FRAUDULENT COVID CONCEPTS

Turning around the Covid-19 'super tanker' – ICU chief

5th April 2022 by Editor BizNews

While not an epidemiologist or vaccinologist, this former ICU chief graphically illustrates the inflexibility of those at the helm of global Covid 19 containment. From the information he shares, it seems like a case of, "we've made up our minds, now don't confuse us with new conflicting data that might force us to change our strategy." There are billions in profits and huge reputations at stake. An analogy would be the World Health Organisation's unrelenting stance on nicotine consumption. An entire monolithic global structure has been created employing hundreds of thousands of scientists, bureaucrats and researchers – all turning their guns on Big Tobacco – however nicotine may be consumed. Yet technology now challenges them with nicotine harm reduction devices proven to save lives and reduce really damaging combustible nicotine consumption. Again, it's the Third World, particularly Africa, that has the most smokers and most stands to benefit from a flexible, country-specific harm reduction approach, with accessibility and price reduction critical priorities. Covid has produced some chillingly similar behaviour. – Chris Bateman

BA.2 is on the horizon – is it time to finally give 'early Covid-19 treatment' a chance?

By Dr Nkosinathi Mdladla*

The first two years of the Covid-19 pandemic have internationally been characterised by cynics as a top-down non-consultative approach, where government-appointed officials seemed uninterested in any outside input. Individuals and experts had different views to the official narrative typically being driven by advisory institutions setting policies and guidelines for the pandemic intervention.

This was followed by an unwillingness to learn and adapt, especially in countries like South Africa where the pandemic arrived only around four months after it started in Wuhan, China. In the calendar of Covid-19, two weeks is a season and there is a lot to learn from that period to formulate strategies relevant to your country based on its unique characteristics and capabilities.

Almost everything that the Ministerial Advisory Committee in South Africa (and many of the international counterparts we seemed to follow lockstep, especially in the USA and the United Kingdom), has been driven by what is seemingly a political narrative with little semblance of it following known and emerging science. The excuse that a "novel virus" was driving the pandemic – and therefore what we knew from prior similar

pandemics and long-standing medical principles of virology and immunology of respiratory coronaviruses disease did not hold true – was exactly that: an excuse that only non-medical people and non-academics could have held since it has caused so much collateral damage someone will have to account.

That lockdown would achieve what was claimed it would is one of the gravest mistakes of this pandemic. "Two weeks to flatten the curve" has not aged well, predictably to most of us who called this an ill-informed strategy from the outset. A principle and policy never adopted or tested prior to Covid-19 – deemed dangerous and discouraged by the WHO as a blanket strategy for every nation out of context of each country's reality – was adopted by many nations including ours.

I was one of the harshest critics of our lockdown, which was completely meaningless for our reality and wrote a piece on its possible negative impacts as soon as the hard lockdown was declared on 26 March 2020, and all of those predictions have come to pass. I tried getting my opinion piece as an academic HOD onto some of South Africa's major mainstream media publications but it was rejected by all, citing the reason that "it went against the official government policy" and they would not publish it. It would seem open discussion would be the first casualty of the pandemic. Data emerging from developed nations has now shown only a 0.2%

reduction in mortality from Covid-19 through lockdowns. The collateral damage in lost employment, business closures, mental health, delayed medical interventions, child development and many other parameters has not been counted fully yet but is known to be significant.

Very early in the pandemic, the business world seemed to have realised this was not a pandemic that threatened the existence of mankind as the vulnerable groups for severe disease and mortality were clearly characterised from as early as China in February/March 2020. This realisation drove what would be the most selfish and grandest pillaging of government coffers by unscrupulous businesspeople using the credentials of respected top university professors who were more than happy to nail their colours to the mast of a politically driven ideology, the goals of which were not just a benevolent attempt to save lives.

Lockdowns and two weeks to flatten the curve

With these lockdowns, non-pharmacological interventions of masking, frequent hand sanitising and physical (social) distancing were mandated and enacted as policy, outdoors and indoors, despite known science and many studies that had shown their inefficacy in managing a respiratory virus. This was an opportune time to make hundreds of millions of rand in selling PPE, hand sanitisers (including deep cleaning of buildings), advertising for physical distancing and building field hospitals or renting

isolation/quarantine facilities including whatever other profits that could be made from the paraphernalia that addressed ‘flattening the curve. These strategies were adopted with unquestioning fervour and once more with a willing cabal of medical experts weighing on the benefits of these NPIs.

These NPI measures are now known to not have made any dent and cloth masks are deemed to potentially increase risks for the individuals wearing them. Schools and businesses were closed to ensure these measures were easy to enforce. The education of children with poor access to remote learning was negatively impacted for two years and will potentially further widen the poverty gap that existed before Covid-19. The impact of these interventions with loss of social interactions among the youth has resulted in significant psychological turmoil translating into increased self-harm and risky behaviour in this group. South Africa does not have the means nor the appetite to document these.

Track and trace and the fraudulent PCR test

The next senseless intervention we adopted and have never been able to shake off or curtail is the PCR test followed by the lateral flow test that changes nothing. The country has spent well over R2bn on Covid-19 testing since the pandemic started excluding the procurement of equipment, salaries for staff and the administration that goes with these tests. For almost the entirety of the first wave, these

tests were meaningless because of the time it took for results to be available, especially the track and trace strategy. The scandal included the amounts the state and private procurers were charged compared to the upfront costs of the tests to the laboratories, with the Competition Commission eventually ruling on the pricing irregularities where laboratories were making up to 10 times the cost of the test.

The science behind the PCR test has been dubious from the outset. Many, including myself, have written about the underlying science of the PCR test and why it was senseless to do widespread testing in poor countries like South Africa. The obvious reasons were its inaccuracy (false negatives), non-specificity (false positives), usefulness (no impact on transmission or patient management) and the dangers of delayed care for other interventions (while waiting for a swab result). Covid-19 was clearly a seasonal syndrome that did not necessarily need testing in asymptomatic individuals. The latter was another fraudulent concept that enabled the peddlers of the PCR test and the 'fear porn' that prolonged the insanity of the pandemic. The FDA eventually withdrew the EUA for PCR tests at the end of 2021 for various reasons with some media outlets saying it was owing to their inability to discriminate the SARS-COV-2 virus from other viruses causing flu.

Operation warp speed and vaccine development

From September/October 2020, Big Tech started discussing the possibility of expedited vaccines that would emerge in late 2020, with early rollouts expected in early 2021. The failure of the past interventions mentioned above – lockdowns, NPIs and track and trace with PCR testing – were suddenly forgotten and the heretofore impossibility of a successful Covid-19 vaccine within a few years was the holy grail that the believers in the former were now looking forward to. This was despite prevailing evidence to the contrary. We have failed to create a successful vaccine for SARS and MERS to this day. We have never been able to create a vaccine for the influenza virus that does not need annual updating, and we have not been able to create one with more than 60% efficacy against transmission for the entire existence of influenza.

With everything pointing towards the impossibility of a successful safe and effective vaccine against Covid-19 within a few years owing to obvious challenges it would face, the medical community and especially high-profile professors of major universities put their names behind the vaccine narrative, with no room to ask questions or request a more nuanced and focused approach targeting those more deserving (the elderly and vulnerable). The expected challenges for vaccines were clear and they asked for a different approach; one that encompassed

other strategies overlooked up to this point including early treatment:

- Mutations were clearly going to be a challenge for the vaccines, yet none of the experts saw this coming. Politicians regularly came onto public fora with their messages of 'safe and effective' and proclaimed the infallibility of the vaccines even against variants.
- Adverse effects with some people unable to take subsequent doses.
- Hesitancy for various reasons including religious and component sensitivity.
- Poor efficacy – >95% efficacy against infection had not been proven in independent studies and was a Pfizer marketing information that the CDC accepted out of hope and not science.

In spite of everything we had known before Covid-19, we once more put all our eggs into one basket and pinned our hopes on the vaccines ending the pandemic. Within three months of the highly vaccinated country's (Israel) major rollout, the challenges of the vaccines were immediately clear. Israel had a Covid-19 wave in the middle of its first rollout, which was a signal of the inefficacy of the Pfizer mRNA vaccine in stopping transmission even in the Beta wave. Chile, Seychelles, Indonesia and Gibraltar soon followed but excuses were advanced each time for why the vaccines failed in those

countries. Israel's fourth wave once more demonstrated the inefficacy of the mRNA Pfizer vaccine in halting transmission, with significant hospital admissions reported in the Omicron wave.

Making a case for early treatment – the pandemic's blind spot

Early treatment has been ignored from the beginning and throughout this pandemic. The narrative was the burying of therapies; hydroxychloroquine seemed to show promise as a Covid-19 repurposed therapeutic. Its adoption by Donald Trump in the middle of a US election campaign would not save it from being malaligned even when it became clear the Surgisphere data that negated it was falsified and fraudulent. In line with the prevailing drive of maximising profits in a pandemic that had a potential to be manageable, only drugs with patents and massive R&Ds seemed to be prioritised in this pandemic. Unfortunately, none of the available recommended drugs that could possibly alter disease progress was available in the outpatient setting. Up to this day, the NEMLC (National Essential Medicines List Committee) still does not have recommended agents for early outpatient treatment of Covid-19.

The three drugs that have survived and have been significantly used in South Africa are corticosteroids, Tociluzimab and Remdisivir. The state has access only to corticosteroids and the other two are unaffordable for wide state sector rollout as they cost

over R30k and R10k respectively for a course of treatment. Another agent Bariticinib was added and authorised for funding in private practice at more than R35k for a course of treatment. These drugs have been considered to be disease-altering agents but many patients still died with some responsible for side-effects that eventually contributed to in-hospital mortality. The indigent state patient who contracts Covid-19 therefore still has no alternative for effective early treatment to prevent hospitalisation and death more than a year after the first vaccines were rolled out.

The UK is currently undergoing a significant wave driven by the BA.2 variant of Omicron. In contrast to what we experienced with our earlier variant of Omicron in South Africa, hospitalisations and mortality are high among the vaccinated in the UK, with the recent ONS data putting this number at 90% for certain patient categories. Based on what we have observed, it is almost a certainty that South Africa's next wave will be driven by this variant or another emerging. What's uncertain is how that variant will behave for the vaccinated and unvaccinated (not previously infected). We know past infection still seems to be protective to a significant degree and this may mean we still have a significant population that will be protected.

In terms of the lockdown instituted to increase hospital capacity in March 2020, we have learnt a few things. Buildings don't treat patients but

personnel do. We have wasted close to R3bn on infrastructure upgrades and the field hospitals that were meant to service state patients in lieu of massive admissions that never materialised. Some of these units were clearly unnecessary and are still unfinished with the possibility they will never be used for this pandemic. The government was advised not to build them but Thusi once more ignored the advice of critical care experts. This was another corruption arrangement that served to benefit a few at the expense of the taxpayer.

The real South African context needs a unique approach and strategy. It is time for other voices to be heard now for the benefit of all South Africans. The major blind spot in our strategies so far has been the deliberate ignoring of general practitioners who see more than 90% of early Covid-19 patients early in their disease. The futility of late/in-hospital treatment of the virus is apparent to all those who have managed the condition late. In the ACCCOS Trial (African Critical Care Covid-19 Outcomes Study), the mortality of this disease in the continent was up to 40% in hospital admitted patients (and possibly worst in non-academic hospitals).

South Africa is one of the world's most unequal societies, with approximately 80% poor and worsening since the pandemic. These citizens do not have access to private healthcare, and therefore, will not have access to the available in-hospital expensive therapies that only the insured can access. The

regulators and the South African Government are failing the majority of South Africans by protecting the market of Big Tech at the expense of their population and not enabling access to repurposed early Covid-19 therapeutics to the majority of citizens. These cheap agents are once more commonly available to the paying patients and those unable to afford them have to rely on the benevolence of kind donors and caring GPs.

There has been a concerted effort to tarnish the remaining of these last cheap therapies in Ivermectin. Yet, it still continues to save many lives through the dedication of many GPs and some specialists who have seen the value and benefit of the drug. Although Ivermectin gets the brunt of the attacks, what gets lost in translation is that its vilification negates the whole concept of early treatment for which Ivermectin is one of many drugs. Through informal forums, many of us tackling early treatment have taught ourselves these therapy combinations and we adapt the protocols based on our observed results. The critical care community has sadly been left out of these developments and is short-changing patients, as the sole belief in the expensive drugs backed by Big Tech is blinding them to the possibilities of traditional doctoring: the trying of drug combinations for better outcomes.

Neglecting early treatment has clearly contributed to late mortality, which goes against the basic principles of medicine. We do not let cancer grow

when we pick it up early, or send patients with early bacterial infections home without treatment and ask them to come back when their diseases have progressed and they need surgery and ventilation. Ignoring the early treatment of Covid-19 for so long has only served those who wanted to profit from the pandemic with significantly inferior agents. This is a scandal that will eventually emerge when some of these agents that are expensive but widely used in private institutions are eventually proven to be inferior to the combination of cheap repurposed therapies. Having been involved in both in-hospital and early outpatient treatment of Covid-19 with repurposed treatments, and as a researcher for the WHO's Solidarity Trial that looked at Interferon B, Remdisivir and Tociluzimab in the first wave in South Africa, I know without prejudice, the superiority and benefits of early treatment and the superiority of these repurposed agents in late treatment, although with modest benefits.

Within six to eight weeks, the BA.2 variant will drive the next wave of Covid-19 in S Africa. How significant it will be is unknown, but what the UK is telling us is that vaccination alone will not be the silver bullet. Early treatment has always been necessary, even if effective vaccines were available (which is currently not the case). Side-effects have forced people to not take subsequent doses and there are people with genuine reasons for exemptions to current vaccines. From January 2021, I held the

belief that repurposed therapies and early treatment, in combination with effective and safe vaccines acceptable to the majority of patients, would be the way to manage this pandemic as we learn to live with the virus. I have never relented on this belief that was based on available science of respiratory viruses and vaccines. We cannot falter once more. We need to be humble and learn from those who are successfully limiting disease progression and deaths with these therapies. Public health measures – including vaccines and the hospicentric model we have spent billions of rand on – have failed many patients and our fiscus. We have sacrificed many patients with these myopic interventions, which had no sound medical proof of benefit and in the process, we have created a new minority of millionaires through the pillaging of limited loans. This is unconscionable!

The NDoH, through the MAC, the NEMLC and provincial governments, needs to prioritise the health of its population over those of Big Tech through the adoption of early treatment as a blanket strategy. What we have spent on the failed interventions will be grossly undermined by what would be achieved with early treatment. It's time!

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Covid-19 management through three waves including the Delta wave. He was the site's co-principal investigator for the WHO's Solidarity Trial on repurposed therapies for severe Covid-19 and the site PI for the ACCCOS Trial, looking at outcomes in the critical care setting in the African context. He has extensive knowledge in the management of Covid-19 using repurposed therapies for both in-hospital and out-of-hospital patients and has managed over a thousand hospitalised patients and close to 800 outpatients, with zero hospitalisations in the latter to date.

https://www.biznews.com/thought-leaders/2022/04/05/ba-2-early-covid-19-treatment