Request to the WORLD HEALTH ORGANIZATION (WHO)

**Purpose:** We call for a debate on choices, investigations into grey areas, dialogue on inconsistencies and a transparent model built with citizens for free and informed decisions about their health.

We call upon the WHO and medical bodies of member countries under the article 1 and article 2 points a, f, g, h, m, p, s of the WHO constitution, which are:

| Article 1 | The objective of the World Health Organization (hereinafter called the Organization) shall be the attainment by all peoples of the highest possible level of health |
| Article 2 | In order to achieve its objective, the functions of the Organization shall be: |
| - (a) | to act as the directing and co-ordinating authority on international health work |
| - (f) | to establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services |
| - (g) | to stimulate and advance work to eradicate epidemic, endemic and other disease |
| - (h) | to promote, in cooperation with other specialized agencies where necessary, the prevention of accidental injuries |
| - (m) | to foster activities in the field of mental health, especially those affecting the harmony of human relations |
| - (p) | to study and report on, in cooperation with other specialized agencies where necessary, administrative and social techniques affecting public health and medical care from preventive and curative points of view, including hospital services and social security |
| - (s) | to establish and revise as necessary international nomenclatures of diseases, causes of death and of public health practices; |
| - (...) | » |

It would appear that these principles have not been respected as demonstrated hereafter.

**Table of contents**

1) Introduction/Facts.................................................................2
2) Analysis of interventions neglected.................................................................3
   Ventilation and encouraging activity in open-air settings........................................3
   Obesity, sports and nutrition.................................................................4
   Nutraceuticals and Vitamin D levels correction.................................................5
   Multidrug therapy .............................................................................6
3) The failure of applied solutions.................................................................8
   Massive vaccination........................................................................8
   Vaccine efficacy and safety evidence.........................................................11
   Vaccine passports or any similar document paper or electronic that confer an undue advantage or pressures someone to vaccinate...............................17
   Masks.................................................................................................19
   Fear propagation..............................................................................21
4) Conclusion .......................................................................................22

1 [https://www.who.int/governance/eb/who_constitution_en.pdf](https://www.who.int/governance/eb/who_constitution_en.pdf) [Accessed 26/03/2021]
1) Introduction/Facts

On 30 January 2020, the World Health Organization declared an international health emergency for the 6th time since 1964.

The SARS COV 2 was, at that time, already present on several continents. At that time, it had already affected many countries.

To cope with this unprecedented situation, several countries have implemented solutions, most of which were dictated by urgency, without careful discernment, weighing between benefits and risks.

As a result, and since then, legions of different generalised containment measures have been adopted.

In less than a year, the police have become the rule and freedom the exception in most countries!

Authors of this referral, all scientists, or renowned doctors, who have distinguished themselves in the care of patients with COVID 19, fully understand the need to prioritise public health when necessary at the cost, undoubtedly, of some freedoms.

In addition to the search for balance, they intend to argue that the measures thus enacted have, for many, no scientific basis and no health legitimacy as their benefit has never been demonstrated, whereas their risks have been identified and are estimated to be huge both individually and collectively.

On an individual level, and as will be explained, the generalised wearing of masks, confinement measures, forced isolation, and mass vaccination have consequences, and the signatories of this letter are astonished that such matters are denied or minimised while the literature abounds on them.

However, the benefit of these decisions is notably insufficient to imagine curbing their genuine risks.

This lack of scientific basis for the measures thus enacted and widely implemented worries the community of international jurists, who will soon submit a considered request to the UN Human Rights Committee to question whether the pandemic served as a pretext for some countries to establish the new bases of a social contract. Which, unbalanced, would allow the restriction of public freedoms and the force of opposition represented by their implementation.

Without being afraid of words, it is up to the Signatory Doctors and scientists to question the World Health Organization on what it intends to implement so that a political, economic and social collapse does not follow the covid19 pandemic. They cannot accept that an infectious disease with limited and manageable medical consequences, can serve as a pretext for questioning the foundations of democratic civilisation nor can they accept that despite themselves, they can be assimilated to promoters of a new political equilibrium.

It is up to your prestigious authority to denounce, following the UN, the political, economic, or philosophical recoveries of the pandemic, recalling the warning of Antonio GUTERRES, on 22 February:

"Using the pandemic as a pretext, authorities in some countries have deployed heavy-handed security responses and emergency measures to crush dissent, criminalise basic freedoms, silence independent reporting and curtail the activities of non-governmental organisations."2

2 Accessed 2 May 2021
The signatories of this request are scientists, and science is their only guidance: a science-based on evidence, a science which evolves, and which cannot be the object of political use, while their word cannot serve as a basis for justifying restrictions on public freedoms.

Some restrictions were for other purposes. They remind us that science cannot accept approximations, especially when these have consequences as severe as those we are witnessing.

They lament that measures of doubtful and insufficiently proven effectiveness have been implemented. In contrast, others, yet with a level of proof, benefit and low risks, have not been favoured or implemented.

The question is all the more pressing because, with more than 3 million deaths associated with Covid-19, we can only see a failure in Europe, America and parts of the Middle East. These regions are worse than the 1889 railroad flu, which may have been caused by the emergence of another Coronavirus, HCOV-OC43.

This failure occurred although this pandemic was predictable and had very low risks for the vast majority of the healthy population, as shown by the WHO's publications.¹

A comparative risk/benefit analysis is proposed with the support of these scientists and physicians. (see Tables 5 and 6).

2) Analysis of interventions neglected

Ventilation and encouraging activity in open-air settings

Data has accumulated to show that the risk of contamination in outdoor settings is very rare, independently of any other factors. It has been estimated to be 18.7 times lower than indoors. [⁴][⁵]

Evidence also suggests that good ventilation reduces infection risks significantly as per your own WHO recommendations [⁶]. This is consistent with prior knowledge indicating that proper ventilation dramatically reduces the risk of infection. It had even been suggested that for influenza, it could be as efficient as having 50% to 60% of the population vaccinated.⁷

This is true for Covid 19 and many other respiratory diseases.

It would be easy to encourage people to increase activity outdoors and encourage businesses to invest in good ventilation.

Businesses with good ventilation could even be encouraged to remain open.

⁵Hua Qian et al. Indoor transmission of SARS-CoV-2 indoor air October 2020 https://doi.org/10.1111/ina.12766
⁶World Health Organization (WHO) Roadmap to improve and ensure good indoor ventilation in the context of COVID-19 https://www.who.int/publications/i/item/9789240021280 Accessed 22 April
This would increase population livelihood, help the economy, reduce underground activities, and help with this pandemic and possibly the next predicted one.

Instead, businesses are closed, and outdoor gatherings are banned in many countries. Once again, measures that strengthen population with likely efficacy are disregarded in favour of measures that weaken people despite insufficient evidence of effectiveness.

Benefits for encouraging outdoor time and promoting investments into good ventilation in shops, businesses, and public places are high, whereas risks are low. Yet shops are closed, and populations are restricted and pushed indoors through curfew mandates and other oppressive restrictions.

**Obesity, sports and nutrition**

Obesity and poor health have been identified as probably one of the highest risk factors associated with severe disease. This has been known since April 2020 and primarily confirmed since then.[8][9][10][11]

Twelve months have passed, and no active campaigns for encouraging exercise/sport, better diet have been conducted in most countries.

Instead, the population was pushed to stay home, stock up on unhealthy foods and moved onto fast food, which remained open in many countries when sports activities were kept closed and outdoors restaurants and cafes were closed.

Encouraging people to stay active, healthy, facilitating nutritious foods and providing nutritionists support for those who need it is feasible; its cost is minimal compared to the cost of other measures.

Such interventions make the population stronger against this disease and probably many others. Yet, it is disregarded by most countries.

Obesity reduction may have saved lives. Efforts to reduce obesity should have been facilitated to offer population choice. Engaging in exercise following a healthier diet may have led to results as studies show results within 6 months. [12] Instead, conditions were created to increase obesity, possibly increasing death.

Actions to reduce obesity and improve nutrition come with few risks and high benefits, including reducing the severity of Covid19.

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Nutraceuticals and Vitamin D levels correction

It has been identified that a large portion of the population in many countries is vitamin D deficient. It has also been accepted that higher levels of vitamin D are helpful with most respiratory diseases.

Studies have confirmed this association for COVID as early as April, and it has primarily been established since then.\textsuperscript{13}\textsuperscript{14}

A recent meta-analysis comprising a little less than one million people shows that vitamin D deficiency is associated with susceptibility, severity and mortality.\textsuperscript{15}

Experimental trials have shown efficacy, including on the elderly, reducing mortality significantly.\textsuperscript{16}\textsuperscript{17}

This further validates what has been known for years associating good vitamin D levels to improved outcome for respiratory diseases.\textsuperscript{18}

Campaigns to help correct vitamin D levels were not conducted in most countries in spite of its benefits for covid and beyond. Instead, lockdowns and masking may have led to further vitamin D deprivation causing harm in adults and children.

If we are searching for the best options, it would be easy with vaccination campaigns happening to propose to those who refuse vaccination a vitamin D correction plan. It could also be suggested to those who accept vaccination, such correction and compare all causes of mortality for all four groups during ongoing vaccination phases 3 and 4. In addition to vitamin d, other nutraceuticals, commonly used, safe and well understood provide sufficient evidence to be used such as Quercetin, Vitamin C, Zinc Sulfate, Artemesia tea...

Evidence, as to benefit, is significant for covid and much more, risks of reaching optimum vitamin d levels are low with high short- and long-term benefits.

Trials with Nigella Sativa have shown very satisfactory results reducing by 4 mortality rate, duration of hospitalization for severe cases and recovery time for moderate cases\textsuperscript{19}\textsuperscript{20}

\textsuperscript{16} Vitamin D Supplementation Associated to Better Survival in Hospitalized Frail Elderly COVID-19 Patients: The GERIA-COVID Quasi-Experimental Study Gaëlle Annweiler Mathieu Corvaisier, Jennifer Gautier, Vincent Dubée, Erick Legrand, Guillaume Sacco, Cédric Annweiler Nutrients November 2020
\textsuperscript{17} MartaEntrenas Castillo et al. Effect of calcifediol treatment and best available therapy versus best available treatment on intensive care unit admission and mortality among patients hospitalised for COVID-19: A pilot randomised clinical study ScienceDirect October 2020 https://doi.org/10.1016/j.jspmh.2020.105751
\textsuperscript{18} Rhaiza Aponte, Cristina Palacios, Vitamin D for prevention of respiratory tract infections (eLENA) June 2017 https://www.who.int/elena/titles/commentary/vitamin_d_pneumonia_children/en/
\textsuperscript{19} Koshak A E et al. Nigella Sativa Supplementation Accelerates Recovery from Mild COVID-19: First Randomized Controlled Clinical Trial (RCT) OSP preprints August 2020 DOI:10.31219/osf.io/urb6f
Multidrug therapy

Ivermectin is safe drug that has been known for decades, used thoroughly and its effects well documented.

As a treatment, it is by definition safer since only given to those who need it, who are already sick and doesn't put at risk other healthy individuals.

In terms of safety, it is safer than any of the vaccines that have undergone a short safety assessment and would have to be administered to healthy individuals with some known side effects and others to be discovered in the short and long term.

Multiple independent RCT trials have been conducted involving more than 2 282 patients. Almost all show efficacy on different categories of populations with great significance. There may be a 75% reduction in mortality with a confidence interval of 95%\(^{[21]}\)\(^{[22]}\). Sample sizes of these trials taken together exceed those used for any of the validated vaccines that all had efficacy samples below 1 000, and most had even lower efficacy samples. Many such trials were independent and free of conflicts of interests.

Looking at the big picture, South Africa's curve reverted after doctors massively decided to start using ivermectin in spite of agencies advising otherwise. They may have saved lives. The government, under such pressure decided to allow off label use of ivermectin, leading to improvement.

In addition to RCT results, multiple observations in nursing homes and doctors' experience have led many doctors to largely use it in numerous countries, and their experience seems to confirm the trial results mentioned.

Based on known safety and evidence showing it was likely effective, some states have embraced Ivermectin and many doctors in other countries where doctors still have freedom of prescription have used it base on evidence and ethics. In other states, some governments have restricted doctors from performing their duty of helping patients with best available science through pressure or even blocking supply thus depriving patients from a chance of a better outcome.

Ivermectin is a cheap public domain molecule that would interfere with significant interests, and all new studies must involve individuals beyond any suspicion of conflicts of interests. The fact that independent researchers confirm the same trend provides even more robust evidence. Treating sick people successfully is safer than injecting healthy individuals with products that are yet to be understood in the short and long term.

At this stage, further fair, independent studies can be conducted to establish the extent of efficacy, but until then, the evidence for risk/benefit is largely favourable and likely more convincing than that of any vaccine.

Early multi drug treatment sequenced and dosed as per clinical directions combined with some nutraceticals has shown positive results for many patients to the extent that when doctors can exercise their duties, it has become

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\(^{[21]}\) Andrew Hill et al. Meta-analysis of randomised trials of ivermectin to treat SARS-CoV-2 infection Research Square January 2021 DOI: 10.21203/rs.3.rs-148845/v1

de facto standard of care by doctors using best available data to best help their patients.  

**Early outpatient treatment with low doses of Hydroxychloroquine combined with a Macrolide for patients without heart conditions has been rejected.**

This is happening at a time where many health agencies are dismissing or delaying such solutions using different evaluation standards and not paying sufficient attention to long-term side effects of new molecules.

Such agencies failed to contribute to improving on use of such emerging solutions and focused their attention on dismissing all solutions instead of exploring them. They favoured waiting for vaccines and treatments provided by private organizations without requiring from the latter same standards of evidence or sufficient caution as to safety.

Hydroxychloroquine and Macrolides are known treatments. Their safety and contra-indications are well established both short and long term, which is not the case for vaccines whose benefit of conditional emergency authorisation with short and long side effects under discovery.

Given that multi-drug therapy sequenced and dosed as per clinical directions has become de-facto standard of care in most world areas, all new interventions whether for treatment or for prophylaxis should be compared to multi-drug therapy and not to a placebo in terms of evidence, niches, benefits and risks both short and long-term.

There have been several outpatient early treatment studies, both RCT and observational, showing efficacy. There have been a few studies indicating no benefit. Some of the few latter studies have been criticised for bias due to conflicts of interests.

The Lancet gate was a demonstration of manipulation to prove a ridiculous claim as to hydroxychloroquine being dangerous. The Lancet study was retracted. Based on one fallacious study that needs to be investigated, the Discovery clinical trial had its hydroxychloroquine/Macrolide early outpatient arm interrupted, leaving people in doubt. This calls for further questioning. Other extensive studies involved patients in late-stage, did not use above mentioned proposed therapy, nor did they use the suggested dosage offered by successful studies.

Failing to demonstrate the absence of efficacy or efficacy, contradicting studies, studies being stopped before a clear conclusion, stopping doctors or even hospitals from continuing studies proves the further failure of many institutions. Investigations are warranted.

### 3) The failure of applied solutions

**Massive vaccination**

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Three countries that had brutal massive vaccination campaigns witnessed their worst epidemic mortality peak and their most prolonged deadliest phase (figures 1, 2, 3, 4 and 5).

In 2 of these cases, their covid mortality exceeded that for all the preceding ten months of the epidemic. These countries are Israel, United Arab Emirates (UAE) and United Kingdom (UK). Israel used mRNA Pfizer, UK used mRNA Pfizer, Moderna and AstraZeneca, UAE used mRNA Pfizer, Sputnik and Sinopharm.

It is interesting to note that this deadly episode coinciding with vaccination happened in Israel and the UK under strict lockdown, including non-essential business closure and stay home mandates.

It is also troubling to see that Israel's mortality peak only follows its cases peak by eight days instead of the usual 14 to 21 days or the 17 days observed in the previous peak, thus possibly hinting at a deadlier, more striking infection or the frailest population dying more than in prior epidemic peak.

New mortality peaks appear in Israel between ages 15-44 and 65+ after the pandemic and after vaccination (figure 4). A similar situation occurred in Belgium who had been spared since the beginning of 2021, coinciding with vaccination acceleration and its extension to the 45-64 years old group with comorbidities. (figure 4)

Kuwait, Bahrain, Uruguay, Seychelles, Hungary, Monaco, Mongolia and to a lesser extent, Chile are also facing a very high mortality coinciding again with massive vaccination. More recently, India started a fast, massive vaccination campaign in late March 2021, coinciding once more with a severe rise in mortality, as shown in figure 2, worse than all prior episodes combined.

Italy, France and Estonia are observing excess all-cause mortality precisely in the age groups 75 to 84 that have been vaccinated mostly by mRNA Pfizer and Moderna and, to some extent, Astrazeneca (Figure 5).

Death coinciding with vaccination repeatedly does not establish causality but calls for fair complete independent investigations as suspicion is raised and numbers are alarming, mainly that this failure adds to prior ones.

Repeating the experiment, with a risk of reproducing results illustrated in (figures 1,2,3,4,5).

Israel, Emirates, UK, Kuwait, Bahrain, India, Uruguay, Seychelles and Chile chose to vaccinate massively, including in some cases, populations at low risk of severe disease sometimes without prior control as to pre-existing ongoing covid infection or pre-existing covid natural cellular immunity.

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30 Wegene Borena, Zoltán Bánki, Katie Bates, Hannes Winner, Lydia Riepler, Annika Rössler, Lisa Pipperger, Igor Theurl, Barbara Falkensammer, Hanno Ulmer, Andreas Walser, Daniel Pichler, Matthias Baumgartner, Sebastian Schönherr, Lukas Forer, Ludwig Knabl, Reinhard Würzner, Dorothee von Laer, Jörg Paetzold, Janine Kimpel Follow-up study in the ski-resort Ischgl: Antibody and T cell responses to SARS-CoV-2 persisted for up to 8 months after infection and transmission of virus was low even during the second infection wave in Austria Medrxiv February 2021 [https://doi.org/10.1101/2021.02.19.21252069](https://doi.org/10.1101/2021.02.19.21252069)

31 Alison Tarke, et al. Negligible impact of SARS-CoV-2 variants on CD4+ and CD8+ T cell reactivity in COVID-19 exposed donors and vaccinees BioRxiv March 2021 doi: [https://doi.org/10.1101/2021.02.27.433180](https://doi.org/10.1101/2021.02.27.433180)
This was done in disregard of a clear risk, benefit analysis for each individual, wasting vaccines that could have been made available to populations at risk in other parts of the world, thus raising ethical, medical and scientific questions.

An investigation should explore how these vaccination campaigns failed to prevent this terrible outcome and if they contributed to it. All hypothesis should be explored, including non-mutually exclusive hypothesis such as Antibodies Dependency Enhancement (ADE) \(^{32}\)[33], Enhanced Respiratory Disease (ERD) \(^{34}\)[35], vaccines side effects, vaccinated population being more infectious, vaccination places being clustering places, counterproductive effect on already naturally immunised population or over-inflated vaccine efficacy on some populations, pressure-selection ... Hospitalisations, heart inflammations, appearances or increases of syndromes must all be documented...Deaths had to occur before acknowledging thrombosis risks. Is it necessary to wait for all the rest?

Benefit/risk was ignored when low risk young and healthy populations were exposed, pressured, tempted to vaccinate with very limited benefit, some short-term risks and unknown long-term risks. \(^{36}\)[37][38][39]

Excess mortality and possible hospitaliterm side effects that are yet to be discovered.

Any treatment must come with counter-indications and clear risk-benefit analysis for every group and for the community. There have been attempts to explain such failure and outcome by variants in UK, South America, and now India. Such variants did not have the same effect in other countries that were not massively vaccinating. It remains unclear if pressure – selection resulting from massive vaccination leads to the selection of variants that elude vaccine immunity, tests and possibly other measures. Such a hypothesis gives current observations that must be considered carefully. If it is not the case then, careful attention must be paid to vaccine side effects on some sub-categories as the cause of such surges in mortality. Suspicions will remain until is explained in each of such cases causes of increased mortality. Vaccination may be a tool that may help with such a pandemic, but an accurate risk-benefit analysis must be done for each category, each vaccine and efficacy on circulating variants based on sufficient data. Massive vaccination independent of such analysis has shown to be a failure to avoid a significant mortality rise in many cases and calls urgently for a nuanced approach.

The reckless mass vaccination becomes more serious when vaccinating those who already contracted covid 19 as this population had been excluded from Pfizer and Moderna trials. Any people that have been excluded from the trial can only be vaccinated within a trial. If they are healthy, their benefit from vaccination was already


\(^{35}\) Patricio L. Acosta, Mauricio T. Caballero, Fernando P. Polack Brief History and Characterization of Enhanced Respiratory Syncytial Virus Disease Clinical and vaccine immunology March 2016 DOI: 10.1128/CVI.00609-15


\(^{37}\) https://clinicaltrials.gov/ct2/show/NCT04368728

\(^{38}\) https://clinicaltrials.gov/ct2/show/NCT04470427

\(^{39}\) https://clinicaltrials.gov/ct2/show/NCT04516746
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low. If they recovered, there is hardly any theoretical benefit and no demonstrated benefit. Risks are present in the short and long term.

By vaccinating covid recovered individuals, in addition to putting them at risk, outside of any trial, a negative alteration of cellular immunity cannot be excluded, which would be counterproductive for all.

Changes to protocols, changing duration between shots as suggested in some cases or adding a third shot as suggested in others must be done within the same standards of evidence requirements consistently and in many cases under a controlled trial approach measuring risks and benefits.

While data accumulated to demonstrate diversity, efficacy, and higher performance in prevention of variant-related infections of naturally-acquired immunity, with demonstrated importance of Lymphocytes qualitative response and mucosal immunity role, while no strong evidence of correlates with serological antibody measures, avoiding or delaying such natural immunity to develop within lower risk population may result in increased or continued risks for all.\textsuperscript{40 41 42 43}

Changes to protocols, changing duration between shots as suggested in some cases or adding a third shot as suggested in others must be done within same standards of evidence requirements consistently and in many cases under a controlled trial approach measuring risks and benefits.

Any population for whom efficacy is not demonstrated can only be vaccinated within a proper clinical trial.

At the very least, this demonstrates that massive vaccination failed to show a visible effect at times when the virus is circulating. High levels of mortality call for an investigation to identify if it has not been counterproductive, possibly making things worse and exposing individuals with little benefit to short and long term side effects.

By vaccinating massively, including those with low benefit, in addition to exposing them to unnecessary risks from first vaccination and from eventual multiplication of vaccinations if new strains emerge requiring new vaccinations. This happening with multiple vaccines calls for caution with the process and adequate attention concerning each vaccine, as well as vaccination multiplication with the same vaccine or a different one. Independent clinical trials would need to be done for such a serious matter to be handled upon extrapolations without sufficient data.

This massive vaccination was done disregarding individual risk/benefit sometimes in some countries without proper informed consent, possibly pressuring or tricking some to vaccinate, exposing them to short term risks and unknown long-term risks without sufficient scientific and ethical basis. It was done disregarding solidarity between nations by vaccinating individuals who do not need it and for whom risks exceed benefits, and it was done without careful control to minimise risks of pressure selection. The final outcome is that the abovementioned countries had a terrible mortality wave, and in the case of Israel, high mortality episodes after the epidemic wave in groups 15-44 and 65+ and in Belgium, excess mortality reappeared after several months.

\textsuperscript{40} SARS-CoV-2 genome-wide T cell epitope mapping reveals immunodominance and substantial CD8$^+$ T cell activation in COVID-19 patients Science Immunology Apr 2021 DOI: 10.1126/sciimmunol.abf7550

\textsuperscript{41} Hall V J et al. SARS-CoV-2 infection rates of antibody-positive compared with antibody-negative health-care workers in England: a large, multicentre, prospective cohort study (SIREN) The Lancet April 2021 DOIhttps://doi.org/10.1016/S0140-6736(21)00675-9

\textsuperscript{42} Jagannathan P et al. Immunity after SARS-CoV-2 infections Nat Immunol April 2021 https://doi.org/10.1038/s41590-021-00923-3

\textsuperscript{43} Dan J M et al. Immunological memory to SARS-CoV-2 assessed for up to 8 months after infection Science Feb 2021 DOI: 10.1126/science.abf4063
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of normality.

**Vaccine efficacy and safety evidence**

The emergency authorisation was given to be used wisely. Past experiences showed us that clinical trials, safety assessments are here for a reason and, in some cases, are not sufficient \(^{44,45,46}\).

This vaccination is based on a limited understanding of short term risks since clinical trials have had short durations for evaluating short term safety (28 days to 4 months) and relatively small samples (12,000 to 25,000 compared to hundreds of millions). Risks of bias are high due to limited studies all done by manufacturers. Lack of critical interpretation of side effects observed during trials, weak pharmacovigilance in most countries in the absence of control groups adds to the problem. In addition to that, many countries stepped out of protocols mainly for logistics reasons or side effects, making extrapolations and adding risk to risk.

Clinical trials phase 3 for proper observation were due for most vaccines in early 2023. Until we have sufficient long-term understanding, fully informed consent is medically, scientifically and ethically needed without pressure or temptation of any kind for everyone's benefit.

This is even more true for mRNA vaccines that rely on a novel technology with unknown positive and negative consequences. Efficacy and safety must be reassessed with new trials for vaccine updates and mutations that may alter behaviour. Efficacy and safety must be reassessed with trials before use outside of clinical trial protocols that led to emergency authorisation or before considering new shots. Efficacy and safety must be reassessed with trials before mixing vaccines or accumulating different versions of vaccines. Safety and efficacy reports and studies from the initial trial must be shared with the population as to continued efficacy and safety.

Observation of efficacy in protecting recipients of vaccines from manufacturers' published studies has its limitations.

1. It relies on a few hundred people; for example, the Pfizer study relies on 650 people in total 550 in the control group and 100 on the intervention group for the entire vaccination period and only 171 individuals if we assess efficacy seven days after the second injection. Moderna and AstraZeneca have similar or smaller samples. The results are statistically valid and even strong for the population tested but cannot be extrapolated beyond to show levels of efficacy on subgroups, in particular those with comorbidities, a combination of comorbidities or for the elderly.

2. Efficacy as to severe Covid relies on ten people for Pfizer.

3. There was no covid mortality in either group, further indicating that the context was one of either low-risk epidemic or low-risk sample. It is difficult to establish a reduction of mortality from such a sample, particularly for those who need it most, that is, the elderly and those with comorbidities.

4. In Pfizer's case, there are questions as to 3410 people excluded with « suspected covid » 1594 in the vaccine group and 1816 in the control group, which would alter efficacy \(^{47}\). In Jansen's case, efficacy seems to be from its recently published study at 66.9%, much lower than claimed 90+%. It seems slightly more effective on 60+ but less effective than Sputnik on that category. \(^{48,49}\)


\(^{46}\) Hallberg, P et al. Pandemrix-induced narcolepsy is associated with genes related to immunity and neuronal survival. EBio Medicine February 2019 DOI:https://doi.org/10.1016/j.ebiom.2019.01.041


\(^{49}\) Logunov D et al. Safety and efficacy of an rAd26 and rAd5 vector-based heterologous prime-boost COVID-19 vaccine: an interim analysis of a randomised controlled phase 3 trial in Russia Lancet Feb 2021 DOI: 10.1016/S0140-6736(21)00234-8

May 2021
5) The decision to vaccinate massive populations relies on a single trial funded and controlled by the manufacturer inducing a bias risk.

6) In the case of Pfizer and Moderna, those with a history of Covid were excluded making benefit/risk for those already infected impossible to evaluate. Such population is probably large in much of Europe and the US. Most of them may have been already at low risk of severe covid or death, and after recovering, their severe covid risk is likely negligible. As they have been explicitly excluded, as their benefit cannot be determined, as their vaccination risk since unknown, must be assumed high, as they are less likely to spread than naive populations and possibly vaccinated, vaccination should be avoided or at least they must be warned.

7) Given suspected large numbers of asymptomatic or lightly symptomatic populations who may not know they had covid, they must at least be offered cellular reactivity tests before making an independent and informed decision.

8) Efficacy relies on small numbers, is demonstrated for populations with limited benefit from vaccination and unknown thus high long-term risks. It is less clear for those at high risk and is not demonstrated on mortality.

Observation of short-term safety also calls for some questioning.

1) In Pfizer's case, there are 371 individuals who have been excluded from the statistical analysis on or prior to seven days after the second injection. No reports have been given about disease course for these individuals. Instead of excluding them, this would have given insight as to ADE risks and risks before the vaccine effect is fully active.

2) The imbalance in these 371 excluded individuals 311 in the vaccine group and 60 in the placebo group calls for further questioning. This questioning becomes all more pressing as reports seem to indicate that such unexplained imbalance with higher levels of infections immediately after vaccination. This imbalance should have been investigated to ensure absence of an increased susceptibility risk after vaccination.\[50\] [51]

3) Excluded populations such as those with a history of covid, immunocompromised, those with immunosuppressive therapies leave us without clinical trial to validate benefit/risk responsibly.

4) There is no data as to risks of if and when immunity starts to weaken in the presence or absence of virus encounter.

5) Significant adverse effects (fever in 16% of the young) comparable to those of the disease itself in younger healthy individuals have been observed. Yet, the outcome of those excluded must be made public before conclusions for Pfizer. Israel mortality analysis, including that of age 15-44 needs to be made public to understand better. Jansen's safety analysis relies on a relatively small sample 3356 individuals.

Observation on long term safety

1) mRNA vaccines are a new technology-, mid- and long-term side effects are unknown.

2) The precautionary principle and responsibility call for assuming that such risk may be significant.

3) Other non mRNA vaccines do not yet have enough observation time, and their risks are unknown.

4) Better midterm understanding would be available in early 2023 when comparing conditions of the intervention group with the control group if we are to have a scientific protective approach.

5) Phase 3 raw data, if released progressively, may give more insight

6) Phase 4 should adapt to compensate for this quasi experimentation by having active monitoring of all vaccinated individuals and releasing such data

7) For consistency, data related to hospitalisations and mortality within 45 days after vaccination should be reported to identify those dead with vaccine just like we identified those who died of covid and monitor for any unusual numbers

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51 [https://www.youtube.com/watch?v=0-7R3r5 -EA Accessed May 12th 2021]
A preliminary study from Denmark suggests some efficacy 64% in infection reduction seven days after Pfizer second dose for Care Home Residents and minimal protection before. This is promising if it translates into a severe course and mortality reduction as it would indicate that one of the niches that need vaccination and are at relatively low risk of long-term side effects would get the benefit. Such niche or benefit could be confirmed after above mentioned all-cause mortality have been fully investigated and explained. It would validate vaccination for a large portion of those at risk.

In addition to previously stated limitations related to sampling, partial unblinding, exclusions, exclusion criteria, efficacy by group, Efficacy demonstrated for those with least benefits and highest risk of side effects, short term perspective... Analysis for several vaccines, including Pfizer and Moderna, was done exclusively on Relative Risk Reduction and did not include Absolute Risk Reduction and Numbers Needed to Treat. This is a way to present information on its best facet, but all these criteria are needed when it is time to make a decision.

For example, in the Pfizer study, if we look at severe disease outcome. There were nine cases in the placebo group out of 21728 and 1 in the vaccine group out of 21720. That is respectively 0,041 % and 0,005 %. That tells that over the study period; vaccination has reduced the risk of severe Covid from 0.041 % to 0.005 % = risk reduction of 0.36 %. It also tells that to reduce one case of severe Covid, and one needs to vaccinate 2715 individuals who will be at risk of short- and long-term side effects if massive vaccination is performed.

On the other hand, for the Pfizer trial, there were 4484 related adverse side effects in the vaccine group and 1095 for placebo. This means a Relative Increased Risk (RIR) of 61 % and an Absolute Increased Risk (AIR) of 15 %, which is high, particularly that adverse events are more common in the younger population who most often have a mild course of the disease. Severe adverse events were in 240 in the vaccine group and 139 in the placebo group, equivalent to an RIR of 27 % and an AIR of 0.46 %. This means to avoid one severe Covid case, 733 will suffer from side effects, and 13 would suffer from severe side effects.

This calls for targeted vaccination towards those with benefit and low risk of such adverse events. The young and healthy are also those at the highest risk of long-term side effects of this novel technology. It goes without saying that those recovered cannot be vaccinated outside of a new clinical trial as they were excluded from the trial, their benefit unknown likely low and risks unknown thus should be assumed high.

Looking at the NNT for Moderna to prevent severe covid, 30 placebo group members had severe Covid, and 185 had covid in the placebo group and 11 in the vaccine group. This corresponds in the context of the trial described by the authors as an environment of « appreciable risk », to vaccinating 15210 individuals. In that context, NNT is around 507 (15210/(30-0)) to prevent severe Covid and around 87 to prevent mild or moderate Covid 19 (15210/(185-11)). The rough result would mean on the short-term vaccinating 15210 individuals results in sparing 173 mild or moderate symptoms, 30 Hospitalisation on the one side.

On the other hand, grade 3+ events occurred in 15.8 % that would mean in the trial context, 2403 individuals had a serious non-life threatening adverse event that may require hospitalisation. Adverse events were more

32 Rask Mountsen-Helms, I et al. Vaccine effectiveness after 1st and 2nd dose of the BNT162b2 mRNA Covid-19 Vaccine in long-term care facility residents and healthcare workers – a Danish cohort study Medrxiv March 2021 https://doi.org/10.1101/2021.03.08.21252200
34 Ronald B. Brown Outcome Reporting Bias in COVID-19 mRNA Vaccine Clinical Trials Medicina February 2021 https://doi.org/10.3390/medicina57030199
common in the younger who had the least benefit from vaccine protection.\textsuperscript{55,56} It also means that in the context of a clinical trial, to avoid a single case of serious Covid 19, 80 individuals would suffer from grade 3 adverse side effect. This is high, and again as the young get the least benefit and are at the highest risk of such adverse events, it calls for targeted vaccination towards those with benefit and low risk of such adverse events. There have also been imbalances in some severe side effects which should have been explored in greater details before proceeding to recommend intervention massively. The young and healthy are those at the highest risk for long term side effects of this novel technology. It goes without saying that those recovered cannot be vaccinated outside of a new clinical trial as they were excluded from the trial, their benefit unknown likely low and risks unknown thus should be assumed high.

Janssen’s vaccine had been approved in Europe and the USA many months before any studies were published\textsuperscript{57}Press releases were marketing it as a product promising 85 \% efficacy; authorities in Europe and the US gave an emergency authorisation for this vaccine and never contested such publicity outside of any scientific publication or even pre-print. As the publication came out a few months later, it turns out efficacy as per the study of the manufacturer is 66.9 \% in preventing Covid 19 that is 18 \% lower. However, it seems to have as good or better RRR for the older population who need it most. For severe covid, there were 19 individuals in the vaccine group and 80 in the placebo group indicating the efficacy of around 80 \% on what is ultimately a small sample. The vaccine group was 19630, and the placebo group was 19 691. That would give us an absolute risk for severe covid of in the context of the trial of 0.09 \% for the vaccine group and of 0.4 \% for the placebo group corresponding to an ARR of 0.31 \%. It would also mean that to avoid one severe covid, and the NNT value would be around 323.

Janssen's study reports sufficient sample sizes for obesity, hypertension and type 2 diabetes. Thromboembolic events occurred in 11 cases in the vaccine group and 3 in the placebo group corresponding to a Relative Increased Risk of 78 \% and an Absolute Increased Risk (AIR) of 0.04 \%, which remains high and should have triggered more attention and more exploration, particularly that one such case was grade 4. RIR of 80 \% and AIR of 0,016 \% was observed for Seizures. Six cases of tinnitus, one cerebral haemorrhage and one case of the Guillain–Barré were observed. AIR of systemic event would be 1.7 \% in the young and 0.4 \% in those above 60. In the context of this trial, for one severe case avoided, five would have a systemic reaction, and 0.33 would have a serious side effect. This is a high number, strongly urging for targeted vaccination towards those with a clearly identified benefit, particularly that long term side effects remain unknown and efficacy towards new variants remains unknown. However, a late publication, arrival of such publication after suspension in the US because of thromboembolic events occurring in the real population, disclosure of such known risk and others by the study after-market authorisation, inconsistencies between the text of the NEJM study and tables S6-S9 of the appendices, all call for caution. This preliminary analysis relies on the text of the NEJM study rather than the appendices.

This only accounts for the short-term risks and further urge towards vaccinating those who have a significant possible benefit. Those with limited benefit are at higher risk of short-term adverse events and long-term ones as we have no knowledge of long-term efficacy or side effects. If need be, this further stresses the importance of targeted vaccination towards those at risk to avoid unwarranted serious side effects and long-term consequences on those with low risk and wasting vaccine doses and preventing others who may benefit from

\textsuperscript{56} FDA's Clinical Investigator Course https://www.fda.gov/media/84954/download Accessed 24 April 2021

May 2021  Page 14
Request to the WHO: Group of scientists, doctors and lawyers - Project English Version

gaining access in less developed countries.

There are exclusions whose outcome has not been published, high rates of significant or severe side effects identified by studies, particularly in young, healthy individuals. There are even inconsistencies in the case of Janssen between the study and its appendices.

We request that the raw data be made public so that at least data can be analysed short term and that ongoing collected data comparing vaccine group and placebo continue to be made public as follow up data for safety.

Economic analysis also favours that course. The above example for Pfizer implies several costs; vaccinating 2715 individuals to prevent a single serious disease comes with a cost of around $95 000 paid to the manufacturer to which must be added:

- cost of the vaccination act.
- Cost of treatments and possibly hospitalisations of grade 3 adverse events caused by vaccines.
- Cost of work stopping.

From which must be deducted:

- cost of treatment of that one serious case and that of mild cases.

Targeted wise vaccination would be beneficial for the health of the vaccinated population, their economy and solidarity between nations.

Multiple reports indicate that vaccinated individuals can still be infected in large proportions, can also be infectious and including turn out to be super spreaders.

As variants are emerging concomitantly with vaccination campaigns using different vaccines, special caution must be taken towards pressure selection, further leading to mutations that escape vaccine immunity. This risk is highest as many vaccines, particularly the ones abovementioned, target only the spike protein. The efficacy of vaccines must be determined against circulating variants from real-life data as preliminary reports indicate significantly reduced efficacy on some variants, at least for Pfizer.\(^{58}\)

Targeted vaccination is needed as new mutations are happening and current vaccines may become obsolete fast; vaccination accumulation comes with risks benefits that will need to be assessed. We cannot just target a collection of failures and add risk to risk into unchartered territories.

Targeted vaccination is warranted as large portions of the population in many countries are already immunised naturally against the full virus and may better resist mutations. Their benefit from vaccination is minimal, if any and their risks depend on vaccines. For that matter, Pfizer and Moderna assumed past infection as being an exclusion criterion.

Efficacy, cost, and safety would be completely different in case of a targeted vaccination towards those at risk, provided efficacy and safety are demonstrated. From a public health perspective, RRR, ARR and NNT can lead

\(^{58}\) Kustin T et al. Evidence for increased breakthrough rates of SARS-CoV-2 variants of concern in BNT162b2 mRNA vaccinated individuals Medrxiv April 2021 doi: https://doi.org/10.1101/2021.04.06.21254882
to very different decisions as to sampling and choosing. A community may be mislead and vaccinate excessively the wrong population with avoidable side effects and long-term consequences.

Many theoretical risks may be feared, particularly from mRNA vaccines. We don't know if multiple vaccinations may lead to unforeseen outcomes, nor do we know bodies' reaction after meeting a mutant or another coronavirus. The truth is we don't know enough and should not add risks to risks. We do not see the efficacy against some emerging strains.

An emergency authorisation was granted to Jansen's vaccine in the US and Europe before the publication of clinical trial results. Its use has been suspended since then in the US, further indicating that we are in unchartered territories independently of future analysis. AstraZeneca vaccine was also suspended in several countries after the harm was suspected on young, healthy individuals who were at low risk of severe covid or covid death. Some of them may have been at negligible risk, had they recovered already from Covid or had they developed cellular immunity with light symptoms.

It has been suggested that manufacturers would adapt their vaccines to new variants. Each adaptation would require a clinical trial and special safety tests associated with vaccine accumulation covering similar targets in a short time span.

It has been suggested to skip all protocols and give some people a third injection or even mix vaccines outside of any trials.

An additional concern arises from Pfizer's and possibly other manufacturers' proposal to vaccinate control groups, thus making it harder to identify imbalances and possible long term side effects. This additional step away from evidence-based science combined with requests to limit manufacturers' liabilities is most worrying.

The absence of carcinogenicity studies also raises questions, as the injected components are lipidic but lead to the production of an unusual free protein whose long-term effects are unknown. The question of cancers can therefore be raised.

There is potential for mRNA vaccines, but it needs to be tested thoroughly as we always did.

Hypotheses need to be tested as often they turn out to be false.

As indicated in the previous section, from mortality data, the data of the big picture paints an image of failure of one size fits all massive vaccination in spite of media trying to present things otherwise and social media trying to control the debate.

There seems to be an imbalance in the analysis of the abovementioned studies exploring in length benefits to the detriment of a short, less extensive analysis of side effects, their consequences, and the definition of long-term side effects. Post-vaccination vigilance is weak in most countries, and little is done for comparisons with control groups.

The evidence for healthy individuals is probably moderate to strong. The benefit for these individuals is weak as they are at low risk of covid mortality. The risk of side effects is high based on known side effects, and that we have no knowledge of long term impacts, particularly for mRNA vaccines.
The evidence for the elderly who have not had covid was weak to moderate and has improved slightly with the abovementioned Danish study. The risk of long-term side effects is to be assessed based on their life expectancy. Ultimately, it should be their decision without pressure or temptation.

Evidence for vaccinating the elderly was not provided by the study but rather by data collected by real-life use on populations. We should be careful with experimentation as data could go one way or another. The elderly were included in the Pfizer trial even if in insufficient numbers. Efficacy was not demonstrated, but they could have hoped for a benefit. Maybe they did, and maybe we will be reassured after excess mortality in the abovementioned countries is fully explained.

The evidence for those who have recovered from Covid is absent. Their benefits are negligible and risks are high. It must also be taken into account current knowledge as to long-lasting memory immunity protective effect. Looking merely at antibodies is insufficient as cellular immunity plays a significant role, possibly more significant than that of antibodies.

The evidence for those under immunosuppressive treatment and those immunocompromised is unknown.

No one can responsibly make a claim as to the long-term safety of these new vaccines. Vaccines have a niche. People should be fully informed without pressure or temptation, but current marketing to magnify advantages and minimise risks is not compatible with science or medicine, nor does it benefit humanity.

A nuanced approach is needed. Tables 1, 2, 3, 4 provide a risk-benefit analysis for three vaccines and different vaccination approaches.

**Vaccine passports or any similar document paper or electronic that confer an undue advantage or pressures someone to vaccinate.**

In addition to being morally, ethically, and legally questionable from a scientific standpoint, such passports are not justified for multiple reasons, as explained in previous sections.

1. They do not guarantee that all vaccinated individuals or even most have sufficient active cellular immunity against circulating strains.
2. They would push individuals with more risks than benefits to vaccinate.
3. They may increase the risk of pressure selection.
4. They do not prevent spreading or even super-spreading from happening.
5. Vaccines are medical interventions that cannot and should not be promoted or pushed as a vulgar product or pushed/pressured without clear counter-indications, precautions and individual risk/benefit understanding.

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59 Holm Hansen C et al. Assessment of protection against reinfection with SARS-CoV-2 among 4 million PCR-tested individuals in Denmark in 2020: a population-level observational study The Lancet March 2021 DOI: [https://doi.org/10.1016/S0140-6736(21)00575-4](https://doi.org/10.1016/S0140-6736(21)00575-4)

60 Abu-Raddad LJ et al. SARS-CoV-2 reinfection in a cohort of 43,000 antibody-positive individuals followed for up to 35 weeks. medRxiv. January 2021 [https://doi.org/10.1101/2021.01.15.21249731](https://doi.org/10.1101/2021.01.15.21249731)

61 Dan M J et al. Immunological memory to SARS-CoV-2 assessed for up to 8 months after infection Science Feb 2021 DOI: 10.1126/science.abf4063

62 Borena W et al. Follow-up study in the ski-resort Ischgl: Antibody and T cell responses to SARS-CoV-2 persisted for up to 8 months after infection, and transmission of the virus was low even during the second infection wave in Austria. MedRxiv February 2021 [https://doi.org/10.1101/2021.02.19.21252089](https://doi.org/10.1101/2021.02.19.21252089)
Some states, never closed, some reopened without a rebound or prophesied surge of cases following such reopening. One may state Russia, Texas, Florida, Tajikistan and Sweden whom never closed, where as other countries saw terrible surges with restrictions in place such as Portugal, or Slovenia. Others saw terrible surges faith restrictions and vaccination such as Israel, the UK and now India.

From a scientific point of view, a vaccinal passport is not supported and maybe counterproductive possibly harmful on an individual and global level as it may push those with negative risk/benefit balance towards vaccination leading to unexpected consequences such as altering immunity in unexpected ways and maybe counter productive. This adds to the fact that we still know little about such products and technologies; agencies have granted debatable exemptions, and some manufacturers are suggesting to vaccinate placebo group making it more difficult to spot or track side effects as serious as cancer, nervous disorders, blood issues, inflammation or altered immune system.

Altered immune systems on a large scale could lead to new pandemics.

There is a very large population recovered or “asymptomatic” that is immune possibly exceeding 2 Billion individuals, they exist in spite of a large efforts, to pretend otherwise. They need to be made aware through cellular testing or their clinical history and be informed of their protection and that such protection alters the benefit risk balance at an individual level and collectively. They should also be made aware that current knowledge indicates that cellular immunity is often long-lasting.

Such population may save vaccines for those who have more benefits than risks, it also would bring global protection from unexpected side effects related to possible immunity alterations or other side effects to be discovered after billions have been vaccinated.

Yet people are being pushed, pressured through media, some health agencies and some regulatory bodies to vaccinate in spite of higher risks than benefits.

Testing for existence of cellular immunity prior to vaccination is a needed option and would contribute to informed consent.

For ethical reasons, authors of this paper do not support segregation and feel the situation does not justify vaccinal passeports.

A simulation was performed, dealing with a corona virus pandemic hosted by the GATES foundation, John Hopkins and WEF late October 2019 right before SARSCOV2 was identified. This simulation seems to have served as a roadmap to countries' reactions except that it had assumed a much higher mortality and treatments to be less effective than they turned out to be. Countries dealt with the epidemic in a similar manner to that indicated during that simulation failing to distinguish that actual mortality was lower, and treatments were more widespread and effective than indicated in that simulation that had already targeted vaccines as the solution. They are now failing to recognize natural immunity that has saved humanity through all past epidemics across multiple mileniums.

It is neither right nor scientific to push people to vaccinate by giving them money, depriving them from education, jobs, travel or social life. It is just pressuring them to vaccinate to achieve a goal we fail to understand.

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63 Folse F K et al.
The BNT162b2 mRNA vaccine against SARS-CoV-2 reprograms both adaptive and innate immune responses medrxiv May 2021
https://doi.org/10.1101/2021.05.03.21256520

64 Ioannidis JPA
Reconciling estimates of global spread and infection fatality rates of COVID-19: An overview of systematic evaluations European Journal of Clinical investigation
https://doi.org/10.1111/eji.13554
It is not science and its benefit or harm has not been demonstrated. In all cases, excessive mortality happening in countries that massively vaccinated must be explained as to who, when, why, what before undertaking further steps...

If we were to be consistent, we would require all to have either test or a proof of reactivity from cellular immunity to circulating strains whether vaccinated or not. We do not support this idea, but it would at least be consistent and would at least demonstrate some resistance to virus independently of vaccination instead of unjustifiably push those with higher risks than benefits towards vaccination without taking responsibility for mandatory vaccination.

The fact that states have been brave enough to reopen and return to populations their civil liberties demonstrate feasibility of such approach in population.

From a democratic point of view, it would become a tool of segregation, division and possibly submission.

In some countries, such a policy is strongly opposed by the population, as is demonstrated by a large inquiry done in France on more than 100 000 individuals by a public institution demonstrating that 67% are strongly opposed, and 72% are opposed to such a passport or certificate. [65]

It has been suggested to maintain such segregation and civil liberties restrictions until you, the WHO, declare the end of the pandemic. However, if SARSCOV-2 follows the same pattern as that of HCOV-OC43, continues to circulate as a common cold, it may be a long time before the WHO declares the end of the pandemic. This may be reinforced if we continue to count those mostly dead of comorbidities as COVID deaths.

Evidence as to vaccine passport stopping the epidemic is absent, and risks are high. All it does is promote vaccination for those with a negative risk-benefit balance to the benefit of manufacturers and those who would profit from setting up a new control system as to populations’ movements. All it does, is promote vaccination for those with a negative risk benefit balance in the interest of a minority. It adds pressure and temptation to a weakened tired population and exposes a large portion to possibly unknown risks with little benefit to them and unforeseen consequences to the community. Such risks take society into uncharted territories harming social, mental and physical health.

**Masks**

One size fits all face-covering for many months in the open air and public places.

Evidence, as to mask efficacy against covid, is weak if that. It is even weaker in outdoors settings where risks are minimal.[66][67] Some Media who have had a large influence in driving the epidemic are starting to relate it. It seems devoid of reason to suggest that vaccination could free people from outdoor masking as this latter is baseless. Data comparing face-covering mandates outdoors suggests a possible counterproductive effect.[68][69]

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[Accessed 26/04/2021]


[Accessed 22 April 2021]
Studies exploring which masks, when, for how long, associated hygiene and feasibility have gone missing.

Mask wearing is a medical intervention, and prolonged wearing comes with unknown risks for adults and children as no population have had to wear masks daily for multiple hours for such prolonged time indoors and outdoors. There is even less data as to prolonged mask wearing for children.

It is different to temporarily wear a high-quality mask under excellent hygienic conditions by a health professional in a closed environment for a few hours and to wear a face cover by a population constantly in the open or in questionable or counterproductive hygienic conditions. The only setting in which the mask seems to have an efficacy is within hospitals where symptomatic patients (pulmonary clinical presentations) are more numerous, or eventually when worn by symptomatic persons in crowded indoors places in period of high virus circulation, thus the air transmission risk is higher. FFP2 masks were the type of masks with the higher rate of lowering the risk. Under such conditions, mask hygiene can be respected thus showing efficacy and minimizing risks linked to prolonged use.

Prior to this epidemic, evidence indicated that face covering and cloths masks were associated with populations developing asthma, being more subject to infections, developing nasal resistance in addition to headaches, possibly leading to increased consumption of anti-inflammatory drugs. We know this from studies done where populations are mandated to cover their faces for religious regions.[70][71][72][73][74]

Breathing pesticides from cotton, detergent, and other chemicals from masks for a prolonged time may also come with its share of future risks. Nobody can responsibly claim to know what the long term side effects are of such constant prolonged wearing of masks on adults or growing children.

Evidence is weak, it is absent outdoors, benefits are limited, some risks are known, others have been hypothesised, and others may still be discovered. Yet masks are enforced in many countries, including outdoors and on children. Authorities imposing such brutal interventions did not accompany it by any monitoring instruments to at least measure efficacy benefits and risks in the short and long term.

Besides its sanitary effect, attention should be given to mechanical effect of “resistance to breathing” induced from long-term mask wearing. It has long been demonstrated that an increased pulmonary effort can cause stress and damages. Still more especially for children in development, long-term mask wearing may be deleterious and cause cascade of long-lasting pathologies.[75][76]

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[70] Marija G. Matic et al. Does Occupational Exposure to Solvents and Pesticides in Association with Glutathione S-Transferase A1, M1, P1, and T1 Polymorphisms Increase the Risk of Bladder Cancer? The Belgrade Case-Control Study PLOS One June 2014 https://doi.org/10.1371/journal.pone.0099448
[75] Akoumianaki E et al. The Injurious Effects of Elevated or Nonelevated Respiratory Rate during Mechanical Ventilation American Journal of Respiratory and Critical Care Medicine April 2018 https://doi.org/10.1164/rcrm.201804-0726CI
Breathing pesticides from cotton, detergent, solvents, plastic and other chemicals for a prolonged time may also come with its share of future risks. Nobody can responsibly claim to know what the long term side effects are of such constant prolonged wearing of masks on adults or growing children.

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**Fear propagation**

Fear has been a tool used by some governments, some media and some members of the medical body to control populations.

Many scientists forgot that chronic stress is harmful may cause deadly and chronic diseases, have a physiological impact and a psychological one. It may weaken the immune system to the extent of increasing epidemic severity in all senses.777879

Those propagating fear successfully, made people afraid of each other, nourishing hatred and guilt based on little or no evidence. They were claiming that healthy people are dangerous, that everyone is potentially dangerous and that our mere existence becomes a threat.

Fear and pressure extended to healthcare providers in some democratic countries. In addition, to co-signatories of the letter, others have expressed support but feared retaliation in their careers or supplies if they contradicted authorities' view.

This adds to harmfull psychological, social, side effects associated to anxiety possibly leading to depression eating disorders, addictions and violence.

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” as defined by the WHO. In addition to physical issues addressed by this letter, following fear propagation, oppression, pressure, absence of debate, mental and social health must become a priority as matter of urgency and the WHO must urge to stop experimenting and contribute to bringing back a free, peaceful, calm society.

**4) Conclusion**

The time has come to drive decisions on science, real data and evidence instead of hypothesis. The benefits and risks of each intervention must be measurable, It is also time to return to proportionality as a large portion of the population has become naturally immune, as Covid mortality is comparable or milder than many recent

influenza strains for young healthy individuals below 70, as it is significantly milder than influenza for children, as treatments have emerged de facto in spite of many health agencies trying to ban them or block them. This disease is no longer new, it is now better studied and understood than many other known diseases.

Just like for covid vaccines, to this date, we do not have independent quality studies indicating risks/benefits of masks use: which masks, where, when, how, when to change them, for whom. Scientifically, we are almost at the same point we were at in 1918.

- Testing medical interventions outside of trials boundaries are taking us seven decades ago.
- Masks took us back a century ago.
- Lockdowns took us back to the middle ages.
- Denying treatment to patients and compromising on the safety of new technologies may be taking us to times before civilisation and Hippocrates.

To this date, re-allocation of cheap molecules whose risks are known were denied support and were demonised. Even when safety was known, compiled trials brought evidence, such drugs were denied emergency use authorisation and were being subjected to different standards of evidence or safety than those applied to vaccines. When results were promising, further studies were never performed, keeping science in doubt.

It is time to evaluate all tools under the same consistent, pragmatic risk/benefit analysis criteria and choose those that prove efficacy, minimise risk, protect freedom, peoples' livelihood physical and mental health.

As natural immunity has progressed in much of the world, as humanity has acquired much understanding, vaccines alongside treatments, population strengthening, protection of the frailest, used wisely may provide us very soon with a favourable outcome.

The following measures are urgently required.

1) Immediate study in cooperation with the abovementioned country authorities to learn where and why the outcome is so disappointing to help choice for whom, when, which risks and which benefits
2) Recommendation to test for ongoing infection before vaccinating
3) Obligation to verify that the individual has healed from Covid either through interviewing him or through cellular immunity testing.
4) Warn against vaccinating those who have had covid already and require that for mRNA vaccines, this be done within clinical trial boundaries.
5) Recommend emergency use authorisation for ivermectin as evidence for its safety is higher than that of vaccines, and it probably shows efficacy.
6) Warn against a vaccine passport or any similar discriminatory tool reminding that vaccinated may spread just as well, and only those with reactive cellular immunity might spread less.\(^{50}\) \(^{81}\)
7) Make a recommendation against the constant masking of adults, particularly outdoors.
8) Make a recommendation against masking children.
9) Make a recommendation to countries to promote good diet, sports and make sure all their decisions help their population become healthier and stronger.
10) Make a recommendation to countries to conduct nationwide active indicatives to correct vitamin D

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\(^{50}\) Sewell et al. Cellular immune responses to covid-19 BMJ 2020;370:m3018 July 2020 https://doi.org/10.1136/bmj.m3018

\(^{81}\) Kristen W. Cohen et al. Longitudinal analysis shows durable and broad immune memory after SARS-CoV-2 infection with persisting antibody responses and memory B and T cells Medrxiv April 2021

https://doi.org/10.1101/2021.04.19.21255739
Request to the WHO: Group of scientists, doctors and lawyers - Project English Version

deficiencies and make sure interventions contribute to that effect.
11) Make a recommendation to countries to conduct nationwide active initiatives to improve ventilation in public places and businesses.
12) Call for an immediate investigation of all suspected actors related to the "lancet-gate." and consequences such as interrupted trials that did not resume, possibly resulting in preventing lives from being saved.
13) Require countries to actively monitor all vaccinating individuals for the eight years following vaccination and report daily publicly all data related to mortality, hospitalisations, disability, autoimmune diseases, blood diseases, respiratory diseases, cancers, idiopathic diseases, in comparison with a control of non vaccinated individuals.
14) Call for an enquiry in cooperation with local authorities of each country as to the reason for excess mortality in each of the countries where excess mortality coincided with vaccination. This is much needed in those countries where vaccination coincided with their worst phase after 14 months.
15) Require ethical sharing of vaccines across nations to protect those who have a benefit instead of harming those with a very limited benefit
16) Make risk/benefit evidence-based decisions in a fair society debate for accepted choices that profit the group and protect minorities and freedom.
17) Contribute to the scientific debate open by this letter and this first benefit/risks comparison grid using consistent criteria. Remind that when assessing risks/ benefits, there are several dimensions, the strength of evidence, short term benefits, long term benefits, short term risk and long term risks.
18) Issue recommendations when there is a benefit beyond covid until covid preliminary benefit evidence becomes stronger (ventilation, vitamin d correction, nutrition and obesity) and only restrict liberties in proportion, for a short time, under democratic control with sufficient evidence of efficacy and never based on hypothesis.
19) Conduct poll analysis as to proportions of populations in different areas who have reactive cellular immunity to better understand needed vaccination level in each area in addition to whom to vaccinate.
20) As a result of the above-requested investigations, communicate transparently as to possibly discovered vaccines risks, suspected ones, from such investigations and clearly acknowledge that long term side effects and risks are not known. Recommend to countries to require fair, informed consent from each vaccinated without pressure or temptation.
21) Require an investigation of all bodies and individuals decision-makers with conflicts of interests.
22) Stop all private funding for all bodies and individuals making decisions.

This request is also made public as an open letter so that humanity can inform itself, study and read the literature, look at the data, and weigh in on the decisions.

Mehra M et al. Retraction—Hydroxychloroquine or chloroquine with or without a macrolide for treatment of COVID-19: a multinational registry analysis Lancet June 2020
https://doi.org/10.1016/S0140-6736(20)31324-6
Figure 1 – Israel, Emirates, UK massively vaccinating
Figure 2 – Worst Covid phase in India, Kuwait and Bahrain coinciding with massive vaccination

Daily new confirmed COVID-19 deaths per million people

Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.

Source: Johns Hopkins University CSSE COVID-19 Data

CC BY
Figure 3 – Uruguay, Hungary, Seychelles

Daily new confirmed COVID-19 deaths per million people

Shown is the rolling 7-day average. Limited testing and challenges in the attribution of the cause of death means that the number of confirmed deaths may not be an accurate count of the true number of deaths from COVID-19.

Source: Johns Hopkins University CSSE COVID-19 Data

CC BY
Figure 4 – Israel mortality rise after wave in young and elderly after vaccination and Belgium 45-64

Still significant excess mortality in 65+ group after covid mortality dropped and after vaccination campaign. It is higher than before vaccination.

Significant excess mortality in 15-44 population after covid mortality dropped and after vaccination campaign.

Vaccination 45-64
With comorbidities
Figure 5 – France and Italy excess mortality in mRNA vaccinated groups

- High excess mortality in mRNA vaccinated populations
- More moderate excess mortality in unvaccinated groups

France

Italy

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Download as Image
Table 1 - Analysis from a study following the single manufacturer clinical trial leading to emergency approval

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<th>Under Clinical trial ecosystem</th>
<th>Pfizer</th>
<th>Moderna</th>
<th>Janssen</th>
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</thead>
<tbody>
<tr>
<td>Main Exclusion criteria</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Those recovered from Covid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Pregnant or breastfeeding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Previous vaccination with a Coronavirus vaccine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) Immunocompromised</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Treated with immunosuppressants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6) Below 18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7) Allergies, Urticaria possibly to vaccines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Below 18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Pregnant</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Total Severe Covid sample used for stats analysis | 10 | 30 | 99 |

| Relative Reduction Risk from severe Covid | 90,00 % | 100,00 % | 80,00 % |
| Absolute Reduction Risk from severe Covid | 0,36 % | 0,20 % | 0,31 % |

| Relative Reduction Risk from new emerging strains South Africa, Brazil, India | Unknown <50 % below 30 %? Data from one preliminary suggests much lower efficacy than that | Unknown <50 % below 30 %? Data from one preliminary suggests much lower efficacy than that | Unknown <50 % below 30 %? Data from one preliminary suggests much lower efficacy than that |

| Absolute Reduction Risk from new emerging strains South Africa, Brazil, India | Unknown | Unknown | Unknown |

| Relative Increased Risk of systemic side effects | 61,00 % | 68,70 % | Unclear in study 9 % to 20 % from phase 2 |
| Absolute Increased Risk of systemic side effects | 15,00 % | 15,80 % | Could not be derived from the study |
| Relative Increased Risk of severe side effects* | 63,00 % | 85,00 % | 85,00 % |
| Absolute Increased Risk of systemic of severe side effects** | 0,46 % | 0,28 % | 0,12 % |

| Long term side effects | Unknown precautionarily assumed high | Unknown precautionarily assumed high | Unknown precautionarily assumed high |

| Number Needed to Treat from Clinical trial strategy to reduce one severe Covid case | 2715 | 507 | 323 |

Note: Janssen's vaccine had been approved before any publications. It turns out from such publication that some risks were known since clinical trial
* 240/139 table S3[32] and 14/3 TableS6-S10[44] Table S6[40]
**(240-139)/21621[32], (14-3)+(234-202)/14358[44], 19 severe Janssen's vaccine / 4 placebo[40]
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Table 2 - Targetted approach to those who need it vs random massive

<table>
<thead>
<tr>
<th></th>
<th>Pfizer</th>
<th>Moderna</th>
<th>Janssen</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost for one reduction of a severe covid under Clinical trial conditions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of systemic/severe reactions</td>
<td>746</td>
<td>805,33+systemic</td>
<td></td>
</tr>
<tr>
<td>Cost of vaccinating 2715 individuals + cost of treating adverse reactions + cost of treating long term effects + cost of work stoppage for those with adverse reactions</td>
<td>Cost of vaccinating 507 individuals + cost of treating adverse reactions + cost of treating long term effects + cost of work stoppage for those with adverse reactions</td>
<td>Cost of vaccinating 323 individuals + cost of treating adverse reactions + cost of treating long term effects + cost of work stoppage for those with adverse reactions</td>
<td></td>
</tr>
<tr>
<td>Financial cost</td>
<td>Cost of vaccinating 2715 individuals + cost of treating adverse reactions + cost of treating long term effects + cost of work stoppage for those with adverse reactions</td>
<td>Cost of vaccinating 507 individuals + cost of treating adverse reactions + cost of treating long term effects + cost of work stoppage for those with adverse reactions</td>
<td>Cost of vaccinating 323 individuals + cost of treating adverse reactions + cost of treating long term effects + cost of work stoppage for those with adverse reactions</td>
</tr>
</tbody>
</table>

**Cost for one reduction of a severe covid targetted approach**

Subject to investigation and explanation of covid mortality in Israel, UK, Emirates, Chile, India and excess mortality in France, Israel and Italy coinciding with vaccination

<table>
<thead>
<tr>
<th></th>
<th>Pfizer</th>
<th>Moderna</th>
<th>Janssen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of systemic and severe reactions</td>
<td>23,2</td>
<td>23,8 from the study</td>
<td></td>
</tr>
<tr>
<td>Cost of vaccinating 12,5 individuals + cost of treating adverse reactions + cost of treating long term effects + cost of work stoppage for those with adverse reactions</td>
<td>Cost of vaccinating 12,5 individuals + cost of treating adverse reactions + cost of treating long term effects + cost of work stoppage for those with adverse reactions</td>
<td>Cost of vaccinating 12,5 individuals + cost of treating adverse reactions + cost of treating long term effects + cost of work stoppage for those with adverse reactions</td>
<td></td>
</tr>
<tr>
<td>Financial cost</td>
<td>Cost of vaccinating 12,5 individuals + cost of treating adverse reactions + cost of treating long term effects + cost of work stoppage for those with adverse reactions</td>
<td>Cost of vaccinating 12,5 individuals + cost of treating adverse reactions + cost of treating long term effects + cost of work stoppage for those with adverse reactions</td>
<td>Cost of vaccinating 12,5 individuals + cost of treating adverse reactions + cost of treating long term effects + cost of work stoppage for those with adverse reactions</td>
</tr>
</tbody>
</table>

Note: Janssen's vaccine had been approved before any publications. It turns out from such publication that some risks were known since the clinical trial.
### Table 3 - Risk-Benefit by group

<table>
<thead>
<tr>
<th></th>
<th>Pfizer</th>
<th>Moderna</th>
<th>Janssen</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Analysis of risk-benefit for those immune and healthy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of Severe Covid</td>
<td>&lt;0,005%</td>
<td>&lt;0,005%</td>
<td>&lt;0,005%</td>
</tr>
<tr>
<td>Risk of short term</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>systemic side effects</td>
<td>15,00%</td>
<td>15,80%</td>
<td>study</td>
</tr>
<tr>
<td>Risk of severe side</td>
<td>0,46%</td>
<td>0,28%</td>
<td>0,12%</td>
</tr>
<tr>
<td>Efficacy for new</td>
<td>Unknown possibly counterproductive</td>
<td>Unknown possibly counterproductive</td>
<td>Unknown possibly counterproductive</td>
</tr>
<tr>
<td>emerging strains</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long term side effects</td>
<td>assumed high</td>
<td>assumed high</td>
<td>assumed high</td>
</tr>
<tr>
<td><strong>Analysis of risk-benefit for those young and healthy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of Severe Covid</td>
<td>&lt;0,1%</td>
<td>&lt;0,1%</td>
<td>&lt;0,1%</td>
</tr>
<tr>
<td>Risk of short term</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>systemic side effects</td>
<td>15,00%</td>
<td>15,80%</td>
<td>study</td>
</tr>
<tr>
<td>Risk of severe side</td>
<td>0,46%</td>
<td>0,28%</td>
<td>0,12%</td>
</tr>
<tr>
<td>Efficacy for new</td>
<td>Unknown &lt;30%?&lt;50%?</td>
<td>Unknown &lt;30%?&lt;50%?</td>
<td>Unknown &lt;30%?&lt;50%?</td>
</tr>
<tr>
<td>emerging strains</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long term side effects</td>
<td>assumed high</td>
<td>assumed high</td>
<td>assumed high</td>
</tr>
<tr>
<td><strong>Analysis of risk-benefit for those at risk</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subject to mentioned requested investigation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of Severe Covid</td>
<td>8,00%</td>
<td>8,00%</td>
<td>8,00%</td>
</tr>
<tr>
<td>Risk of short term</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>systemic side effects</td>
<td>11,00%</td>
<td>12,00%</td>
<td>study</td>
</tr>
<tr>
<td>Risk of severe side</td>
<td>0,46%</td>
<td>0,28%</td>
<td>0,12%</td>
</tr>
<tr>
<td>Efficacy in doubt as</td>
<td>Unknown &lt;30%?&lt;50%?</td>
<td>Unknown &lt;30%?&lt;50%?</td>
<td>Unknown &lt;30%?&lt;50%?</td>
</tr>
<tr>
<td>new strains keep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>emerging</td>
<td>Unknown precautionarily assumed high but lower as they assumed high but lower as they have a lower life expectancy.</td>
<td>Unknown precautionarily assumed high but lower as they have a lower life expectancy.</td>
<td>Unknown precautionarily assumed high but lower as they have a lower life expectancy.</td>
</tr>
<tr>
<td>Long term side effects</td>
<td>have a lower life expectancy.</td>
<td>have a lower life expectancy.</td>
<td>have a lower life expectancy.</td>
</tr>
<tr>
<td><strong>Analysis of risk-benefit for frontliners who correlate with super-spreaders (not immune naturally)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of Severe Covid</td>
<td>&lt;0,1%</td>
<td>&lt;0,1%</td>
<td>&lt;0,1%</td>
</tr>
<tr>
<td>Risk of short term</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>systemic side effects</td>
<td>15,00%</td>
<td>15,80%</td>
<td>study</td>
</tr>
<tr>
<td>Risk of severe side</td>
<td>0,46%</td>
<td>0,28%</td>
<td>0,12%</td>
</tr>
<tr>
<td>Efficacy in doubt as</td>
<td>Unknown &lt;30%?&lt;50%?</td>
<td>Unknown &lt;30%?&lt;50%?</td>
<td>Unknown &lt;30%?&lt;50%?</td>
</tr>
<tr>
<td>new strains keep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>emerging</td>
<td>Unknown precautionarily assumed high but lower as they assumed high but lower as they have a lower life expectancy.</td>
<td>Unknown precautionarily assumed high but lower as they have a lower life expectancy.</td>
<td>Unknown precautionarily assumed high but lower as they have a lower life expectancy.</td>
</tr>
<tr>
<td>Long term side effects</td>
<td>have a lower life expectancy.</td>
<td>have a lower life expectancy.</td>
<td>have a lower life expectancy.</td>
</tr>
</tbody>
</table>
### Table 4 - Screening Issues

<table>
<thead>
<tr>
<th></th>
<th>Pfizer</th>
<th>Moderna</th>
<th>Janssen</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For all groups</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Propagation reduction</strong></td>
<td>Unproved... Reports showing the opposite and suspicion as to vaccine pressure selection leading to mutations</td>
<td>Unproved... Reports showing the opposite and suspicion as to vaccine pressure selection leading to mutations</td>
<td>Unproved... Reports showing the opposite and suspicion as to vaccine pressure selection leading to mutations</td>
</tr>
<tr>
<td><strong>Legal Aethical</strong></td>
<td>Cannot be forced, tempted or pressured as some or many may have a negative risk/benefit balance, and data doesn't seem to support preventing spreading. Both conditions would have to be fulfilled.</td>
<td>Cannot be forced, tempted or pressured as some or many may have a negative risk/benefit balance, and data doesn't seem to support preventing spreading. Both conditions would have to be fulfilled.</td>
<td>Cannot be forced, tempted or pressured as some or many may have a negative risk/benefit balance, and data doesn't seem to support preventing spreading. Both conditions would have to be fulfilled.</td>
</tr>
<tr>
<td><strong>Legal</strong></td>
<td>Excluded profiles must remain excluded as risk benefits cannot be extrapolated. Can only be vaccinated under clinical trial conditions</td>
<td>Excluded profiles must remain excluded as risk benefits cannot be extrapolated. Can only be vaccinated under clinical trial conditions</td>
<td>Excluded profiles must remain excluded as risk benefits cannot be extrapolated. Can only be vaccinated under clinical trial conditions</td>
</tr>
<tr>
<td><strong>Legal</strong></td>
<td>Dosage and protocol must follow clinical trial protocols without changes to dose or approach.</td>
<td>Dosage and protocol must follow clinical trial protocols without changes to dose or approach.</td>
<td>Dosage and protocol must follow clinical trial protocols without changes to dose or approach.</td>
</tr>
</tbody>
</table>

Note: Janssen's vaccine had been approved before any publications. It turns out from such publication that some risks were known since clinical trial.

Severe Covid in Moderna trial is defined in protocol document. Out of 30 cases described as severe in the placebo group - moderna trial only 1 was admitted in ICU. Calculated reduction rates were done on basis of 30 but if goal is to reduce ICU pressure, with 1 case from placebo no statistics can be drawn.
### Table 5–Comparing risk benefits of vaccinating populations and treatment using same standards of evidence and criteria

<table>
<thead>
<tr>
<th>Vaccination of Naïve, below 55 years old, healthy people</th>
<th>Short Term Benefits</th>
<th>Long Term Benefits</th>
<th>Short Term Risks</th>
<th>Long Term Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure / Marketed</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Vaccination of Naïve, with high-risk profile*</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Pressure / Marketed</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Vaccination of recovered patients, all ages</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Pressure / Marketed</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Vaccination of people with ongoing Covid infection, all ages</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Pressure / Marketed</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Vaccination of other groups for whom efficacy is not proved</td>
<td>unclear</td>
<td>unclear</td>
<td>unclear</td>
<td>unclear</td>
</tr>
<tr>
<td>Pressure / Marketed</td>
<td>Pressure / Marketed</td>
<td>Pressure / Marketed</td>
<td>Pressure / Marketed</td>
<td>Pressure / Marketed</td>
</tr>
<tr>
<td>Treatment with Ivermectin</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Pressure / Marketed</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Early outpatient multi-drug therapy as per clinical directions</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Pressure / Marketed</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

*Provided answers are provided as too high covid mortalities observed in Emirates, UK, Israel, Chile, India, in addition to excess mortality in vaccinated ranges in Italy and France
### Table 6–Comparing actions and interventions using the same standards of evidence and criteria

<table>
<thead>
<tr>
<th>STRENGTH OF EVIDENCE</th>
<th>SHORT TERM BENEFITS</th>
<th>LONG TERM BENEFITS</th>
<th>SHORT TERM RISKS</th>
<th>LONG TERM RISKS</th>
<th>In many countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity, sports and nutrition</td>
<td>6</td>
<td>5</td>
<td>6</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Nutraceuticals and Vitamin D correction</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Aeration and encouraging activity in open air settings</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Universal masks in open air and for children</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Massive vaccination</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Vaccinal passport or any similar document paper or electronic</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Treatment with Ivermectin</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Early outpatient multi-drug therapy as per clinical directions</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Fear propagation</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
Request to the WHO: Group of scientists, doctors and lawyers - Project English Version

Signed by

200+ Doctors and scientists
from 18 countries
from 5 continents

Request sent to the WHO with signatory list

May 2021