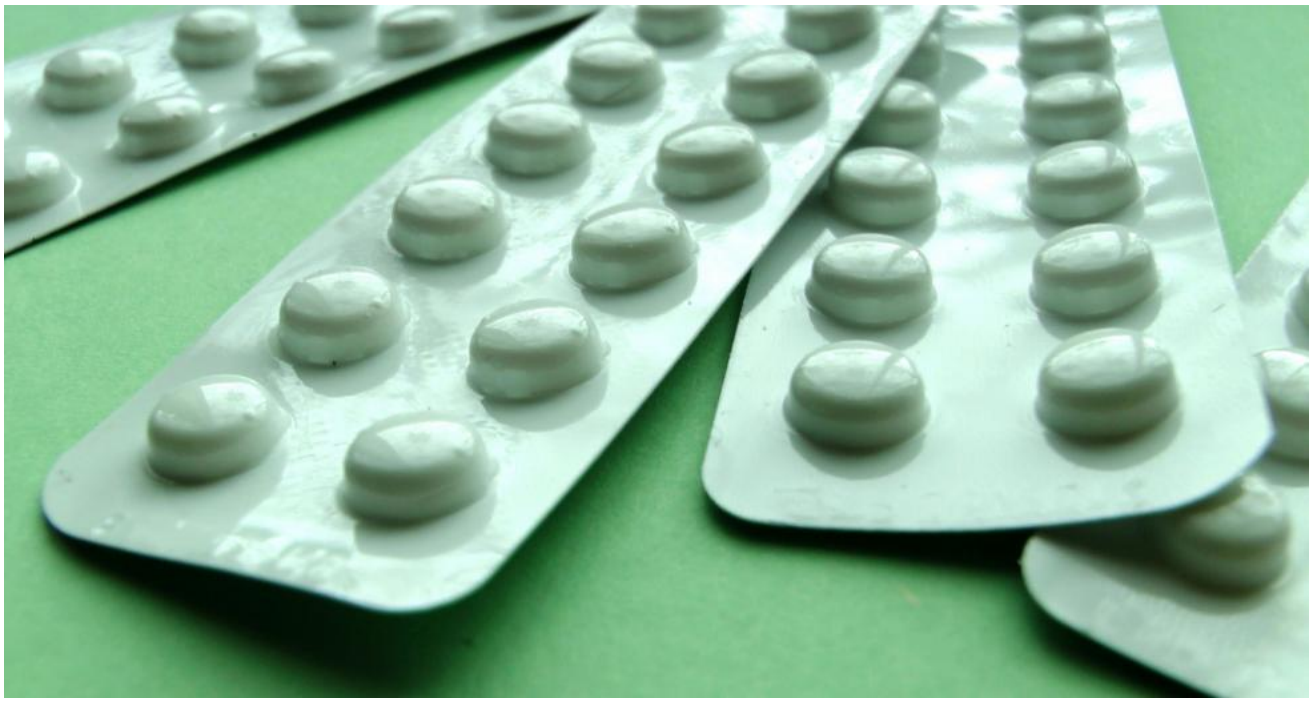
Coronavirus

The Hydroxy-chloroquine Scandal



by Iain Davis

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From the outset of the Coronavirus pandemic, and the lockdown regimes that followed, we have been repeatedly told, by all the usual suspects, institutions and the mainstream media, that the only way to get *back to normal* is with a vaccine; precisely echoing the calls of the Bill and Melinda Gates Foundation.

Certainly, the UK government was quick to invest in vaccine development. In their Coronavirus Action Plan, published on 3 March, the focus was overwhelmingly on vaccines. The *Action Plan* noted that a vaccine may not prevent infection from SARS-Cov-2 but could rather *manage symptoms* of the potentially resultant syndrome, COVID-19:

> Given that there is currently neither a vaccine against COVID-19 nor any specific, proven, antiviral medication, most treatment will therefore be **towards managing symptoms** … **innovate responses including** diagnostics, drugs and **vaccines** …

This notion that a proposed vaccine may not actually stop SARS-CoV-2 infections, but rather *manage symptoms* of COVID-19, was clearly signalled by Pascal Soriot (CEO of AstraZeneca), who are partnering with Oxford University to develop a SARS-CoV-2 vaccine. Speaking on the BBC's *Andrew Marr Show* on 24 May, Soriot stated:

> We are quite confident the vaccine will work, actually. The question is, will it completely clear the virus or stop people being sick … This is what happens with the flu vaccine, for instance … It simply stops people from being sick … Being protected against being sick would already be a big plus.

UK Prime Minister Boris Johnson has, so far, held a number of discussions with Bill and Melinda Gates about the COVID-19 crisis. On 4 June, the UK government hosted the GAVI vaccine alliance Replenishment Summit in London. The Gates Foundation gave GAVI $1.2 billion in 2019 and was among its founding partners. It has contributed more than $4.1Bn to GAVI during its two-decade-long mission to create *"healthy markets for vaccines."*

Bill Gates and Boris Johnson were the keynote speakers at the summit. In his address, Johnson stated:

> I want to say a particular thank you to Bill and Melinda Gates for their generosity, their philanthropy, yet again, and their continued leadership in humanity's battle against disease … Just as we have great military alliances like NATO … so we now need that same spirit of collaboration and collective defence against the common enemy of disease … It will require a new international effort to co-operate on the surveillance and sharing of information that can underpin a global alert system … it will need a radical scaling-up of our global capacity to respond, exactly as Bill [Gates] has set out.

As Johnson's comments reveal, there is much more than just healthcare riding on the back of Coronavirus vaccine development. The vaccine itself sits at the centre of a web of surveillance, restricted freedom of movement and restricted access to employment and services based upon your allocated immunity status.

A whole new tech industry, combining global corporations and intelligence agencies, is springing up to monitor, control and surveil populations. Perhaps we could call this the *"disease intelligence industrial complex."*

A Vaccine That Doesn't Need To Work

Johnson's *Coronavirus Action Plan* announcement followed the World Health Organisation's February summit with the Global Research Collaboration for Infectious Disease Preparedness and Response (GLOPID-R).

GLOPID-R's list of funding organisations, with significant financial interests in vaccine sales, is notable. For example, there is the Gates Foundation, the Coalition for Epidemic Preparedness Innovation (CEPI), the Wellcome Trust, and the French medical research agency Inserm (Institut national de la santé et de la recherche médicale).

The two-day WHO / GLOPID-R summit took place on 11-12 February. One month later, on 11 March, the WHO declared a global coronavirus pandemic. The summit produced the Target Product Profile (TPP) which needs to be met in order for the WHO to approve any proposed COVID-19 vaccine.

The WHO would prefer that the vaccine prevent SARS-CoV-2 infections, but it doesn't have to, so long as it reduces the worst effects of COVID-19. It doesn't need to be 100% effective either; 70% is fine.

Since, at the time of writing, COVID-19 is said to have impacted 0.1% of the global population, allegedly killing less than 0.006%, the WHO's measure of success for a global vaccine being that it protect 70% of the global population from a disease that doesn't affect 99.9% of the population, the chances of WHO approval for anything look pretty good — an inert saline solution should do the job. It is not surprising, then, that vaccine developers are so confidently looking forward to a global market and global profits.

A cheap, widely available *off-patent* drug that achieves exactly the same thing as the vaccine must, therefore, be seen as a problem.

Why Not Hydroxychloroquine?

When the world is presented with a virus which is claimed to cause a potentially fatal disease for which there is no known treatment, and if our only claimed wish is to *"save lives,"* trialling any and all potential treatments makes obvious sense.

Resistance to trials would suggest that *saving life* may not be the priority. If the evidence shows that powerful public health bodies and foundations have apparently colluded to stop trials, there can be little doubt another agenda has taken precedence over *saving lives*.

When the WHO declared a global pandemic, chloroquine, and its modern form hydroxychloroquine, were the most obvious candidates for investigative clinical trials. Its possible effectiveness had, after all, been noted since at least 2005.

Scientists and doctors around the world took note of early promising clinical trials in China. In France, Prof. Didier Raoult, one of the world's most published microbiologists, announced his own trials. He stated that he thought it would be foolish not to trial chloroquine more widely.

Prof. Didier Raoult

Scientists at Stanford University agreed, reporting apparent treatment success in both China and South Korea. The Stanford team also advocated more thorough clinical trials of chloroquine and hydroxychloroquine.

Yet resistance to trialling hydroxychloroquine was immediately evident. Raoult was attacked in France for suggesting hydroxychloroquine could work to prevent the most severe, life-threatening, symptoms of COVID-19. These attacks, which we would characterise as a disinformation campaign, came from the mainstream media, other scientists who worked for Inserm, and politicians.

The persistent claim, repeated ad nauseam by the mainstream media, that hydroxychloroquine presents some sort of severe heart risk, simply isn't true.

The cardiovascular risks for hydroxychloroquine are overwhelmingly associated with acute poisoning, often intentional, when used in combination with other antiviral drugs, or with prolonged high-dosage use.

There is virtually no cardiovascular risk at all to taking it, as recommended, for short-course treatments — as you would if you took it as a prophylaxis for COVID-19.

The case fatality rate (CFR) for the oldest COVID-19 patients has been reported to rise to more than 14%. Raoult's largest field study, of more than one thousand patients treated with hydroxychloroquine, showed that the CFR for the oldest patients dropped to 0.5%.

Raoult is by no means the only scientist or doctor to have seemingly proven the efficacy of hydroxychloroquine for treating COVID-19; especially as a prophylactic.

Doctors in New York found that hydroxychloroquine treatment increased survival rates; Brazilian doctors discovered that treating patients with hydroxychloroquine reduced their chances of requiring hospital treatment by nearly 300%, with no notable adverse events; Chinese doctors reduced fever duration and improved the clinical outcomes for patients treated with chloroquine; doctors in Spain used hydroxychloroquine to increase patient survival rates; researchers in the U.S. found that the addition of zinc further improved outcomes; doctors treating Chinese patients with hydroxychloroquine found no increase in adverse events for their patients; and a systemic review of the available evidence by Indian researchers concluded:

> There is theoretical, experimental, preclinical and clinical evidence of the effectiveness of chloroquine in patients affected with COVID-19. There is adequate evidence of drug safety from the long-time clinical use of chloroquine and hydroxychloroquine.

However, if we were to rely on the MSM for our information, we would not know any of this. Why are they apparently so eager to convince us that hydroxychloroquine is harmful? Why are the WHO, Inserm and the UK's Medicines and Healthcare Products Regulatory Agency (MHRA) determined that hydroxychloroquine trials won't proceed?

The Problem With Hydroxychloroquine

The leading scientific advocates of hydroxychloroquine recommend that it should primarily be used in the early stages of COVID-19, or even prior to developing the

syndrome, as a prophylactic. Should the person develop the symptoms of COVID-19, they could, for example, begin a course of what has become known as the Marseilles Treatment: hydroxychloroquine with the antibiotic azithromycin (HCQ+AZ) plus zinc to aid absorption.

Struggling to comprehend the seemingly inexplicable resistance to trialling HCQ+AZ, Prof. Harvey Risch, MD, from Yale University, argued that HCQ+AZ should immediately be used as an early therapy for COVID-19 patients. He wrote:

> Hydroxychloroquine+azithromycin has been widely misrepresented in both clinical reports and public media…..Five studies, including two controlled clinical trials, have demonstrated significant major outpatient treatment efficacy……These medications need to be widely available and promoted immediately for physicians to prescribe.

His is far from the only eminently qualified opinion questioning the irrational blocking of treatment with hydroxychloroquine. In Michigan, the Association of American Physicians and Surgeons (AAPS) have launched an appeal against an FDA injunction to allow them to prescribe hydroxychloroquine for their COVID-19 patients.

The WHO's Solidarity Trials to test hydroxychloroquine were launched on 18 March. The WHO stated that four hundred hospitals in thirty-five countries had recruited 3,500 patients to take part. At the same time, the WHO launched its Solidarity Trial for potential vaccines.

The UK government did not take part in the WHO's Solidarity trials, instead running their own Recovery Trial and separate COPCOV and PRINCIPLE trials.

The Recovery Trial's core funding comes from the Gates Foundation, Wellcome Trust and Oxford University, among others. Oxford University is running vaccine trials, in partnership with AstraZeneca. The Recovery Trial was not investigating the prophylactic potential of hydroxychloroquine.

The COPCOV trial was due to assess hydroxychloroquine's prophylactic efficacy in protecting healthcare workers against contracting COVID-19.

The PRINCIPLE trial was perhaps the most relevant of all. Vulnerable over-fifties, and people over 65, were to be offered hydroxychloroquine in a large-cohort study of patients in primary care (GP practices and community care settings).

In France, Inserm ran its own *Discovery Trials* in parallel with the WHO's Solidarity Trials. Again, they were only assessing hydroxychloroquine in isolation, for the most ill

patients. Only the UK's COPCOV and PRINCIPLE trials were assessing potential preventive efficacy. COPCOV also had an international arm.

However, none was trialling the recommended *Marseilles Treatment*.

Initially Inserm refused point-blank to trial hydroxychloroquine at all. Four days before the launch of the WHO's Solidarity Trials, Prof. Yazdan Yazdanpanah, head of France's health emergency rapid response committee (REACTing — REsearch and ACTion targeting emerging infectious diseases) stated that the Discovery Trials would exclude chloroquine (hydroxychloroquine) and would only trial patented drugs:

> We have not retained it [hydroxychloroquine] for the moment, in particular because of its undesirable effects. It also has frequent interactions with other drugs. However, intensive care patients are often treated with multiple drugs.

This followed a decision on 15 January, made by the then French Minister of Solidarity and Health, Agnès Buzyn, to reclassify hydroxychloroquine in all its forms as a poisonous substance.

Prior to this decision, for more than fifty years, the French had been able to buy hydroxychloroquine over the counter. Once demand shot through the roof, as the COVID-19 crisis unfolded, they suddenly could no longer get it without a prescription.

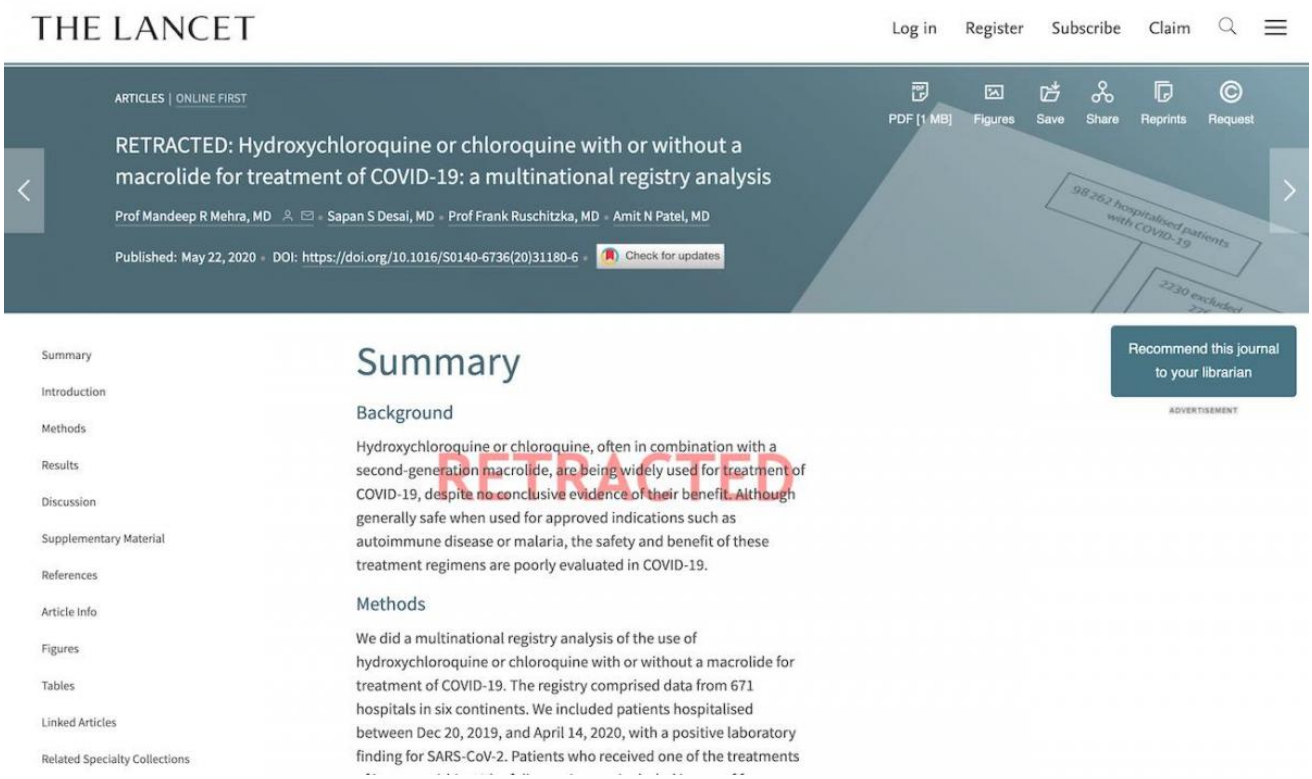
With the WHO initially including hydroxychloroquine in their Solidarity Trials, Inserm had little option but to reluctantly include it in their Discovery Trials on *Solidarity* launch day, 22 March. Inserm stated in its press release:

> We analyzed the data from the scientific literature concerning the SARS and MERS coronaviruses as well as the first publications on SARS-COV2 from China to arrive at a list of antiviral molecules to be tested: remdesivir, lopinavir in combination with ritonavir…….and hydroxychloroquine. The list of these potential drugs is also based on the list of experimental treatments classified as priorities by the World Health Organization.

This can be seen as little more than disingenuous back-peddling. *The data from the scientific literature* hadn't changed in the space of a few days. If REACTing previously considered the hydroxychloroquine risks too high, no new evidence had emerged to alter that assessment.

Hydroxychloroquine Trials Abandoned for No Reason At All

Within days of the hydroxychloroquine trials starting, on 22 May *The Lancet* published a study by a team of four U.S. researchers from Brigham and Women's Hospital Center for Advanced Heart Disease. The paper alleged that hydroxychloroquine presented too high a risk of *ventricular arrhythmia* and potentially increased mortality for COVID-19 patients.



The WHO suspended hydroxychloroquine Solidarity Trials on 25 May. U.S. researchers did the same, as did German public health authorities, Inserm and many others. The WHO effectively triggered all the suspensions.

The study published in *The Lancet* was not just a scientific fraud, it was a glaringly obvious scientific fraud. All the data for the Brigham study came from a single source, Surgisphere, which promotes itself as a medical data mining company and which was founded by one of the study's authors, Dr. Sapan S. Desai.

Scientists around the world immediately noticed significant problems with the Surgisphere data. The data were too homogeneous for a global study; it seemed impossible that four researchers could collate such a massive hoard of data. Claims

that this had all been achieved in a matter of weeks were laughed at by many genuine scientific researchers.

Surgisphere claimed it had a *global network* of participating hospitals, which would have required global ethics and data protection approval from every individual hospital. These claims were widely considered literally unbelievable.

Medical researchers and scientists from around the world wrote an open letter to *The Lancet* expressing their deep concerns about the study. *The Lancet* initially offered a minor correction, attempting, but failing, to account for the erroneous data.

Consequently *The Lancet* issued a statement saying *"serious scientific concerns"* had been brought to their attention. When *The Lancet* requested that Surgisphere participate in a data audit, it seems Dr. Desai declined. At this point, the other three authors of the study requested that *The Lancet* withdraw the paper, which it did on 3 June. Richard Horton, editor of *The Lancet*, said:

> This is a shocking example of research misconduct in the middle of a global health emergency.

Yet, despite the fact that scientists from across the globe were able to spot the fake paper with ease, neither *The Lancet* nor the world's leading experts in public health, the World Health Organisation, could. Instead, it suspended trials of a potentially life-saving medication, that had only just begun, in the middle of a supposed global pandemic.

When the WHO made its suspension, on 26 May, the UK MHRA did the same. They suspended all trials initially, but then reinstated the Recovery trial: the only trial of the three which is *not* investigating hydroxychloroquine's potential as a prophylactic.

Like the WHO, the MHRA either didn't exercise any due diligence — or don't care about *saving lives*.

The same day, despite there being no UK completed trials of Gilead Science's remdesivir, the MHRA approved it for hospital treatment of COVID-19 patients anyway. They based this on the expert recommendation of the Commission on Human Medicines (CHM).

According to the CHM's declaration of interests (p. 141–p. 247), there doesn't seem to be a single pharmaceutical corporation which *isn't* well represented among its members. Gilead Sciences has strong ties with the CHM.

The MHRA decision, and the CHM recommendation, followed the release of remdisivir trial data from the U.S. which suggested the drug could aid recovery of seriously ill patients by up to 31%.

That U.S. National Institute of Health (NIH) study was funded by the Gates Foundation-backed NIAID, headed by Dr Anthony Fauci. NIAID made a $37.5 million grant in February for the research.

Unlike hydroxychloroquine, remdesivir is patented. With 25 years left to run, Gilead Sciences can charge whatever they like for their drug until 2037 at the earliest.

A number of other studies have not been able to find any significant benefit from remdisivir. The WHO withdrew some of these unfavourable remdesivir studies from their trial database, as it had accidentally uploaded them. Other remdisivir trials were stopped when adverse effects were observed.

Following exposure of the Surgisphere fake science, the WHO initially claimed it would reinstate their hydroxychloroquine Solidarity Trials. However, this didn't happen.

On 5 June, the Recovery Trial team announced that it had found no benefit from hydroxychloroquine. Prof. Peter Horby, Chief Investigator for the trial, said:

> Hydroxychloroquine and chloroquine have received a lot of attention and have been used very widely to treat COVID patients despite the absence of any good evidence. The RECOVERY Trial has shown that hydroxychloroquine is not an effective treatment in patients hospitalised with COVID-19 ...

This was immediately reported by the mainstream media and the WHO announced it had terminated their hydroxychloroquine arm of the Solidarity trials. Citing data from its own trials and Inserm's Discovery trials, yet to be released, the WHO stated:

> This decision applies only to the conduct of the Solidarity trial and does not apply to the use or evaluation of hydroxychloroquine in pre- or post-exposure prophylaxis in patients exposed to COVID-19.

The only released data has come from the Recovery Trial, also referenced by the WHO. Yet the Recovery Trial has also been exposed as scientific nonsense. The Deputy Chief Investigator of the Recovery Trial, Prof. Martin Landray, gave an interview to France-Soir. What he revealed was quite remarkable.

Firstly, the mortality rate of the hydroxychloroquine patients was a staggering 25.7%.

The recommended hydroxychloroquine dose for an adult in the UK is no more than 200 — 400 mg per day. In France, 1800 mg per day is considered to be *lethal* poisoning.

Yet, across 175 UK hospitals, 1542 patient participants in the Recovery Trial were given 2400 mg (six times the recommended maximum dose), in the first twenty-four hours. This was followed up by ten days at twice the recommended maximum dose at 800 mg.

It isn't really clear what the objective was. This wasn't so much a trial of effectiveness; it looked more like an experiment in toxic poisoning. That would seem to account for the atrocious mortality rate.

Explaining that the dose was chosen by using computer-generated mathematical models, Prof Landry stated:

> The doses were chosen on the basis of pharmacokinetic modelling, and these are in line with the sort of doses that you use for other diseases such as amoebic dysentery.....For a new disease such as Covid, there is no approved dosing protocol. But the HCQ dosage used [is] not dissimilar to that used, as I said, in for example amoebic dysentery.

Hydroxyquinoline — not hydroxychloroquine — is used for the treatment of amoebic dysentery. Perhaps it is not without good reason that Prof. Didier Raoult described the Recovery Trial as "the Marx Brothers doing science," though given the terrible death toll, it doesn't really seem like much of a laughing matter.

What can we conclude from all this? It seems the WHO, the MHRA, Inserm, and public health bodies around the world have used fake science, fake data, deliberately destructive studies and what appears to be wilful ignorance to make sure hydroxychloroquine is never trialled as a preventive COVID-19 treatment.

The repeated statements, from numerous sources, that there is no scientific evidence to justify the use of the *Marseilles Treatment* as a prophylactic treatment for COVID-19 are risible. Should it ever be widely acknowledged as effective, the already spurious argument for a COVID-19 vaccine would be wholly untenable.

Only the most naive could imagine there aren't many powerful individuals, foundations and institutions, including governments, who wish to stop the preventive treatment efficacy of HCQ+AZ with zinc ever being proven.

The Indian Council of Medical Research (ICMR) has stated that it will continue to advocate the use of hydroxychloroquine for front-line health workers, as no notable adverse reactions were evident. Dr Samiran Panda, director of the ICMR-National AIDS Research Institute, reported the results of Indian trials into its use as a prophylactic treatment for health professionals:

> The main conclusion that can be drawn after analysing the data is that hydroxychloroquine has beneficial effects in infection risk reduction from the fourth dose onwards…….[hydoxychloroquine] will help cut the risk of infection by 80% in healthcare workers who are not already sick.

Iain Davis writes at In This Together.

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