

Open letter to all Australian Health Ministers, Health Departments, Doctors, Politicians and Health Regulators, re: coronavirus prevention and containment

I am a Clinical Nutritionist and Naturopath, based in Brisbane and with many years of experience in treating acute and chronic health conditions. I am an evidence-based practitioner, using only proven therapies and treatments for my clients. I specialise in inflammatory and immune system related conditions.

Regarding the current coronavirus infection spreading around the world and Australia (confirmed as a Pandemic by the World Health Organisation), I have been following the statistics and government advice, and I would like to share my thoughts, based on evidence and clinical experience.

Regardless of how the coronavirus came to be, the following facts are relevant:

- SARS-CoV-2 is the official virus name, and the infection itself is COVID-19, as designated by the WHO, herein referred to as “coronavirus”
- The coronavirus causes a respiratory infection, allegedly transmitted via aerosol droplets, mucus secretions and infected fomites (objects touched by those infected with this virus)
- The TGA have recently published announcements to all health practitioners to not recommend any treatments or products that claim to prevent or treat this coronavirus, unless there is proven evidence of their effectiveness against this *specific* virus
- With this virus being so new, there was NO evidence of anything, pharmaceutical or natural as being proven effective at the time of the TGA announcement
- The virus appears to survive much longer than other viruses out of the body on surfaces
- Improved hygiene practices such as washing of hands, coughing into the crook of one’s elbow, and self-isolation have been proven in the past to be effective in reducing the risks of other respiratory infections
- There are no published studies showing the effectiveness of handwashing or improved hygiene against this specific coronavirus. I’m not saying that this should not be done, as *past* published evidence and anecdotal evidence (from observations, not clinical studies) shows handwashing can reduce transmission risks
- But the TGA and health departments have only been recommending handwashing, sanitising, social distancing (a totally new concept), and other hygiene practices as preventions or to reduce the risks of this coronavirus, despite a lack of evidence
- There are many other preventative and treatment strategies and products which have similarly been proven to be effective in the past against all other known coronaviruses (which cause the common cold infections, and previous pandemic viruses of SARS and MERS), but according to the new TGA guidelines, these preventions or treatments cannot be recommended by any health practitioners because there is “no current evidence”. All health practitioners in Australia are effectively “gagged” and cannot make any recommendations to prevent infections or save the lives of our fellow Australians.

I will summarise some statistics of the pandemic, and bring to light some new and missing evidence, and proven recommendations for further reducing the risks of this new virus. Or you can jump to the Conclusions for a brief summary!

Statistics

Some statistics on the current coronavirus infection include (as at 28th March 2020):

Country	Coronavirus Mortality Rate
Australia	0.39%
USA	3%
China	3.9%
Italy	10.10%

Conclusion: the Italian Government, like Australia, is classifying deaths by many causes as from COVID-19 (*Australian Bureau of Statistics, 2020b*). Italy also has demographic, cultural and other factors contributing to a higher incidence and mortality rate (*Centre for Evidence Based Medicine, 2020*). There is a significant difference in mortality rates in different countries, or more accurately, by location.

There are many other major causes of daily deaths in the world, compared to the coronavirus:

Reason	Daily Deaths
Hunger	2,500 (UN, Food and Agriculture Organization)
Malaria	2,739 (UNICEF)
AIDS	2,100 (HIV.gov)
Influenza	795 - 1,781 (CDC/WHO)
Coronavirus/COVID-19	270 (as at 11/3/2020), now approx 2000
Total deaths per day	144,000 (Institute for Health Metrics and Evaluation, 2010)

Conclusion: we cannot believe the "official" death rates, when the Australian government and health departments from WHO recommendations, classifies any death as a "COVID-19" death even if someone were to die from a chronic health condition (*Australian Bureau of Statistics, 2020b*).

These are additional statistics I have analysed (as at 28th March 2020):

Number coronavirus incidences by location/hemisphere

Coronavirus incidences	Northern Hemisphere	Southern Hemisphere	Equatorial region
No. countries affected	133	48	16
Incidences confirmed	96.8%	1.4%	1.8%
Deaths confirmed	98.8%	0.22%	1.0%

Conclusion: There is a significant difference between the number of COVID-19 cases and deaths between those who live in the northern hemisphere vs southern.

Or a different analysis of the Australian mortality rate (as at 30th March 2020) (*Australian Bureau of Statistics, 2020*):

Australian Population	25,464,116
Coronavirus incidences	4,460
Coronavirus deaths	19
Coronavirus incidences (% population)	0.000175%
Coronavirus deaths (% population)	0.000000746%

Conclusion: Is this really worth shutting the country down for?

What is significant about the northern hemisphere as a factor of the coronavirus?

It is typical to see many more respiratory infections in winter than summer. Transmission rates and incidences of the common cold, influenza and pneumonia are greatly increased in the cooler months. The infection started in China, in their winter, and spread much more quickly through northern hemisphere countries in their cooler months of winter and early spring. There are several reasons for this difference in seasonal activity in respiratory infections:

1. **Humidity and temperature** – the warmer months are generally more humid, especially in more tropical areas. Humidity appears to slow rates of infection transmission by causing infected droplets from coughing or sneezing to fall to the ground instead of floating more in the air and being transmitted to infect people nearby. In the MERS coronavirus outbreak, studies showed a higher temperature and humidity resulted in significantly less lower respiratory tract infections of 45% (*Fagbo et al., 2017*)
2. **Latitude** – Where one lives on the planet, especially their latitude or distance from the equator, determines their Ultra-Violet (UV) light exposure in a given period. People in cities closer to the equator are exposed to more UV-B light on their skin. Direct UV-B radiation on exposed skin is needed to make vitamin D. People living much further away from the equator need more time in direct sunlight to make the same amount of vitamin D (*Leary et al., 2017; van der Mei, 2007; Tamerius et al., 2011*)
3. **Vitamin D deficiency** – vitamin D acts as an anti-inflammatory hormone in the body, and regulates the expression of many genes to have a major systemic benefit to one's health. Vitamin D isn't just needed for bone health, but assists the immune system, reduces the rates of viral respiratory infections and influenza, reduces lung conditions like asthma, and can even reduce the risks of many cancers (*Hosseini-Nezhad & Holick, 2014; Martineau et al., 2017*). Vitamin D can also offer antiviral and antibacterial actions as well as stimulating the innate immune system (which identifies and deals with unknown or new infections) (*Martineau et al., 2017*). Vitamin D deficiency can occur in any season, even in sunny Queensland in summer! (*Leary et al., 2017*). Vitamin D deficiency, especially in winter, can be a major cause of respiratory infections (*Fagbo et al., 2017*) and in this study, a vitamin D deficiency amongst a large percentage of the population (which occurs in winter) is **the cause of influenza respiratory infection epidemics** (*Cannell et al., 2008*).

There are other factors for the seasonal causes of influenza infections, including temperature, other concomitant infections, other nutrient deficiencies (selenium, vitamin E) (*Tamerius et al., 2011*), and more. There are other environmental and cultural factors which contribute to the differences in mortality rates between many countries, such as smoking status, air pollution, sleep quality and quantity and others.

The fact that Australia is now entering the cooler months highlights the importance of reducing the risks of respiratory infections using vitamin D supplementation interventions.

Virus Transmission and Severity, and the Germ Theory

The transmission of a virus, its severity, and the rate of incidences and mortality depend entirely on the strength and function of each individual person's immune system. This is confirmed with the majority of people with the coronavirus having very mild symptoms. It is only when someone is

immune compromised or with a chronic health condition which has reduced their immune system function, that the infection to take hold in their body more quickly and severely. Having a compromised or immune system, perhaps together with ineffectual medical treatments (or no treatments) any virus is going to cause more severe complications like pneumonia.

The transmission, severity, incidences and mortality are not dependent on the coronavirus at all. This is old 1800s germ theory "science". Yet the health officials and media are blaming the virus and trying to stop the virus itself, which is futile and prolongs the pandemic. Washing hands, regular hygiene and isolation are not enough! In conjunction with improved hygiene, prevention and treatments should also focus on the individual, by supporting one's immune system to protect them for prevention, or to fight off the infection better.

The old Germ Theory promoted by Koch and Pasteur no longer applies as not everyone who is exposed to a virus actually develops symptoms or has the infection. This breaks Koch's famous postulates of the germ theory (*MedicineNet, 2019*), which states that a pathogen must cause the disease in EVERY case of exposure, which doesn't happen. Some more recent experiments have been conducted and results published, after deliberately infecting individuals with a flu virus - even with a strain that was similar to the one which allegedly caused huge mortality rates in the 1918 Spanish flu pandemic. In this study, researchers found less than 40% of those who inhaled the virus actually developed symptoms! And of those who did develop symptoms, they were very mild to mild, and none had any serious symptoms at all (*Cannell et al., 2008*).

Evidence-based preventative (and treatment) strategies which should be recommended:

- **Vitamin D** - Vitamin D supplementation can reduce risk of infections by reducing inflammation, reducing viral replication rates, reducing age-related morbidity, Vitamin D supplementation during winter has been shown to support immune system function and reduce the incidence of influenza A by approximately one third (*Urashima, Segawa, Okazaki, Kurihara, Wada, & Ida, 2010*). A very recent study by *Grant et al (2020)* found evidence that vitamin D supplementation could reduce the risk of influenza and COVID-19 infections and deaths, but required a higher therapeutic dose than the low recommended daily intakes.
- **Vitamin C** – In early studies, a vitamin C deficiency is associated with pneumonia (an often deadly complication of a COVID-19 infection). Vitamin C deficiency is also associated with a reduced immune system function and increases susceptibility to respiratory infections, and vice versa, with infections causing a decrease in vitamin C concentrations (*Hemilä, 2017*). Several studies are currently underway in China using vitamin C interventions, with results still to be published.
- **Zinc** - is deficient in 49% of adults in the coronavirus risk age group of 51-70 (*Boudrealt et al. 2017*), and in people who are frequently exposed to stress. Zinc is needed for good immune system support, as well as reducing inflammation and oxidative stress, and improving the immune system response against viruses (*Wessels, Maywald, & Rink, 2017*). A zinc deficiency is often seen in those with acute respiratory distress syndrome (ARDS), and contributes to lung injury from the use of a respirator (*Boudrealt et al. 2017*).
- **Keeping up good water intake** – water is needed to keep mucous membranes moist as they act as a protective barrier against viruses in the respiratory tract (*Chen, 2009*)

- **Eating a good variety of quality foods** – your food provides nutrients needed for immune systems function. Nutrient deficiencies reduce immune system function and increase susceptibility to infections.
- **Reducing intake of refined and processed carbohydrate foods** - in a recently published study from China, patients with COVID-19 who had poorly managed blood sugar levels and Type 2 Diabetes were at much higher risk of increased incidence, more severe symptoms, and a higher mortality rate. High blood sugar increases inflammation and blood pressure, but reduces immune system function, whereas a well-controlled blood sugar level improved the outcomes of those with COVID-19 and pre-existing diabetes (*Zhu et al., 2020*). Type 2 Diabetes develops over time from a diet high in carbohydrate-rich foods (>60% of total daily energy from poor food choices), causes insulin resistance, insulin depletion from pancreatic insufficiency, obesity, and cardiovascular and heart disease, being the highest risk factors for incidence and mortality of COVID-19 (*Frost, 2003*).
- **Getting sufficient and quality sleep** - as sleep is needed to maintain good function of the immune system Studies show reduced sleep reduces immune system function and increases susceptibility to respiratory infections (*Prather, Janicki-Deverts, Hall & Cohen, 2015*)
- **Moderate and regular exercise** - a moderate exercise program can improve immune system function and reduce the risk of infections, but intensive training seen with athletes can have the opposite effects (*Jones & Davison, 2019*).

These recommendations and interventions are cheap, very easy to recommend and implement, and will have a very quick response. They can also reduce the strain on the hospital system by reducing infection rates and severity of symptoms, or in the case of those already having severe symptoms in hospital, these interventions can shorten the severity of symptoms and save lives.

I started recommending these preventative treatments back in January when news of the infection emerged. At the time there was no TGA ban on such advice.

The TGA and Expert Recommendations

The scientifically referenced and relevant recommendations in this document have been proven in the past to be safe and effective against many respiratory infections such as influenza and other types of coronavirus. New evidence has been published recently on these preventions and treatments, yet these recommendations are not approved by the TGA, and one must really ask why?

I see the TGA's guidelines of effectively banning all Australian health practitioners (medical and alternative/complementary) from giving any preventative or treatment advice, as being overly cautious. Yes there was little to no evidence for *anything* (either medical, pharmaceutical or natural) being effective as a preventative or treatment against this particular coronavirus at the time of their guidelines being announced. However, in times of something new like this novel coronavirus, past evidence and anecdotal evidence **MUST** be seen as the highest form of scientific evidence available. To restrict or ignore past evidence and anecdotal evidence is immoral, and will likely cause many more people to lose their lives in this virus outbreak, as well as prolong the outbreak, disrupt many businesses and perhaps cause the collapse of many companies, threaten the livelihoods of many workers and especially the casual workforce, affect the economy and stock markets, reduce investments, cause further desperation and panic amongst the public, cause social unrest, and more.

There have been a lot of new published studies since the TGA guidelines were announced, giving more clues as to what are some of the causative factors for increased risk of a COVID-19 infection, and for suitable preventions and even treatments. The TGA guidelines now must be updated to reflect this new evidence, and allow health practitioners to give additional preventative strategies and treatment options and further "flatten the curve" for all Australians.

We have next to nothing to lose by implementing these preventative strategies, but there is so much to lose if we do not.

COVID-19 PCR Testing

The current PCR pathology test for COVID-19 is highly inaccurate. The PCR process was developed to **increase** the amount of a **subset** of the genetic code of a virus DNA (*Ghannam & Varacallo, 2018*). The inventor of the PCR process has publicly said it should not be used for pathology testing, based on studies showing it is inaccurate as PCR testing is not standardised with different labs or countries use different variations of the test (*Teo & Shaunak, 1995*), is not designed to give a definitive binary result of a "positive" or "negative" confirmation, is affected by contamination that can produce misleading results (*Ghannam & Varacallo, 2018*), is not consistently reproducible and gives a high percentage of false positive and false negative results that were observed in all laboratories (*Defer et al., 1992; Zhuang et al., 2020*). Even the World Health Organisation's PCR Working Group demonstrated high levels of false-positive and false-negative results (*World Health Organisation, 2011*).

In addition, limiting testing of the coronavirus to only people who meet a set criteria is skewing the rates of incidences. Hence the rates of incidences are not accurate and cannot be believed, yet the government and health authorities are making significant changes to laws to restrict rights and freedoms based on inaccurate statistics of the coronavirus pandemic, as well as an inaccurate test used to determine those statistics, and more recently the COVIDSafe app that is also reliant on accurate PCR testing!

We can't actually believe any of the "official" statistics of incidences or mortality rates of this pandemic when:

1. The PCR test is inaccurate, as explained here, and
2. The WHO and governments (including Australia) are recommending deaths from chronic health conditions and all respiratory infections (flu or pneumonia), to be caused by COVID-19, whether the patient was tested by a faulty PCR test or just ASSUMED to be having the virus (*Australian Bureau of Statistics, 2020b*).

Thus inflating the true incidence rates and the mortality rates, which then gets turned into a fear campaign by the media, and knee-jerk reactions by state and federal governments to implement a raft of laws to restrict our rights and freedoms as well as wrecking the economy and many businesses, all for a generally mild infection for most people.

Instead, consider using faecal testing, as the SARS-CoV-2 virus has been detected in stool samples (*Warish et al., 2020*).

Flu vaccinations during the coronavirus pandemic

The Federal and state governments of Australia have been adding new laws to mandate flu vaccinations for healthcare workers or for the public to visit relatives in aged care, or even for general work. I believe that this decision is irresponsible, is not based on scientific evidence and can actually **increase** the risks of someone getting the coronavirus. The flu vaccine does not prevent or reduce the risks of getting the coronavirus infection - it's a different type of virus. Several published studies, however, have found that flu vaccinations can cause a phenomenon called "vaccine-associated virus interference"; that is, recently vaccinated individuals may be at increased risk for other respiratory virus infections, especially coronaviruses (*Wolff, 2020*). This study, on military personnel found a 36% increase in coronavirus infection risk after a flu vaccine (*Wolff, 2020*).

Another study by Cowling and colleagues (2012), found those who had the flu vaccine, who had no other respiratory viruses beforehand, over a follow-up period of 9 months had a significantly increased risk of confirmed non-influenza respiratory virus infections compared to a placebo group. The study also found no significant reduction in confirmed flu infections in the test group (those who had the vaccine), meaning that the flu vaccine was ineffective.

Herd immunity

Herd immunity has been discussed by some experts and being used as a strategy by some countries such as Sweden and Japan. Herd immunity is a theoretical belief that if sufficient numbers of people are immune to an infection (the "herd"), the spread of the infection could be reduced or stopped, thus protecting those who are not immune to the infection.

The theoretical percentage of the population who need to be immune to an infection has been increased over time from 50% to 80% to 90% to 95%, depending on the infection. The estimate has increased as outbreaks were still occurring in populations which had reached the previous "herd immunity" levels through vaccinations for many infectious diseases. Outbreaks still occur in populations with 100% vaccine coverage. Hence vaccination programs are not working.

The NHMRC have published a suggested herd immunity rate for the coronavirus in Australia of 61% (*MacIntyre, 2020*), based on the rate of transmission, in turn based on a faulty test as described above.

Unfortunately, health officials have confused herd immunity with "natural immunity" from contracting an infection, and "vaccinated immunity" from vaccinations. They are very two different concepts. Herd immunity **never** occurs from vaccinations for several reasons:

1. Vaccines only give short-term temporary "immunity" from 6 months (in most flu vaccines) to just a few years for most others. Vaccine-induced immunity is significantly reduced at 5 years after initial whooping cough vaccination and 2x boosters (*Lavine, Bjørnstad, de Blasio, Storsaeterf, 2012*), and other studies show the same for other vaccines
2. Not everyone who gets a vaccine develops immunity. This is why boosters or multiple shots are needed, to try and force immunity a second or third time (or more) in those who did not achieve immunity from previous shots. Seroconversion rates (ie, immunity developed via antibodies) can be as low as 16% effectiveness in the annual flu vaccines for some age groups (*Sequirus, 2018*), hence in most vaccines, many people do not develop immunity

3. With 75.2% of the Australian population being adults over 19 years (*Australian Bureau of Statistics, 2020a*) and assuming that most adults do not get regular boosters, when the temporary vaccine immunity wears off a couple of years afterwards, those adults are no longer immune. So there is no longer any "herd" to protect those who cannot have the vaccine; herd immunity does not exist!
4. Vaccinated women of a child-bearing age who have lost their temporary vaccine immunity cannot pass on this immunity to the foetus, in comparison to women with natural acquired immunity passing that onto the foetus via the placenta and breastfeeding (*Jackson, 2006*).

Herd immunity is only possible from more people being exposed to the actual infection, and developing antibodies that last a lifetime. Countries that are implementing a herd immunity strategy to combat the coronavirus allow healthy and younger people to continue their normal lives without any lockdowns or business shutdowns. Yes they may contract the infection but without chronic health conditions they are likely to develop only mild or even no symptoms. But they will develop immunity, will shorten this pandemic as the virus will die out, and will increase the level of true natural herd immunity that will protect others.

Those at risk of the virus with chronic health conditions should be recommended to continue to isolate themselves, but those who are young and healthy should be allowed to leave their homes, travel, and resume normal daily activities.

Herd immunity is never achieved from vaccination programs. In fact, the population loses more herd immunity as more people are vaccinated.

Recommendations:

For the prevention of coronavirus infections, reducing transmission rates, reducing duration and severity of symptoms, and other benefits, I recommend the State and Federal governments and their respective Health Departments undertake the following:

- Increase social media marketing and traditional media coverage of better preventative strategies – more than just washing your hands and improved hygiene practices
- Include recommending preventative strategies that are evidence-based, and have previously been shown effective against respiratory infections, viruses in general and/or other coronavirus strains:
 - **Vitamin D** – at least 1200IU per day, and safe sun exposure regularly. A study by *Grant et al. (2020)* recommended a higher dose of 10,000IU per day for a few weeks, followed by 5,000IU per day to get vitamin D levels in the range of 100-150nmol/L for the best benefit of prevention, and a higher dose for treatment
 - **Vitamin C** – at least 1000mg per day for children, and up to 6-8g per day for adults. A Cochrane systematic review of placebo-controlled trials found that children taking 1-2g (1000-2000mg) vitamin C daily shortened the duration of a common cold infection (a type of coronavirus) by 18% and reduced their severity. In adults the results were smaller (*Hemilä & Chalker, 2013*). Best results for reducing respiratory infection duration and symptoms, including preventing pneumonia (a major complication in COVID-19 infections), requires a higher therapeutic dose of up to 6-8gm per day for adults (*Hemilä, 2017*).

- **Zinc** – 20-30mg per day for adults, and age/weight equivalent for children
- **Other nutritional advice** – eating a healthy diet for a variety of nutrients
- **Reducing foods that cause high blood sugar levels** - such as sugary foods and drinks, grain-based products, and dairy foods
- **Drinking sufficient water** - to keep mucous membranes moist and prevent viral infections, and even using saline nasal sprays if required
- **Getting good quality and quantity sleep** - of 7-8 hours per night
- **Moderate exercise.**
- Recommend cautions on using or self-prescribing anti-inflammatory medications such as Aspirin, NSAIDs, and others during a coronavirus infection. Studies have shown that the 1918 Spanish flu did not cause the high number of deaths, but from bacterial pneumonia (*National Institutes of Health, 2008*) in conjunction with a new medication at that time - Aspirin, which was prescribed in too high a dose and it affected lung function in those who took it (*Starko, 2009*). NSAIDs and other anti-inflammatory medications suppress the immune system responses to an infection, leading to more severe symptoms, a longer duration of illness and higher risks of serious complications and deaths (*Basille, Plouvier, Trouve, Duhaut, Andrejak, & Jounieaux, 2017*).

Conclusion

The novel coronavirus pandemic is nothing like what we have seen before. Hence novel strategies must be implemented to deal with it. Banning recommendations of previously-proven prevention and treatment strategies is immoral when there are many lives at stake.

There are many factors which influence your individual risk for contracting this infection, most of which are environmental. There are also cultural and geographic factors which can significantly increase your risk, which we see in the referenced studies here.

Incidences of respiratory infections (from colds, flu, pneumonia, asthma, and the new coronavirus) can be reduced with preventative vitamin D, vitamin C, zinc, and other natural interventions, and these should be recommended.

The reported statistics of incidences and mortality are highly inflated due to inaccurate PCR testing, and manipulative recording of deaths to blame the cause on COVID-19. Then these inaccurate statistics are used by governments to implement knee-jerk reactive legislation that destroys lives in many other ways with failed businesses, investments, jobs, and the economy.

A natural "herd immunity" strategy should be implemented to combat the virus, by allowing those who are fit and healthy to resume normal lives, travels and work. Those at risk with chronic health conditions should continue to isolate themselves while also working on improving their immune systems as detailed above. This way, we have a chance of achieving the herd immunity rate of 61% which can slow down the true rate of incidences and mortality, and bring this pandemic to an end quickly.

Please consider the abovementioned simple, cheap, and readily-available preventative and treatment recommendations in the overall prevention and treatment plans for the coronavirus pandemic. All of this evidence (and more) is available in peer-reviewed medical journals. Clinical Nutritionists and Naturopaths like myself have been using and recommending these preventions and

treatments for all manner of viral infections with great success in the past, and they should be considered based on past evidence of safety and effectiveness against this coronavirus. As the medical system has no effective strategies or proven medications for this specific infection, it makes sense to use existing therapies such as the above. If not, in the reviews and inquiries after this pandemic, the public will be wondering why these simple and effective therapies were not allowed, or not tried, and why more peoples' lives could not be saved.

Thank you for your consideration.

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