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Privacy & Access Department
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Via Email: dana.doucette@saskhealthauthority.ca

**Attention: Ms. Dana Doucette**

**Re: *The Local Authority Freedom of Information and Protection of Privacy Act* – Access to Information Request**
**Our File No. 75231**

On the Saskatchewan Health Authority ("SHA")'s website (https://www.saskhealthauthority.ca/our-organization/quality-care-patient-safety/privacy-personal-information/privacy-access ) it states:

> "Before submitting a formal access to information request, please contact the Privacy and Access department via the contact information below. Often, the information already exists and the request can be filled without engaging a formal process."

This letter is pursuant to that request.

We seek information pursuant to *The Local Authority Freedom of Information and Protection of Privacy Act* (Sask) as below. Your assistance in facilitating the access to this information is appreciated.

If it is more convenient for you, we would welcome responses in sections, emailed to me and my assistant Terri (TRussell@wwobllp.com ). In other words, please do not wait until all the questions from all the sections are answered before replying to us.

Please note that the livelihoods of many Saskatchewan people are on the line, so we would appreciate your urgent attention to this matter.

** N.B.: We are authorized to incur up to $2,500 in costs to access the following information, so please track the ongoing cost and if you are unable to complete the responses within that budget please contact me before proceeding beyond that amount. **

**1. Transmissibility**

On your website (https://www.saskatchewan.ca/government/news-and-media/2021/november/09/covid-19-vaccination-remains-best-protection-against-serious-illness ) dated Nov. 9, 2021 it states:

> "COVID-19 Vaccination Remains Best Protection Against Serious Illness…
>
> The COVID-19 vaccine is not a cure. It will not prevent every COVID-19 transmission. It will reduce the risk of transmission…"
> (Underlining added)

We question the SHA's assertion that the Pfizer & Moderna injections reduce the risk of transmission, particularly with respect to the Omicron variant. First, in this study (https://www.medrxiv.org/content/10.1101/2021.09.28.21264262v1 ) researchers from several California universities concluded:

> "We found no significant difference in cycle threshold values between vaccinated and unvaccinated, asymptomatic and symptomatic groups infected with SARS-CoV-2 Delta."

Second, in a Nov. 19, 2021 article in The Lancet, "The epidemiological relevance of the COVID-19-vaccinated population is increasing" (https://www.thelancet.com/journals/lanepe/article/PIIS2666-7762(21)00258-1/fulltext ) it states:

> "High COVID-19 vaccination rates were expected to reduce transmission of SARS-CoV-2 in populations by reducing the number of possible sources for transmission and thereby to reduce the burden of COVID-19 disease. Recent data, however, indicate that the epidemiological relevance of COVID-19 vaccinated individuals is increasing… [T]he COVID-19 case rate per 100.000 was higher among the subgroup of the vaccinated compared to the subgroup of the unvaccinated in all age groups of 30 years or more."

Third, in this Sept. 30, 2021 study "Increases in COVID-19 are unrelated to levels of vaccination across 68 countries and 2947 counties in the United States" (https://link.springer.com/article/10.1007%2Fs10654-021-00808-7) Harvard researchers conclude:

> "At the country-level, there appears to be no discernable relationship between percentage of population fully vaccinated and new COVID-19 cases in the last 7 days (Fig. 1). In fact, the trend line suggests a marginally positive association such that countries with higher percentage of population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days. The lack of a meaningful association between percentage population fully vaccinated and new COVID-19 cases is

> further exemplified, for instance, by comparison of Iceland and Portugal. Both countries have over 75% of their population fully vaccinated and have more COVID-19 cases per 1 million people than countries such as Vietnam and South Africa that have around 10% of their population fully vaccinated… Across the US counties too, the median new COVID-19 cases per 100,000 people in the last 7 days is largely similar across the categories of percent population fully vaccinated (Fig. 2)… Of the top 5 counties that have the highest percentage of population fully vaccinated (99.9–84.3%), the US Centers for Disease Control and Prevention (CDC) identifies 4 of them as "High" Transmission counties."

Fourth, according to Ontario's COVID-19 data (https://covid-19.ontario.ca/data) as of January 8, 2022 that up to about Dec. 23, 2021 the unvaccinated had more cases per 100,000 people then both the partially vaccinated and the fully vaccinated, but as of about Dec. 23, 2021 the lines cross over and there were more cases per 100,000 among the fully vaccinated than the unvaccinated.

Fifth, according to this Wall Street Journal Commentary (https://www.wsj.com/articles/omicron-makes-bidens-vaccine-mandates-obsolete-covid-healthcare-osha-evidence-supreme-court-11641760009?mod=opinion_lead_pos5 ) Nobel Prize winner Dr. Montagnier states:

> "…data from Denmark and the Canadian province of Ontario indicate that vaccinated people have higher rates of Omicron infection than unvaccinated people...
>
> …there is no scientific basis for believing these mandates will curb the spread of the disease."

Sixth, according to Reuters (https://www.reuters.com/business/healthcare-pharmaceuticals/who-says-more-research-needed-vaccine-efficacy-against-omicron-2022-01-11/ ) on January 11, 2022 the World Health Organization essentially admitted that the current "vaccines" are not effective enough in preventing Omicron infection:

> "A World Health Organization technical body said on Tuesday that current COVID-19 vaccines may need to be reworked to ensure they are effective against Omicron and future variants of the coronavirus.
>
> The technical group, made up of independent experts, said it would consider a change in vaccination composition and stressed that shots needed to be more effective in protecting against infection…
>
> A vaccination strategy based on repeated booster doses of the original vaccine composition is unlikely to be appropriate or sustainable."

Lastly, at a January 12, 2022 press conference, Premier Scott Moe, while reading from prepared notes, said (https://www.facebook.com/PremierScottMoe/videos/248885413990059/ at 5:00):

> "Vaccination is not preventing the spread of Omicron. We need to be very clear and honest about that."

1.1 Therefore, given the substantial & mounting evidence rebutting your assertion that the Pfizer or Moderna COVID-19 injections "reduce the risk of transmission", what evidence is the SHA relying on for this claim?

1.2 In light of the new evidence emerging since Nov. 9, 2021, is the SHA willing to retract this statement?

## 2. Natural Immunity

According to your website at https://www.saskhealthauthority.ca/news-events/news/why-do-i-still-need-vaccine-if-ive-already-had-covid , which is dated Nov. 19, 2021 it states:

> "Currently, the evidence is showing that the protection provided by a full COVID-19 vaccine series is stronger and longer than the protection from natural infection," reported Dr. Satchan Takaya, Infectious Diseases Specialist and Medical Lead for Infection Prevention and Control for the Saskatchewan Health Authority."

However, in a Dec. 8, 2021 article as reported by CNBC, Pfizer's CEO Albert Bourla stated that "[P]reliminary research shows the new omicron variant can undermine protective antibodies generated by the vaccine the company developed with BioNTech."
-See https://www.cnbc.com/2021/12/08/omicron-pfizer-ceo-says-we-may-need-fourth-covid-vaccine-doses-sooner-than-expected.html

Further, on Nov. 11, 2021 Dr. Paul Alexander compiled a report entitled, "140 Research Studies Affirm Naturally Acquired Immunity to Covid-19: Documented, Linked, and Quoted"
-See https://www.drpaulalexander.com/blogs/news/122-research-studies-affirm-naturally-acquired-immunity-to-covid-19-documented-linked-and-quoted

2.1 What "evidence" is the SHA relying on regarding natural immunity, also described as the immunity conferred from previous COVID-19 infection?

2.2 Is the SHA continually updating its policy regarding natural immunity, particularly in light of Omicron's ability to "breakthrough" the protection provided by the Pfizer injections?

2.3 Dr. Marc Hellerstein received his medical degree from Yale University and his Ph.D. from MIT, and is a professor at the University of California - Berkeley. In a Dec. 11, 2020 article, "What are the roles of antibodies versus a durable, high quality T-cell response in protective immunity against SARS-CoV-2?" he states:

> "Although most vaccine candidates are focusing on spike protein as antigen, natural infection by SARS-CoV-2 induces broad epitope coverage, cross-reactive with other betacoronviruses."
> -See https://www.sciencedirect.com/science/article/pii/S2590136220300231

What does the SHA mean by "protection" provided by the Pfizer or Moderna "vaccines"?

2.3.1 Specifically, is the SHA considering not only the production of antibodies, which are now known to decrease fairly quickly over time, but also the role of T-cells, B cells, antibody-secreting plasma cells, and the full range of a person's immune response?

2.4 Given the huge body of evidence regarding natural immunity, why is the SHA not considering its role in ending this pandemic?

2.5 Does the SHA have any data on reinfection among people with natural immunity to COVID-19?

2.5.1 Does the SHA have any data on whether a person who recovered from previous infection transmitted to anyone else?

2.5.2 Is the SHA comparing the transmissibility to others of (i) people who have recovered from previous infection versus (ii) people with 2 or 3 Pfizer or Moderna injections? If not, why not?

2.6 According to an August 3, 2021 article in the Globe and Mail, "Unvaccinated Canada: Who's left behind, and why aren't they getting their COVID-19 shots?" (https://www.theglobeandmail.com/canada/article-unvaccinated-canada-whos-left-behind-and-why-arent-they-getting-their/ ):

> "Canadians who have so far declined to get a shot tend to skew younger, but otherwise they don't conform to a tidy profile."

Does the SHA have data on who Saskatchewan's unvaccinated people are? Do they tend to be in low risk age categories?

## 3. Deaths

According to the SHA's COVID-19 dashboard (https://dashboard.saskatchewan.ca/health-wellness ), as of February 4, 2022 there have been 1,005 deaths.

3.1 Were these deaths "caused" by COVID-19?

3.2 If a person had a number of co-morbidities, and COVID-19 was only a 1% contributing factor to their death, would that be counted as a COVID-19 death?

3.3 Please explain the SHA's methodology in determining whether a person's death is counted in the above dashboard.

3.4 Has this methodology changed over time, or has this been the same approach since March of 2020? If yes, please explain how, why & when the SHA's methodology changed.

3.5 According to the Association of American Physicians and Surgeons' website (https://aapsonline.org/bidens-bounty-on-your-life-hospitals-incentive-payments-for-covid-19/?fbclid=IwAR2YA8_SyvyY_QNKutnr5sYg_xIqYeGyxRzT5HNR7JlXnZ6Uklg-k3rBYeQ ):

> [T]here are deaths from restrictions on effective treatments for hospitalized patients. Renz and a team of data analysts have estimated that more than 800,000 deaths in America's hospitals, in COVID-19 and other patients, have been caused by approaches restricting fluids, nutrition, antibiotics, effective antivirals, anti-inflammatories, and therapeutic doses of anti-coagulants.

3.5.1 Does the SHA have any data regarding how many deaths in Saskatchewan were caused by restrictions on effective treatments for hospitalized patients, including but not limited to, any restricting of fluids, nutrition, antibiotics, effective antivirals, anti-inflammatories, and therapeutic doses of anti-coagulants? Please explain.

3.5.2 Does the SHA have any data regarding how many deaths in Saskatchewan occurred after restrictions on effective treatments for hospitalized patients, including but not limited to, any restricting of fluids, nutrition, antibiotics, effective antivirals, anti-inflammatories, and therapeutic doses of anti-coagulants? Please explain.

3.5.3 Does the SHA have any data regarding any deaths occurring after any restrictions of hydroxychloroquine, fluvoxamine and/or ivermectin? Please explain.

3.6 If a death occurred within 21 days of a person receiving an approved COVID-19 "vaccine", would that count toward the unvaccinated statistics, the vaccinated, or some other category? Please explain how the SHA arrived at this approach.

3.6.1 Has the approach to accounting for deaths which occur within 21 days of receiving such a "vaccine" been the same since March 1, 2020 or has it changed? Please explain any changes.

3.6.2 Does the SHA have any evidence of any correlation between people receiving such a "vaccine" and dying with COVID-19 within 21 days? Please explain.

3.6.3 How many deaths occurred within 21 days of receiving an approved COVID-19 "vaccine"? Please provide the monthly counts.

3.7 According to a November 27, 2021 article in the Saskatoon StarPhoenix, "After deadliest year in half a century, Sask. on track for higher deaths" (https://thestarphoenix.com/news/local-news/taking-a-deep-dive-on-deaths-covid-19-and-others-over-the-last-two-years ):

> "Saskatchewan recorded 10,107 deaths from all causes in 2020 — the most in one calendar year in the last half-century — amid the COVID-19 pandemic…
>
> Deaths linked officially to COVID-19 account for about one-quarter of the increase in overall deaths last year compared to the average from the five previous years…

> Drug toxicity deaths increased substantially from fewer than 100 in Saskatchewan over the first five years of the last decade to 172 to 2018 and 179 in 2019. These deaths skyrocketed to 314 in 2020, a jump of 135 over 2019, which is less than a quarter of the higher number of deaths last year."

What data does the SHA have on all cause mortality/"excess mortality" for 2021, compared to pre pandemic?

3.7.1 Are comparable resources being devoted to addressing the significant increase in non-COVID-19 deaths as are being devoted to addressing the COVID-19 deaths? Why or why not?

3.8 How many people without comorbidities in the following categories, have suffered a death caused by COVID-19 - meaning COVID-19 was 50% or more responsible for the death?

0 – 4:
5 – 11:
12 – 18:
19 – 30:
31 – 40:
41 – 50:
51 – 60:
61 – 70:
71 – 80:
80+

## 4. Hospitalizations

According to the SHA's COVID-19 dashboard (https://dashboard.saskatchewan.ca/health-wellness ), as of February 4, 2022 there are 363 hospitalized cases.

4.1 Were these hospitalizations "caused" by COVID-19?

4.2 If a person went to the hospital because of a broken arm, and they tested positive for COVID-19 but were asymptomatic, would this be counted as a hospitalization in the above dashboard?

4.3 Please explain the SHA's methodology in determining whether a person's hospitalization is counted in the above dashboard.

4.4 Has this methodology changed over time, or has this been the same approach since March of 2020?

4.5 Does the SHA have separate statistics which distinguish between hospitalizations caused by COVID-19 and those which are referred to as "incidental hospitalizations"?

-See for example https://globalnews.ca/news/8497344/covid-19-saskatchewan-incidental-hospitalization-reporting/ , which is not reflected in the dashboard as of January 7, 2022.

4.6 Does the SHA have data on whether people with natural immunity are being hospitalized, including the ICU, at the same rate as the unvaccinated, partially vaccinated, doubly vaccinated and triple vaccinated? If not, why not?

4.7 According to the Association of American Physicians and Surgeons' website (https://aapsonline.org/bidens-bounty-on-your-life-hospitals-incentive-payments-for-covid-19/?fbclid=IwAR2YA8_SyvyY_QNKutnr5sYg_xIqYeGyxRzT5HNR7JlXnZ6Uklg-k3rBYeQ ):

> The CARES Act, which provides hospitals with bonus incentive payments for all things related to COVID-19 (testing, diagnosing, admitting to hospital, use of remdesivir and ventilators, reporting COVID-19 deaths, and vaccinations)…
>
> The hospital payments include:
>
> -A "free" required PCR test in the Emergency Room or upon admission for every patient, with government-paid fee to hospital.
> -Added bonus payment for each positive COVID-19 diagnosis.
> -Another bonus for a COVID-19 admission to the hospital.
> -A 20 percent "boost" bonus payment from Medicare on the entire hospital bill for use of remdesivir instead of medicines such as Ivermectin.
> -Another and larger bonus payment to the hospital if a COVID-19 patient is mechanically ventilated.
> -More money to the hospital if cause of death is listed as COVID-19, even if patient did not die directly of COVID-19.
> -A COVID-19 diagnosis also provides extra payments to coroners.
>
> CMS implemented "value-based" payment programs that track data such as how many workers at a healthcare facility receive a COVID-19 vaccine. Now we see why many hospitals implemented COVID-19 vaccine mandates. They are paid more.
>
> Outside hospitals, physician MIPS quality metrics link doctors' income to performance-based pay for treating patients with COVID-19 EUA drugs. Failure to report information to CMS can cost the physician 4% of reimbursement.

4.7.1 What payments or fees do hospitals receive relating to COVID-19?

4.7.2 What payments or fees do doctors receive relating to COVID-19?

4.7.3 At any point in time, have there been any payments, government-paid fees and/or incentives from pharmaceutical companies for administering a PCR test? If yes, please provide details.

4.7.4 At any point in time, have there been any payments and/or other incentives for any positive COVID-19 diagnoses? If yes, please provide details.

4.7.5 At any point in time, have there been any payments and/or other incentives for any COVID-19 admissions to hospitals? If yes, please provide details.

4.7.6 At any point in time, have there been any payments and/or other incentives for using specific drugs or treatments for COVID-19, such as remdesivir, and not others? If yes, please provide details.

4.7.7 At any point in time, have there been any payments and/or other incentives if a COVID-19 patient is mechanically ventilated? If yes, please provide details.

4.7.8 At any point in time, have there been any payments and/or other incentives if cause of death is listed as COVID-19, even if patient did not die directly of COVID-19? If yes, please provide details.

4.7.9 At any point in time, have there been any payments and/or other incentives to coroners relating to COVID-19 diagnoses? If yes, please provide details.

4.7.10 At any point in time, have there been any payments and/or other incentives based on how many staff at a healthcare facility have received a COVID-19 "vaccine"? If yes, please provide details.

4.7.11 At any point in time, have there been any other payments and/or other incentives for anything relating to COVID-19 not addressed above? If yes, please provide details.

4.8 If a hospitalization occurred within 21 days of a person receiving an approved COVID-19 "vaccine", would that count toward the unvaccinated statistics, the vaccinated, or some other category? Please explain how the SHA arrived at this approach.

4.8.1 Has the approach to accounting for hospitalizations which occur within 21 days of receiving such a "vaccine" been the same since March 1, 2020 or has it changed? Please explain any changes.

4.8.2 Does the SHA have any evidence of any correlation between people receiving such a "vaccine" and being hospitalized with COVID-19 within 21 days? Please explain.

4.8.3 How many hospitalizations occurred within 21 days of a person receiving an approved COVID-19 "vaccine"? Please provide the monthly counts.

4.8.4 Does the SHA have any evidence which suggests that the immune system may be temporarily suppressed after a person receives an approved COVID-19 "vaccine"?

4.8.5 Has the SHA suppressed, concealed or destroyed any evidence or findings relating to COVID-19? If yes, please explain.

4.8.6 Has the SHA intentionally avoided further investigations of any preliminary evidence or findings? If yes, please explain.

4.9 Has the SHA done any comparative analysis with any other province(s) relating to any relationship between hospitalizations, cases and deaths within 21 days of people receiving an approved COVID-19 "vaccine"? In particular, has the SHA compared our data with Alberta's?

4.10 How many hospitalizations has COVID-19 caused for people in the following age categories?

0 – 4:
5 – 11:
12 – 18:
19 – 30:
31 – 40:
41 – 50:
51 – 60:
61 – 70:
71 – 80:
80+

4.10.1 Please provide the monthly admissions for the data in response to question 4.10.

## 5. Daily case counts

According to the SHA's COVID-19 dashboard (https://dashboard.saskatchewan.ca/health-wellness ), as of February 4, 2022 the "Seven-day Average of Daily New Cases" is 867.

5.1 If the same person tests positive twice 5 days apart, would this count as 2 cases?

5.2 What processes has the SHA put in place to ensure the number of cases is not artificially inflated by the same person testing positive multiple times?

5.3 According to Public Health Ontario's website (https://www.publichealthontario.ca/en/about/blog/2021/explained-covid19-pcr-testing-and-cycle-thresholds ):

> PCR tests tell you if the virus is detected (positive) or not (negative)…
>
> The PCR machine makes millions of copies of the DNA by running multiple "cycles" (like a washing machine). This process is called amplification…
>
> The cycle threshold (Ct) value is the actual number of cycles it takes for the PCR test to detect the virus…

> Ct values are influenced by a number of factors including the PCR test kit, when the sample was collected, the machine used for testing, the technique of the health professional obtaining the sample and the type of sample (sampling method). In fact, different samples from the same person may result in different Ct values.

5.3.1 What is the cutoff point for the number of cycles for positive results?

5.3.2 How did the SHA determine that cutoff point was appropriate? Has it changed over time? Please explain.

5.3.3 What is the Ct value the SHA uses in determining a positive test? Has it changed over time? Please explain.

5.3.4 Is the SHA's cutoff point and Ct value for positive tests consistent with other jurisdictions in Canada and internationally?

5.3.5 Is it true that the SHA continues to use this test at an elevated Ct level beyond what the World Health Organization or the CDC recommend? Please explain.

5.3.4 Given the financial incentive payments for COVID-19 related matters, how did the SHA address its own conflict of interest in determining the appropriate cutoff point for cycles?

5.4 If a new case occurred within 21 days of a person receiving an approved COVID-19 "vaccine", would that count toward the unvaccinated statistics, the vaccinated, or some other category? Please explain how the SHA arrived at this approach.

5.4.1 Has the approach to accounting for new cases which occur within 21 days of receiving such a "vaccine" been the same since March 1, 2020 or has it changed? Please explain any changes.

5.4.2 Does the SHA have any evidence of any correlation between people receiving such a "vaccine" and then testing positive for COVID-19 within 21 days? Please explain.

5.5 Does the SHA have data comparing the rate of infection among people with natural immunity, the unvaccinated, partially vaccinated, doubly vaccinated and triple vaccinated? If not, why not?

## 6. Adverse events

"Adverse Events Following Immunization for COVID-19" ("AEFI") is found at the SHA's website (https://www.saskatchewan.ca/government/health-care-administration-and-provider-resources/treatment-procedures-and-guidelines/emerging-public-health-issues/2019-novel-coronavirus/covid-19-vaccine/covid-19-vaccine-information/covid-19-vaccine-details/adverse-events-following-immunization-for-covid-19 ).

Does the SHA have further data broken down by age?

6.1 Is there a way to compare (i) AEFIs for people under 30, with (ii) hospitalizations for unvaccinated healthy people under 30? If yes, please advise.

6.2 Given that "Pharmacovigilance" is the process of collecting, monitoring, and evaluating Adverse Events for safety signals to reduce harm and promote safety to the public in the context of pharmaceutical and biological agents, when was the SHA's AEFI system last updated?

6.3 Given that there is research which concludes there is "serious under-reporting of adverse drug reactions" in some cases (see for example https://link.springer.com/article/10.2165/00002018-200427070-00004 ) what is the SHA's underreporting factor for AEFIs in relation to the COVID-19 injections?

6.3.1 Please advise as to the underreporting factor for both non-serious AEFIs, serious AEFIs not including deaths, and AEFIs which are deaths, and the methodology for calculating said underreporting factors.

6.4 Please confirm whether the SHA, or agents on behalf of the SHA, has/have entered into without prejudice settlement agreements, including confidentiality agreements, with people who have suffered 1 or more AEFIs.

6.4.1 If yes to the above, how many such settlements were entered into, in each of 2020 & 2021?

6.4.2 If yes to the above, how much money was paid as part of said settlements in each of 2020 & 2021?

6.5 Has the SHA recognized the potential carcinogenic/mutagenic concern that is well established in the field of toxicology regarding the swabs used in the collection process for the PCR and Rapid Antigen testing?

6.5.1 Does the SHA have any data regarding risks associated with frequent testing?

6.5.2 What information regarding risks of frequent testing, particularly in children, is the SHA disseminating, and how is this information being disseminated?

## 7. The 4 Pillars of Pandemic Response

To what extent, if any, has the SHA engaged teams of doctors to address the following:

1. Reducing spread of the illness;
2. Early treatment;
3. In-hospital treatment; and
4. "Vaccination".

7.1 To what extent, if any, has the SHA required its doctors to provide weekly or monthly reports with evidence reviews and scientific updates regarding the above 4 "pillars of pandemic response"?

7.1.1 Is there a feedback loop for physicians who are treating COVID-19 in Saskatchewan to advise the SHA what is working and what is not, such that the SHA can change and update its protocols? Please explain.

7.1.2 Does the SHA have a specific mechanism in place to collect data and collaborate with all parties involved in vaccine safety, including Health Canada, to continually monitor and evaluate the safety of the "vaccines"? Please explain.

7.2 What processes are in place, if any, to continually improve on each of the above 4 "pillars of pandemic response"?

7.2.1 Is the SHA randomly auditing the different processes to ensure alignment with policy obligations?

7.3 With respect to early treatment and/or in-hospital treatment, to what extent if any, does the SHA endorse a multi-drug treatment protocol? Why or why not?

7.3.1 With respect to early treatment, does the SHA endorse the use of hydroxychloroquine, either by itself or in combination with other drugs? Why or why not? What evidence does the SHA have to justify its position?
-See https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7534595/

> "Hydroxychloroquine is effective, and consistently so when provided early, for COVID-19: a systematic review"

7.3.2 With respect to early treatment, does the SHA endorse the use of vitamins C, D, zinc or melatonin? Why or why not?
-See https://www.health.harvard.edu/blog/do-vitamin-d-zinc-and-other-supplements-help-prevent-covid-19-or-hasten-healing-2021040522310

> "Based on the science, there is reason to be hopeful that supplements such as vitamin C or D, zinc, or melatonin might help in the fight against COVID-19. While there's no proof yet that they do, additional research could show a benefit in certain situations, or with a different dose or formulation of the supplement. So it's worth keeping an open mind."

7.3.3 With respect to early treatment, does the SHA endorse the use of fluvoxamine? Why or why not?
-See https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(21)00448-4/fulltext

> "Treatment with fluvoxamine (100 mg twice daily for 10 days) among high-risk outpatients with early diagnosed COVID-19 reduced the need for hospitalisation defined as retention in a COVID-19 emergency setting or transfer to a tertiary hospital."

7.3.4 With respect to early treatment, does the SHA endorse the use of Ivermectin? Why or why not?
-See
https://journals.lww.com/americantherapeutics/fulltext/2021/08000/ivermectin_for_prevention_and_treatment_of.7.aspx

> "Conclusions:
> Moderate-certainty evidence finds that large reductions in COVID-19 deaths are possible using ivermectin. Using ivermectin early in the clinical course may reduce numbers progressing to severe disease. The apparent safety and low cost suggest that ivermectin is likely to have a significant impact on the SARS-CoV-2 pandemic globally."

7.3.5 With respect to early treatment or in-hospital treatment, does the SHA endorse the use of Remdesivir? Why or why not? What evidence does the SHA have to justify its position?
-See https://www.forbes.com/sites/williamhaseltine/2022/01/10/the-challenges-of-treating-covid-19-lessons-from-gileads-remdesivir/?sh=7d3b7aa070df

> "In a recent study published in the New England Journal of Medicine, researchers at the Baylor University Medical Center in Dallas, TX and affiliated institutions found that a three-day course of remdesivir lowered the risk of hospitalization by 87.5% in symptomatic, non- hospitalized COVID-19 patients."

7.3.6 With respect to early treatment or in-hospital treatment, we note that as of November 1, 2021 the SHA endorses the use of monoclonal antibodies. According to a Nov. 3, 2021 article by the CBC entitled, "Sask. has treated 6 people with monoclonal antibodies for COVID-19, despite hundreds of available doses" (https://www.cbc.ca/news/canada/saskatchewan/6-people-treated-monoclonal-antibodies-1.6235694 ) it states:

> "[The] SHA is aiming to treat five to seven patients a day with monoclonal antibodies, but it hasn't reached that number yet largely due to a recent decrease in COVID-19 cases and limited eligibility…
>
> …there is no cost to the province for the treatment because it's being provided by the federal government."

7.3.6.1 To what extent are monoclonal antibodies being used to treat patients? Please explain.

7.3.6.2 Since monoclonal antibodies have been authorized to treat patients, has there been a decrease in hospitalizations and ICUs? Please explain.

7.3.6.3 Is it correct that a lack of training for hospital staff has resulted in monoclonal antibodies not being used to treat patients, to the extent they could otherwise be used? Please explain.

7.3.6.4 Given that monoclonal antibodies were approved for use under the Emergency Authorization process in November of 2020 (See https://www.canada.ca/en/public-services-procurement/news/2020/11/government-of-canada-signs-new-agreement-for-a-covid-19-antibody-therapy0.html ) why was the implementation of this treatment delayed for nearly a year?

7.4 With respect to the "vaccines", why is this option being promoted to the virtual exclusion of all other options?

-For example, see January 22, 2022 opinion piece in the Globe and Mail by Dr. Norman Doidge:

> "Vaccines are a tool, not a silver bullet. If we'd allowed more scientific debate, we would have realized this earlier - More than two years since COVID-19 emerged, our kit of solutions – and the mindset needed to use them – is too small. It's time to listen to the science in a broader way"
>
> (https://www.theglobeandmail.com/opinion/article-vaccines-are-a-tool-not-a-silver-bullet-if-wed-allowed-more-scientific/ )

7.4.1 With respect to the "vaccines", what role did the pharmaceutical companies, such as Pfizer & Moderna, play in developing the SHA's policies?

7.4.2 Are the SHA's policies regarding vaccination based in part on studies/research funded by pharmaceutical companies?

7.4.3 How is the SHA identifying and addressing potential conflicts of interest in the studies/research it is accepting, which ultimately inform its COVID-19 policies?

7.4.4 What is the SHA's policy on vaccination of children and net benefit to risk ratio?

7.5 Has the SHA partnered with the University of Saskatchewan and/or the University of Regina to develop improved protocols to any of the above 4 "pillars of pandemic response"?

7.6 According to a July 8, 2021 article in the Medicine Hat News: "Former head of Alberta Emergency Management Agency blasts governments and 'lockdowns' in webinar" (https://medicinehatnews.com/news/local-news/2021/07/08/former-head-of-alberta-emergency-management-agency-blasts-governments-and-lockdowns-in-webinar/ ), David Redman states:

> "Each province and territory in Canada has a pandemic response plan, Redman added. "And they're written on the hard lessons learned – that we learned from all the previous pandemics and from other experiences in responding to emergencies." "

On the SHA's website dated Sept. 16, 2009 (https://www.saskatchewan.ca/government/news-and-media/2009/september/16/saskatchewan-releases-updated-pandemic-plan ) it states:

> SASKATCHEWAN RELEASES UPDATED PANDEMIC PLAN

There is a link (file:///C:/Users/Louis/Downloads/Pandemic%20overview%20(2).pdf ) to a 2 page document entitled:

> SASKATCHEWAN HEALTH PANDEMIC INFLUENZA PREPAREDNESS PLAN: AN OVERVIEW
> September 2009

7.6.1 Is David Redman correct in that Saskatchewan had a pre-existing pandemic response plan prior to March of 2020?

7.6.2 If yes, are the above September of 2009 documents that pre-existing pandemic response plan?

7.6.3 Was the pre-existing pandemic response plan executed? Why or why not?

7.6.4 David Redman further states:

> "[E]mergency management agencies should have been placed in charge to develop concepts and plans, Redman said, "we handed it to health."

Who has been in charge of Saskatchewan's pandemic response, emergency management agencies or public health?

7.6.5 What role, if any, have Saskatchewan's emergency management agencies played in responding to the COVID-19 pandemic?

7.6.6 Who is the person in charge of Saskatchewan's emergency management agencies who has been engaged in responding to the COVID-19 pandemic, as opposed to public health officials?

## 8. Risk stratification

As reported in a Dec. 13, 2021 CTV article, according to Dr. Peter Jüni, the head of Ontario's Science Advisory Table, "Age is the most important risk factor…"
-See https://toronto.ctvnews.ca/ontario-needs-to-address-myth-that-omicron-is-mild-head-of-science-table-says-1.5705025

Therefore, risk stratification must be applied with every single inference we make in the pandemic. However, we have the same one-size fits all policy recommendations for people working with young people as we do for people working in long-term care facilities.

8.1 How did the SHA engage in risk stratification, if at all, to develop its policies for Saskatchewan's varied people and workplaces?

8.2 Given that "age is the most important risk factor" how has the SHA sought to minimize infringing people's rights by differentiating higher risk versus lower risk environments. For example, how do the guidelines differ for people who work with seniors versus people who work with children and youth aged 5 – 18 years old?

## 9. Free Speech & Integrity of Evidence

There are multiple reports in the mainstream media of doctors being disciplined, pressured, coerced, etc. for deviating from the established COVID-19 narrative, including Saskatchewan's own Dr. Francis Christian.

-See https://www.jccf.ca/surgeon-fired-by-college-of-medicine-for-voicing-safety-concerns-about-covid-shots-for-children/
-https://www.cbc.ca/news/canada/british-columbia/bc-doctors-misinformation-covid-19-1.6021489
-https://northernontario.ctvnews.ca/englehart-ont-doctor-sanctioned-for-disgraceful-conduct-related-to-covid-19-1.5603594
-https://edmonton.ctvnews.ca/regulatory-group-warns-several-alberta-doctors-about-sharing-covid-19-misinformation-1.5596182
-https://www.thestar.com/news/gta/2021/09/28/restrictions-imposed-on-doctor-accused-of-spreading-covid-misinformation.html
Etc.

9.1 What role did the SHA play in ensuring Saskatchewan's doctors spoke only in a manner consistent with the established narrative regarding COVID-19? For example, were memos sent out to Saskatchewan's physicians advising as to consequences for deviating from the narrative? Was access to the SHA's resources, such as operating rooms, leveraged to ensure compliance with the establishment's narrative?

9.1.1 What communications occurred between the SHA and the College of Physicians and Surgeons of Saskatchewan to ensure that doctors would not spread "misinformation" about COVID-19?

9.1.2 Who decides whether any duly licensed doctor's medical opinion is "misinformation"?

9.1.3 What communications were sent to doctors regarding granting medical exemptions with respect to COVID-19?

9.1.3.1 What communications were sent to doctors regarding granting 90 day exemptions, or any other exemptions, from testing after a person recovered from COVID-19?

9.1.3.2 Did the SHA decrease and/or eliminate access to PCR tests to reduce testing exemptions for people who recovered from COVID-19? If so, when and why?

9.2 In light of the above, some doctors may not feel comfortable expressing their true medical opinions about various aspects about COVID-19. What, if anything, is the SHA doing to ensure that doctors are free to share their genuine medical experiences and opinions about COVID-19, even if they differ from the accepted narrative, to ensure that the SHA's policies are based on the best and most comprehensive data?

9.3 Further to the above, there is some evidence that publishers are refusing to publish scientific papers/research which are contrary to the established COVID-19 narrative.

For example, according to The American Journal of Cardiology's website (https://www.ajconline.org/article/S0002-9149(14)01767-6/pdf#%20 ) Dr. Peter McCullough's medical bio includes:

> "In October 2002, he returned to the Detroit area and to William Beaumont Hospital as a Consultant Cardiologist and Division Chief of Nutrition and Preventive Medicine--where he remained until August 2010, when he became the Chief Academic and Scientific officer of the St. John Providence Health System, also in Detroit. In February 2014, Dr. McCullough joined Baylor Scott & White Health as Vice Chief of Internal Medicine at BUMC, Chief of Cardiovascular Research of the Baylor Heart and Vascular Institute, and Program Director of the cardiovascular disease fellowship program at BUMC."

HeartPlace is a cardiology medical facility located in Dallas, Texas and according to their website (https://www.heartplace.com/dr-peter-a-mccullough ):

> Dr. Peter McCullough is board certified in internal medicine, cardiovascular diseases, and clinical lipidology…
>
> Dr. McCullough has broadly published on a range of topics in medicine with > 1000 publications and > 600 citations in the National Library of Medicine… Dr. McCullough is a founder and current president of the Cardiorenal Society of America, an organization dedicated to bringing cardiologists and nephrologists together to work on the emerging problem of cardiorenal syndromes. His works have appeared in the New England Journal of Medicine, Journal of the American Medical Association, Lancet, British Medical Journal and other top-tier journals worldwide. He is the editor-in-chief of Reviews in Cardiovascular Medicine and senior associate editor of the American Journal of Cardiology. He serves on the editorial boards of multiple specialty journals. Dr. McCullough has made presentations on the advancement of medicine across the world and has been an invited lecturer at the New York Academy of Sciences, the National Institutes of Health, U.S. Food and Drug Administration (FDA), and the European Medicines Agency. He has served as member or chair of data safety monitoring boards of 24 randomized clinical trials.

However, despite Dr. McCullough's impeccable qualifications, extensive experience and internationally recognized expertise, he stated the following according to LifeSiteNews on Nov. 16, 2021 (https://www.lifesitenews.com/blogs/dr-mccullough-sues-medical-journal-for-refusing-to-publish-papers-showing-covid-shot-risks-in-children/ ):

> "According to McCullough, the journal, "Elsevier," originally published the study, but scrubbed it just days before the FDA met to discuss approval for the injections to 5-11 year olds.
>
> "This is an overt act of censorship," he said. "We will be launching a full scale lawsuit against Elsevier, and it's going to be for breach of contract." "

9.3.1 Is the SHA aware of this potential publication bias regarding the studies & research which are informing our COVID-19 policies?

9.3.2 How is the SHA, if at all, accounting for this potential publication bias, to ensure that the SHA's policies are based on the best and most comprehensive studies & research, not just those which reinforce the established narrative?

9.4 Further to the above, according to the Informed Consent Action Network ("ICAN")'s website (https://www.icandecide.org/ican_press/ican-demands-cdc-authors-withdraw-rigged-natural-immunity-study/ ):

> On October 29, 2021, 53 authors put their name on a paper that they should be, at best, deeply ashamed of and, at worst, held liable for. Seventeen of those authors were members of CDC's COVID-19 Response Team. ICAN sent them a letter detailing the gross scientific misconduct evidenced in the paper and demanded that they withdraw their names from the study.
>
> The non-peer-reviewed paper titled Laboratory-Confirmed COVID-19 Among Adults Hospitalized with COVID-19–Like Illness with Infection-Induced or mRNA Vaccine-Induced SARS-CoV-2 Immunity — Nine States, January–September 2021 purports to compare the risk of infection between those who previously tested positive for SARS-CoV-2 and those who received a COVID-19 vaccine.
>
> It misleadingly concludes that the unvaccinated have more than a 5x greater risk of becoming infected with COVID-19 than those who are vaccinated. If this strikes you as absurd based on the dozens and dozens of peer-reviewed studies that show the opposite result, and based on everything we know about natural immunity, that is because it is.

9.4.1 Is the SHA aware of this potential corruption of scientific integrity regarding the studies & research which are informing our COVID-19 policies?

9.4.2 How is the SHA, if at all, accounting for this potential corruption, to ensure that the SHA's policies are based on the best and most comprehensive studies & research, not just those which reinforce the established narrative?

9.5 Has the SHA's "dashboard" been modified to support a policy objective as opposed to reflecting accurate data? Please explain.

9.5.1 Has the SHA highlighted any data at the expense of other data to advance a policy objective as opposed to reflecting accurate data? Please explain.

9.6 Is the SHA able to confirm whether any of the components of the current vaccine trials have been peer-reviewed by independent bodies bearing no conflicts of interest and no reporting bias?

9.7 According to several online news website, the US Food and Drug Administration had "asked a federal judge for permission to make the public wait until the year 2096 to disclose all of the data it relied upon to license Pfizer's Covid-19 vaccine.

That is not a typo. The FDA wanted court approval to have up to 75 years to publicly disclose this information."

(See https://news.bloomberglaw.com/health-law-and-business/why-a-judge-ordered-fda-to-release-covid-19-vaccine-data-pronto )

Given the importance of transparency regarding all aspects of the COVID-19 vaccines, what is the SHA's position and response to the FDA's and Pfizer's attempt to conceal critical information for 75 years?

## 10. Privacy

10.1 In light of revelations that the Public Health Agency of Canada is collecting data from millions of mobile phones without consent, please advise whether the SHA is collecting, tracking, using or analysing any data from the mobile phones of Saskatchewan citizens and/or residents.
-See https://nationalpost.com/news/politics/opposition-mps-call-for-committee-tolaunch-emergency-probe-of-use-of-mobile-data

10.2 If so, how is the SHA collecting, tracking, using or analysing said data?

10.3 The SHA has encouraged Saskatchewan citizens and residents to download the e-health app onto their mobile phones. Does the SHA's e-health mobile app track a person's movement?

10.3.1 Does the e-health mobile app provide any information to the SHA, or any other person or entity, without the phone owner's consent? If so, please provide details.

10.4 On May 19, 2021 Canada's Federal, Provincial and Territorial Privacy Commissioners issued a joint-statement regarding COVID-19 vaccine passports (See https://www.priv.gc.ca/en/opc-news/speeches/2021/s-d_20210519/ ).

Therein, our privacy commissioners stated:

> Page 1: At its essence, a vaccine passport presumes that individuals will be required or requested to disclose personal health information – their vaccine/immunity status – in exchange for goods, services and/or access to certain premises or locations. While this may offer substantial public benefit, it is an encroachment on civil liberties that should be taken only after careful consideration…
> (Underlining added)
>
> Vaccine passports must be developed and implemented in compliance with applicable privacy laws. They should also incorporate privacy best practices in order to achieve the highest level of privacy protection commensurate with the sensitivity of the personal health information that will be collected, used or disclosed.
>
> Page 2: Above all, and in light of the significant privacy risks involved, the necessity, effectiveness and proportionality of vaccine passports must be established for each specific context in which they will be used.
> (Underlining added)
>
> • **Necessity:** vaccine passports must be necessary to achieve each intended public health purpose. Their necessity must be evidence-based and there must be no other less privacy-intrusive measures available and equally effective in achieving the specified purposes.
> • **Effectiveness:** vaccine passports must be likely to be effective at achieving each of their defined purposes at the outset and must continue to be effective throughout their lifecycle.
> • **Proportionality:** the privacy risks associated with vaccine passports must be proportionate to each of the public health purposes they are intended to address. Data minimization should be applied so that the least amount of personal health information is collected, used or disclosed.
>
> The necessity, effectiveness and proportionality of vaccine passports must be continually monitored to ensure that they continue to be justified. Vaccine passports must be decommissioned if, at any time, it is determined that they are not a necessary, effective or proportionate response to address their public health purposes.

10.4.1 Given that the "vaccine" mandates encroach upon the civil liberties as described by our Privacy Commissioners, please identify how the SHA satisfied the "careful consideration" test.

10.4.2 Please identify the "privacy best practices" the SHA considered in developing or advising on the vaccine mandate "in order to achieve the highest level of privacy protection commensurate with the sensitivity of personal health information that will be collected, used or disclosed."

10.4.3 With respect to the "Necessity" requirement, please identify how the vaccine mandate is necessary to achieve each intended public health purpose.

10.4.4 What are the specific intended public health purposes driving the vaccine mandate?

10.5 Further to the above section on "Transmissibility", in a September 28, 2021 study entitled, "No Significant Difference in Viral Load Between Vaccinated and Unvaccinated, Asymptomatic and Symptomatic Groups Infected with SARS-CoV-2 Delta Variant" the Abstract states:

> We found no significant difference in cycle threshold values between vaccinated and unvaccinated, asymptomatic and symptomatic groups infected with SARS-CoV-2 Delta. Given the substantial proportion of asymptomatic vaccine breakthrough cases with high viral levels, interventions, including masking and testing, should be considered for all in settings with elevated COVID-19 transmission.
> (See https://www.medrxiv.org/content/10.1101/2021.09.28.21264262v1 )

In other words, both vaccinated and unvaccinated spread COVID-19 and testing therefore should not be imposed only on the unvaccinated.

Further, in a September 2, 2021 Freedom of Information Act request by ICAN (Informed Consent Action Network) which is a US not-for-profit organization "whose mission is to raise public awareness about vaccine safety and to provide the public with information to give informed consent.", ICAN's request to the American CDC stated the following:

> Documents reflecting any documented case of an individual who: (1) never received a COVID-19 vaccine; (2) was infected with COVID-19 once, recovered, and then later became infected again; and (3) transmitted SARS-CoV-2 to another person when reinfected.

The CDC's November 5, 2021 response was:

> A search of our records failed to reveal any documents pertaining to your request. The CDC Emergency Operations Center (EOC) conveyed that this information is not collected.
> (See https://aaronsiri.substack.com/p/cdc-admits-crushing-rights-of-naturally )

In other words, after formal demand, the CDC conceded it did not have proof of a single instance of a naturally immune individual spreading the virus.

In order for people to give informed consent to any vaccine mandate, they require that the evidence which is being relied upon for the "necessity" criterion address these 2 issues, ie. (i) that vaccinated people have similar viral loads as unvaccinated, and (ii) that naturally immune people may spread the virus less than vaccinated people.

10.5.1 Given that "the necessity must be evidence-based", please provide the evidence upon which the SHA is relying to justify the necessity of the vaccine mandate in any work environment.

10.6 Please provide the analysis of the "other less privacy-intrusive measures" which were found to be inadequate.

10.7 With respect to the "Proportionality" requirement, please provide the due diligence to ensure the privacy risks associated with the vaccine mandate are proportionate to each of the public health purposes they are intended to address.

10.8 With respect to the "Proportionality" requirement, please advise how "Data minimization will be applied so that the least amount of personal health information is collected, used or disclosed."

10.9 Our Privacy Commissioners stipulate that, "The necessity, effectiveness and proportionality of vaccine passports must be continually monitored to ensure that they continue to be justified." (Underlining added)

How will such be "continually monitored" to ensure compliance with this legal requirement?

10.10 What is the threshold when vaccine mandates will no longer be a justified encroachment on our civil liberties?

10.11 Our Privacy Commissioners stipulate that, "Vaccine passports must be decommissioned if, at any time, it is determined that they are not a necessary, effective or proportionate response to address their public health purposes."
(Underlining added)

How can the people of Saskatchewan be assured that this legal requirement for decommissioning will be strictly enforced?

10.11.1 How does the SHA interpret the word "decommissioned"?

## 11. Informed Consent

11.1 Who is authorized to administer the COVID-19 “vaccines”?

11.2 What guidelines are in place to determine informed consent? Has this changed since March of 2020? Please explain.

11.3 What information is provided to the people administering said “vaccines” to assist them with getting informed consent?

11.3.1 Is this information updated as new information becomes available? Please explain.

11.4 What information is provided by the people administering the “vaccines” to the people receiving said “vaccines”, both orally and in the form of documentation in order to obtain informed consent?

11.4.1 Is this information uniform across all the people administering the “vaccines”?

11.4.2 Is there an audit system and/or any other quality controls in place to ensure accurate and consistent information is being provided by the people administering the “vaccines” to the people receiving the “vaccines”? Please explain.

11.4.3 Is there FULL disclosure of ALL the potential side effects and risks by the people administering the “vaccines” to the people receiving the “vaccines”?

11.4.4 What side effects and risks are supposed to be communicated by the people administering the “vaccines” to the people receiving the “vaccines”?

11.4.5 Given that the Phase III clinical trials are ongoing for the COVID-19 “vaccines”, are recipients of said “vaccines” being advised that they are part of the Phase III clinical trials? Please explain.

11.4.5.1 Do prospective recipients of a “vaccine” have to first consent to being a subject in a clinical trial?

11.4.5.2 Are prospective recipients informed in the same way that drug trial participants have traditionally been informed adhering to all the rules and regulations which are incumbent in these trials?

11.4.5.3 Given the speed with which the COVID-19 vaccines have had to be developed, what has changed regarding the information which is provided to participants in the Phase III clinical trials?

11.4.6 If a person experiences an adverse event from a dose, are they provided with any additional information regarding successive doses and their informed consent for same? Please explain.

11.5 Before a prospective recipient of a "vaccine" provides consent, what is in place to ensure that person is psychologically stable, cognitively mature and free from any form of duress, so as to ensure they can adequately provide informed consent?

11.5.1 How often have proxies been used to provide informed consent for an approved COVID-19 "vaccine"?

11.5.2 What processes are in place to ensure that said proxies are duly vetted and authorized to provide said informed consent for another?

11.6 Is the Patient Advocate involved if an adverse event occurs? Please explain.

11.6.1 How is the independence of the Patient Advocate ensured in such cases?

11.6.2 Do Patient Advocates receive any payments and/or other incentives for anything relating to COVID-19?

11.6.3 Have Patient Advocates provided any feedback and/or recommendations regarding COVID-19 protocols? Please explain.

11.6.4 Has the SHA changed any of its COVID-19 policies as a result of Patient Advocates?

11.7 What mechanism is in place, if any, between the SHA and the School Boards to address potential concerns of parents/students regarding "vaccines"?

11.8 What are the material risks associated with the approved "vaccines" which people should know about?

11.8.1 What special or unusual risks are associated with the approved "vaccines" which people should know about?

11.9 What are the material risks associated with the approved COVID-19 tests which people should know about?

11.9.1 What special or unusual risks are associated with the approved COVID-19 tests which people should know about?

11.9.2 Are any components of any of the COVID-19 tests known to be carcinogenic?

11.9.3 Are there recommended limits on the frequency or duration for testing? For example, if a person tested every day for 6 months are there any known risks associated with such? Please explain.

## 12. Pregnancy/Breastfeeding/Family Planning

12 In an article published on the John Hopkins University website, dated June 28, 2021 entitled, "Global policies on COVID-19 vaccination in pregnancy vary widely by country according to new online tracker - Johns Hopkins project provides worldwide snapshot of policies influencing access to COVID-19 vaccines for pregnant and lactating people", the following is stated:

> …countries around the world vary widely in their policies on COVID-19 vaccination in pregnancy…
> …
> "The variability in policy positions is in part a consequence of the absence of evidence on vaccines in pregnancy, because pregnant and lactating people are excluded from the vast majority of clinical trials. As a result, public health authorities and recommending bodies are developing guidance on COVID vaccines and pregnancy with far less evidence than they have for most other populations," said Ruth Faden, founder of the Johns Hopkins Berman Institute of Bioethics.
> (-https://hub.jhu.edu/2021/06/28/tracker-map-of-vaccine-policies-for-pregnant-women/ )
> (Underlining added)

12.1 Given that pregnant and lactating women are excluded from the vast majority of clinical trials, how did the SHA develop its COVID-19 policies regarding pregnant and lactating women?

12.2 Is there any long-term safety data regarding the approved "vaccines" and pregnancy? Please explain.

12.2.1 Have there been any adverse events for pregnant women and/or unborn children associated with the approved "vaccines"? Please explain.

12.3 Is there any long-term safety data regarding the approved "vaccines" and breastfeeding? Please explain.

12.3.1 Have there been any adverse events for breastfeeding women and/or breastfeeding children associated with the approved "vaccines"? Please explain.

12.4 Can the SHA confirm that the approved "vaccines" have no effect on fertility for pregnant women? Please explain.

12.4.1 Can the SHA confirm that the approved "vaccines" have no effect on the fertility of an unborn child when injected into his or her pregnant mother? Please explain.

12.4.2 Can the SHA confirm that the approved "vaccines" have no effect on fertility for men? Please explain.

12.5 Does the SHA track the number of miscarriages? If so, how?

12.6.1 Please provide the miscarriage data from January of 2018 – present.

12.6.2 Was there any correlation with an increase in the number of miscarriages and the roll-out of the approved "vaccines"? Please explain.

12.7 What are the additional material risks associated with the approved "vaccines" which pregnant and/or breastfeeding women should know about?

12.7.1 What additional special or unusual risks are associated with the approved "vaccines" which pregnant and/or breastfeeding women should know about?

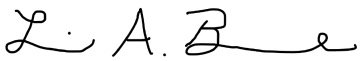
12.8 What are the additional material risks associated with the approved COVID-19 tests which pregnant and/or breastfeeding women should know about?

12.8.1 What additional special or unusual risks are associated with the approved COVID-19 tests which pregnant and/or breastfeeding women should know about?

We thank you again for your urgent attention to this matter.

Sincerely,

**Willows Wellsch Orr & Brundige LLP**

Per: 

**Louis Browne**