S. study.[115] A Finnish study found the incidence of MIS-C to be 0.45 per 100,000 in all children under 18 years old.[116]

It is important to note that the risk of MIS-C is not additive to the risk of myocarditis after COVID-19 infection as it has been shown that 30% of those with MIS-C have myocarditis, cardiac dysfunction, or coronary artery dilatations.[113] Another study out of New York demonstrated that 53% of MIS-C patients have myocarditis.[117]

Although MIS-C can certainly be a severe disease, and ICU admission is frequent in up to 73%, the mortality is still very low at 1.2-1.9%[118,119] and is most common among 16-20 year olds at 43% compared to 20% in the 6-11 year old group with the median age of death being 15.8 years.[119]

With respect to comorbidities in MIS-C, a similar pattern emerges: 36-39% of all MIS-C patients have an underlying medical condition, and of those with a pre-existing condition, 74-81% had obesity.[117,119] When looking at mortality data from MIS-C, 69% had an underlying medical condition, most commonly obesity at 46%.[119]

With all the MIS-C data above, it is important to consider Kawasaki disease in the big picture. Of course, MIS-C is a novel entity that did not exist pre-COVID-19, but we have known about Kawasaki disease for decades and because they are similar in their presentation, it would be worth looking at the incidence of Kawasaki disease since the pandemic began.

The average incidence of Kawasaki disease in Finland from 2016 through 2019, pre-pandemic, was, on average 6.1 per 100,000 (6.6 per 100,000 in 2019 & 2018, 5.4 per 100,000 in 2017, 5.9 per 100,000 in 2016), and during the pandemic, it dropped by 51%.[116] A similar study in Chicago noted a 67% decrease in Kawasaki disease between April and December 2020 and when studied over a full 12 months through March 2021, this decrease persisted.[120] In Japan, they noted a 33% decrease in Kawasaki disease.[121] In Korea, the mean incidence of Kawasaki in the 10 years pre-pandemic was 31.5 per 100,000, and dropped 40% to 18.8 per 100,000 from February-September 2020, during the pandemic.[122] When looking at pre-pandemic vs during the pandemic in age <4 years, the incidence dropped from 123 to 80 per 100,000, and in 5-10 year olds, it dropped from 23.8 to 10.6 per 100,000.[122] Another study in Japan demonstrated a 60% decrease.[123]

Long COVID

Long COVID is the term that has been used to describe symptoms lasting greater than 4 weeks after COVID-19 infection, but there is quite a bit of variability with that timeframe as some studies use >12 weeks, and others >6 months. The incidence of long COVID in pediatrics is

variable but somewhere in the range of 4%,[124] 4.4%,[125] 4.6%,[126] although some describe the incidence as high as 42%[127] or 64%[128]. However, no difference was seen in the prevalence of persistent symptoms between infected and uninfected children,[124,129] suggesting that persistent symptoms may more accurately be a reflection of the mental health burden related to the pandemic and lockdowns and restrictions.

Clear Lies from the Media and our own Governments

Governments and governing health bodies will reiterate without scientific debate how the vaccines are thoroughly studied, have been administered 7 billion times, and are safe. Most of us would not normally question what we are being told by experts. But these are not normal times. And we are being lied to, obviously and with complete disregard to our intelligence. On October 6, 2021, the *New York Times* ran a story explaining the risk COVID-19 posed to our children, just 3 weeks before the FDA was set to meet to review COVID-19 vaccine approval for 5-11 year olds, and so any data related to this population was at the forefront of many parents' thoughts. The article stated that 900,000 children had been hospitalized in the U.S. from COVID-19.[130] The true number of those hospitalized ***with*** COVID-19 (certainly ***not from COVID-19*** given the asymptomatic rate is ~40%), was 63,000.[131] That's a glaring mistake by over 800,000!! Following it being found and called out, the NYTimes retracted their number the next day. But the headline was already out and had been seen by exponentially more people than had their retraction.

When governments and health bodies speak of misinformation, this is what is actually happening. How many see those headlines and front-page newspaper articles and form their opinion already, before a retraction is put out, hidden somewhere at the very bottom of the online article or at the back of the newspaper? At the very least, only a fraction compared to those who see the original fear-inducing article and use that to form their opinion.

Similarly, on Oct 13, 2021, Dr. Deena Hinshaw, Alberta's chief medical officer of health, had a virtual press conference to describe the first pediatric COVID-19 death in Alberta.[132] That is certainly concerning even if it was 21 months into the pandemic. But it wasn't true. That this family had to deal with anything other than the fact that they no longer had their brother, son, nephew, and grandson with them is terrible. This family felt obligated to call this for what it was: "fake news" as described by the sister, who went onto social media to explain that her brother died from advanced brain cancer and just happened to also be incidentally and asymptomatically COVID-19 positive. This is at once honorable and admirable on the part of the family while also infuriating and deceptive on the part of Dr. Hinshaw.

The bottom line is that these are just a couple of examples that have been caught, and therefore brought to the forefront, or at least the back pages. How many more lies are there? Two should be enough for us to question their motives and their policies. I would also take this opportunity to ask:

Who, in fact, are the ones providing the misinformation?

Is it those providing evidence from real-world scientific studies asking for dialogue and debate, who are being discredited, ostracized, and censored, or those in power who do not engage in scientific debate but rather speak in slogans like "safe and effective" and “let’s get back to normal”, whose résumés and research funding is at risk if these vaccines are not universally adopted?

Please consider why natural immunity is being ignored or why negative tests will soon not matter when it comes to domestic travel and other instances. It could only be because the goal is not to ensure safety for the population from the actual COVID-19 risk. The goal must be to simply get as many shots in the arms as they can. Risks come secondary to profit in this scenario and that is the most terrifying aspect.

Unbeknownst to most, Pfizer has a well-documented history of violations. Since 2000, they have had to pay over $4.6 billion because of various offenses.[133] In fact, Pfizer is responsible for the largest health care fraud settlement in the history of the U.S. Department of Justice, at $2.3 billion, in 2009, and at the time, the Assistant Attorney General explained that it was an example of the pharmaceutical company putting profits ahead of patient welfare.[134]

In the very likely event that these vaccines are approved among the 5-11 years olds in Canada, I strongly encourage you and hope that all of us, as parents, critically analyze **ALL** of the information before us, and do what we have always done: the best we can for our kids. And when it becomes obvious that the risks of these vaccines outweigh their marketed and purported benefits, please speak up. So many respected physicians, scientists, and other health care professionals have risked everything to speak out so they can present the complete information to the public. They have been discredited, disparaged, and many have lost their license for this. This is precisely why this letter remains anonymous. It seems absurd that, in this age, we cannot present our scientific and genuine concern for our patients. But make no mistake about it, it is true. I am at risk by writing this. So please respect what so many have risked and help us and help your children by protecting them. Be vocal. Be loud. Help others know they are not alone. Pass this letter to as many as you can. Write to your school boards, your sporting associations, your political leaders, everyone who is deciding to restrict activities and discriminating based on an individual’s personal health decision.

In the end, our society is at greatest risk not from COVID-19 itself, but from a loss of freedom, a loss of informed consent, and a loss of a generation who will be mandated to have a vaccine that has not been sufficiently tested long-term in a population who is not at risk of significant disease from COVID-19.

Sincerely yours, always here and present to stand for all children,

Deeply concerned pediatrician

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