**Covid-19 Related Arkansas School Information**

# The Case for Unrestricted Full Reopening of Arkansas Schools and a Return to Representative Local Governance

***Presented By: Reopen Arkansas***
***Revised 16 Oct 2020***

**EXECUTIVE SUMMARY**: This paper is presented by the grassroots citizens' group, Reopen Arkansas, as a service to local elected school boards and school officials. It offers an overview of current Covid-19 (CV19) related information and discusses the need for a return to policy development and control by local school boards and elected officials. To date, local officials have had no voice in the development of CV19 school policy in the State. Herein we suggest action to return to representative governance.

CV19, which began as a health crisis and, "two weeks to flatten the curve," has undeniably devolved into a political and social crisis. The latest medical data and science shows children and young adults are simply not at risk of serious adverse outcomes. They are, in fact, at far greater risk from the common flu – more on that below. Were our current measures reasonable or necessary, it begs the question, why weren't the measures in place long ago, every flu season? As a State, our response has been to treat our youth in school settings as if they are at high-risk of serious adverse outcomes. School reopening policies and response are arguably doing more damage educationally, socially, mentally, and medically, than CV19 itself.

Unfortunately, despite significant lobbying and persuasion attempts, the State Governor, and the Arkansas Dept. of Health (ADH), solely control the state response through perpetual "emergency" declarations. The Governor has indicated he sees no end in sight. He has sustained the "emergency" through a "casedemic," which bears no relationship to actual, communicable, disease. "Cases" are not infections – more on that below. We now know a great deal more about risk of CV19 to our youth. However, we have based school policies on a general, over-arching risk assessment that fails to take into account that our youth are not at the same risk-level as the elderly, or those with serious comorbid medical issues. This is a travesty and disservice to our youth, schools, and communities. Parents are keeping their children out of in-person school not because of CV19 risk, but rather because of the over-the-top, arbitrary CV19 policies. Students, including those in higher education, are at a greater risk of serious harm from driving or walking to campus than they are from CV19, yet we've instituted education policies that risk significant and lasting social, emotional, health, and educational harm, all in the name of CV19, which represents little to no risk to our youth. There is not one single documented case of a child death from CV19 associated with school reopening in the nation, much less the State.

The emergency is over. It is time to return to the representative governance called for in our constitution, and restore local representative voices to CV19 related school policy and decision making.

## 1. RISK TO YOUTH AND SCHOOL POLICIES:

We now know that **the risk of serious adverse outcomes to children from CV19 is near statistical zero.** Additionally, Children do not appear to play a major role in the spread of CV19, either in a school environment or outside of a school environment (Ref Attachment 2, School and Youth Risk Information). There is simply no medical reason or scientific evidence to close, modify, limit, or restrict our public schools. We are doing untold harm to our youth presently and for years to come via our current CV19 school policies. Children are being sent home in a revolving isolation cycle due to allergy symptoms, or because they sat next to someone deemed to have been in close contact with someone else deemed as a "possible" or "probable" CV19 "case", absent any symptoms of illness. Parents state-wide who have the means to do so are pulling their children from public school because of the arbitrary, medically unsupported, and completely unnecessary CV19 school policies which are disrupting education and harming their children socially, emotionally, and medically. Children are not at risk from CV19, yet we have imposed the same arduous policies on our children as we have for those in high-risk categories. We urge you to immediately pursue revision of Arkansas Covid 19 policies regarding our youth populations and schools.

According to a real-time study by Brown University, which looked at data collected from more than 550 schools across 47 states, the study found no support for the fear of school reopening as a source of significant CV19 spread. According to the national real-time, Covid 19 School Response Dashboard, as of Oct 2nd, 2020 the study included over ½ Million Students and **the confirmed student infection rate was just 0.06 percent**, with no reported hospitalizations. The confirmed teacher/staff infection rate was slightly higher, but at only 0.24 percent.

Source: Covid 19 School Response Dashboard (link above) and articles:

1. https://www.npr.org/2020/09/23/915738935/new-dashboard-tracks-coronavirus-cases-in-schools-across-47-states?fbclid=IwAR0Goe53Dy_f7gmS56cYIcnopO5XnBKc5Lcdeli5avu30IUHi4uS7n5dQkA
2. https://thehill.com/policy/healthcare/public-global-health/517787-study-less-than-one-percent-of-teachers-students

Additionally, a look at world-wide evidence from industrialized nations which never closed their schools shows the following:

a. "At no time was there a medical reason for the closure of **elementary schools**, as the risk of disease and transmission in children is extremely low. There is also no medical reason for small classes, masks or 'social distancing' rules in elementary schools."

* Source: https://swprs.org/facts-about-covid-19/?fbclid=IwAR2VcLLrrJEcKMwa0NYK4WG9eb16IyaHqe_8mTLWsxwZH7nses9O--y8Rxw

b. "Data from the Netherlands also confirms the current understanding that children play a minor role in the spread of the novel coronavirus. The virus is mainly spread between adults and from adult family members to children. The spread of COVID-19 among children or from children to adults is less common."

Source: https://www.rivm.nl/en/novel-coronavirus-covid-19/children-and-covid-19

c. “Our investigation found no evidence of children infecting teachers. One secondary case (in a child in a high school) was presumed to have been infected following close contact with two student cases. The other secondary case was presumed to have been infected by a staff member (teacher) who was a case. SARS-CoV-2 transmission in children in schools appears considerably less than seen for other respiratory viruses, such as influenza. In contrast to influenza, data from both virus and antibody testing to date suggest that children are not the primary drivers of COVID-19 spread in schools or in the community. This is consistent with data from international studies showing low rates of disease in children and suggesting limited spread among children and from children to adults. Data from the whole of NSW also demonstrate children (aged <19 years) represent 4% of all cases of COVID-19 despite being approximately 23% of the population.”
Source: http://ncirs.org.au/sites/default/files/2020-04/NCIRS%20NSW%20Schools%20COVID_Summary_FINAL%20public_26%20April%202020.pdf

d. The face mask requirement at school is damaging for children’s general well-being and should be abolished. In an open letter to the Belgian Education Minister, 70 doctors wrote, in part: “Mandatory face masks in schools are a major threat to their (children’s) development. It ignores the essential needs of the growing child. The well-being of children and young people is highly dependent on emotional attachment to others… ‘the face mask requirement makes school a threatening and unsafe environment, where emotional closeness becomes difficult.’ “There is no large-scale evidence that wearing face masks in a non-professional environment has any positive effect on the spread of viruses, let alone on general health. Meanwhile, healthy children living through Covid-19 heal without complications as a standard and that they subsequently contribute to the protection of their fellow human beings by increasing group immunity.” The physicians conclude: “The only sensible measure to prevent serious illness and mortality caused by Covid-19 is to isolate individual teachers and individual children at increased risk.”
*Source: https://www.brusselstimes.com/news/belgium-all-news/health/130480/face-mask-obligation-in-school-major-threat-to-childrens-development-doctors-say/?fbclid=IwAR3Uo0W3orH2wfHuuV9W_Ie4l42pTAknO9gljDMS68MGc0Q3T_EV4djatt0

e. Via “*The Moral Case for Opening Schools*,” we learn: “Herd immunity cannot eliminate deaths; like ordinary flu viruses, Covid-19 will remain endemic even if a vaccine arrives. But herd immunity ends the epidemic by greatly slowing the spread. The elderly and other high-risk people still need to be careful—and Gupta favors continuing policies to shield them from the virus—but the best long-term strategy for protecting them is letting low-risk people build up herd immunity right now. That means reopening schools and allowing young people to study and congregate without masks.”

“Martin Kulldorff, a Harvard epidemiologist, noted that not a single child in Sweden has died from Covid, and that Swedish teachers did not suffer unusually high rates of infection, even though the country never closed schools for those under 16, and didn’t force students to wear masks. For American children under 14, the risk of dying from Covid is lower than the risk of dying from the flu or pneumonia, according to the calculations of

Avik Roy, President of the Foundation for Research on Equal Opportunity. For teenagers and young adults, it's much lower than the risk of being murdered. For anyone under 55, it's lower than the risk of dying from accidents, from cancer, or from heart disease. If college students are willing to get in a car, why should they be terrified of sitting in a lecture hall? And why should they be reviled—much less expelled—for fraternizing with other students and helping to build up herd immunity?" Source: https://www.city-journal.org/achieving-herd-immunity?fbclid=IwAR3yBbl4kPrqZZY12YWOZr3TgNsKqA1QcIjA6fDg0vrI5R9HjBhTu72k-aQ#.X2qP1wlxEBJ.twitter

f. According to a study by the Committee to Unleash Prosperity, keeping schools closed or restricted is dangerous to our children on a number of fronts, and the study provides the following information:

"Acording to CDC Director Dr. Robert Redfield, on July 7, 2020: *"The greater risk to our society is to have schools closed."* The American Academy of Pediatrics, the principal medical society representing 67,000 pediatricians, concluded that it is not safe for children to be denied full-time classroom instruction.

**Compared to when students were in classrooms, how have student homework and/or assignment completion rates been during distance learning? Are they:**

| | | Type of School | | Grades teaching | | | | % Low-Income Students | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Scenario | Total | District | Charter | Primary | Middle | High School | Combined | 0-33% | 34-66% | 67%+ |
| Much better than before | 2% | 2% | 8% | 3% | 3% | 2% | - | 3% | 2% | 2% |
| Somewhat better than before | 10% | 9% | 15% | 7% | 11% | 12% | 16% | 8% | 13% | 9% |
| About the same as before | 21% | 21% | 20% | 20% | 20% | 21% | 24% | 25% | 18% | 18% |
| Somewhat worse than before | 40% | 39% | 45% | 44% | 36% | 38% | 33% | 47% | 43% | 32% |
| Much worse than before | 27% | 29% | 12% | 26% | 30% | 27% | 27% | 17% | 23% | 39% |

In addition to the loss of instruction time, full or partial school closures have substantial negative mental health consequences. Carol Burris, a former teacher and award-winning principal, explains why it is vital that schools find a safe way to open for their most vulnerable students:

*"Combating truancy, school phobia, student depression, and drug dependency were part of our everyday work. The tragedy of student suicide was not unknown to us. Some students needed help talking to parents about their pregnancy or support in leaving an abusive relationship. And then there were the students living with parents who themselves*

*were unwell. "Students at risk can easily slip through cracks. Due to the isolation of remote learning, those cracks have become crevices. Anecdotally, pediatricians are reporting rises in depression, obesity, and stress disorders as well as young children having heart palpitations absent a physical cause. "Research tells us that socially isolated children and adolescents are at risk of depression and anxiety. We know that too much screen time can result in inattention and impulsivity, and mental health disorders in both children and adolescents."*

Even a one percent increase in the suicide rate among high school students would cause more deaths than have died with COVID-19 so far in that age group.

COVID Presents Far Lower Risk to Children than the Flu Risk We Accept Every Year *"For children (0-17 years), cumulative COVID-19 hospitalization rates are much lower than cumulative influenza hospitalization rates at comparable time points during recent influenza seasons."* * CDC COVIDView

Children are at far lower risk of hospitalization or death with COVID than they are with lab-confirmed influenza, a risk we accept without any extraordinary measures. Therefore, if any modifications of school operations are justified based on risks to children, they should logically have been made historically and should be permanent. It is immoral to deny children education and social interaction on account of a disease which does not present a significant risk to them.

**COVID and Lab-Confirmed Influenza Hospitalizations Per 100,000 Population, CDC EID**

| Age | COVID-19 | 4Y Flu Ave | Flu 2020 | Flu 2019 | Flu 2018 | Flu 2017 |
|---|---|---|---|---|---|---|
| 0-4 | 8.9 | 69.1 | 93.7 | 70.9 | 71.0 | 40.8 |
| 5-17 | 4.0 | 19.9 | 24.4 | 20.0 | 19.5 | 15.5 |

**COVID Age Stratification: School-Age Children 0.03 Deaths Per 100,000 Population**

| | Deaths With COVID | Total Deaths | Deaths Without COVID | Deaths With COVID as Share of Age Group Deaths | Population | Cumulative Deaths With COVID Rate Per 100,000 Population | Age Group % of U.S. Population | Age Group % of all Deaths with COVID | Age Group % of all Deaths Without COVID |
|---|---|---|---|---|---|---|---|---|---|
| Under 1 year | 9 | 6,896 | 6,887 | 0.1% | 4,128,810 | 0.22 | 1.2% | 0.0% | 0.6% |
| 1-4 years | 6 | 1,325 | 1,319 | 0.5% | 16,438,858 | 0.04 | 4.9% | 0.0% | 0.1% |
| 5-14 years | 14 | 1,995 | 1,981 | 0.7% | 41,008,879 | 0.03 | 12.3% | 0.0% | 0.2% |
| 15-24 years | 142 | 12,369 | 12,227 | 1.1% | 43,106,877 | 0.33 | 12.9% | 0.1% | 1.0% |

Children are not a significant source of community transmission. A joint study by the national health authorities of Sweden, where primary schools never closed, and Finland, where schools reopened May 13, found: "*closure or not of schools had no measurable direct impact on the number of laboratory confirmed cases in school-aged children in Finland or Sweden."*

**Number of teachers, cases among them and relative risk compared to other professions**

| Teachers in | Number of teachers 2019/2020 | Number of cases | Median age at diagnosis | Relative risk* (95% CI) |
|---|---|---|---|---|
| Day care | 157,263 | 192 | 45 | 0.9 (0.7-1.1) |
| Primary school | 105,418 | 160 | 50 | 1.1 (0.9-1.3) |
| Secondary school | 30,357 | 29 | 47 | 0.7 (0.5-1) |

*compared to other professions

Source "f" above: https://committeetounleashprosperity.com/wp-content/uploads/2020/07/CTUP_NotSafeToKeepSchoolsClosed_Study-1.pdf

g. Parents for Mask Free Education cites a large number of studies and medical journal papers highlighting the inefficiency of masks, as well as the dangers to school children from their use. *"There is no evidence to suggest that wearing masks will prevent the spread of infection in the general population. Improper use of masks may in fact increase the risk of infection. Masks do not act as an effective barrier against disease when they are worn for extended periods of time. In addition, removing your mask incorrectly can spread virus to your hands and face."* - Infection, Prevention and Control CANADA. They further warn of the dangers of present school policies via the article Social Isolation is Generation of Kids.

## 2. COVID-19 AT PRESENT – AN OVERVIEW AND RELATIVE RISK:

Knowledge and information regarding CV19 have evolved rapidly but have not always been reported in a timely and accurate manner. While Arkansas has reported approximately 1500 CV19 "related" deaths to date, according to the ADH via an Oct 9th, FOIA response, they are unable to differentiate as to the number of deaths "from" Covid-19 (with Covid-19 as the primary cause of death), as opposed to "with" CV19. (Ref Attachment 2). The vast majority had one or more serious underlying medical conditions. The average age of CV19 deaths corresponds closely with the normal age of expected mortality in the elderly. Further, ADH was and is unable to justify their isolation and quarantine of thousands of Arkansas Residents. When asked for data on the number or percentage of persons who contracted CV19 following isolation order due to contact with a probable or CV19 positive person, ADH admitted they did not track this data.

a. HOSPITALIZATIONS: According to an ADH FOIA response of 7/9/2020, 42.8 percent of CV19 Hospitalizations were FIRST hospitalized for reasons other than Covid019. The below ADH data, from 10/9/2020 ADH FOIA response, show the relative risk of hospitalization in various demographic groups in Arkansas, and relative risk in visiting various public places. As you can see below, the risk is minimal, and nearly non-existent in our youth populations:

**COVID-19 Hospitalization Rates in Arkansas**
**(update 10-7-2020)**

| REDCap 10/7/2020 | Current | Rates per 100,000 | Total | Rates per 100,000 |
|---|---|---|---|---|
| **Hospitalization** | 886 | 29.4 | 5740 | 190.5 |
| **Gender** | | | | |
| Male | 452 | 30.5 | 2833 | 191.4 |
| Female | 433 | 28.2 | 2903 | 189.3 |
| Transgender | 0 | - | * | - |
| Unknown | * | - | * | - |
| **Race/Ethnicity** | | | | |
| White | 518 | 21.4 | 3330 | 137.3 |
| Black | 212 | 43.3 | 1662 | 339.4 |
| AI_AN | * | * | 13 | 38.4 |
| Asian | 15 | 59.8 | 61 | 343.4 |
| NH_PI | 24 | | 163 | |
| Multiracial | * | * | 17 | - |
| Other | 54 | - | 313 | - |
| Unknown | 60 | - | 181 | - |
| Hispanic | 91 | 39.0 | 692 | 296.8 |
| **Age Group** | | | | |
| 0-17 years | 27 | 3.8 | 131 | 18.6 |
| 18-24 years | 37 | 13.2 | 194 | 69.1 |
| 25-44 years | 128 | 16.7 | 933 | 121.9 |
| 45-64 years | 244 | 32.4 | 1970 | 261.6 |
| 65+ years | 449 | 87.7 | 2510 | 490.4 |
| **With underlying condition** | 315 | 10.5 | 2828 | 93.8 |
| **Vent** | 139 | 4.6 | 715 | 23.7 |
| **Vent_Age Group** | | | | |
| 0-24 years | * | * | 9 | 0.9 |
| 25-44 years | 12 | 1.6 | 80 | 10.5 |
| 45-64 years | 47 | 6.2 | 268 | 35.6 |
| 64+ years | 76 | 14.8 | 357 | 69.8 |
| **Vent_with underlying condition** | 61 | 2.0 | 345 | 11.4 |

0.19%
0.26%
0.49%
0.02%

Data source: REDCap, CDC Wonder
REDCap Data Retrieved October 7, 2020 at 9 AM.
* Counts less than 5 are suppressed.
Note: Hospitalization rates are calculated by the number of residents of a defined area who are hospitalized with a positive SARS-CoV-2 laboratory test divided by the total population within that defined area.
Note: Bridged-race Vintage 2018 (2010-2018) postcensal population estimates (released by NCHS on 6/25/2019). Available on CDC WONDER

**Community Exposures and Hospitalizations - REDCap (10-7-20)**

Table 1. Individuals Have Been to One of The Following Locations in the 14 Days Prior to Onset of Symptoms or Positive Test.

| Community exposures | N | Rate per 100,000 |
|---|---|---|
| Restaurant | 3068 | 101.8 |
| Bar | 359 | 11.9 |
| Outdoor venues | 418 | 13.9 |
| Gym/Indoor athletic facility | 641 | 21.3 |
| Casino | 127 | 4.2 |
| Church | 2695 | 89.4 |
| Outdoor athletic facility (sports) | 444 | 14.7 |
| Retail Stores | 7538 | 250.1 |

0.1%
0.01%
0.01%
0.02%
0.09%
0.2%

Note: One individual can report multiple locations.
Note: Of the 7538 that reported retail stores, 5992 also reported other locations.

Table 2. Hospitalization Rate per 100,000 by Time of COVID-19 testing.

| Hospitalization | N | Rate per 100,000 |
|---|---|---|
| COVID tested when admit | 2036 | 67.6 |
| COVID tested after admit | 2739 | 90.9 |
| COVID tested before admit | 630 | 20.9 |
| missing test date | 12 | 0.4 |

Data source: REDCap, CDC Wonder
Data Retrieved October 7, 2020 at 9 AM.
Note: Hospitalization rates are calculated by the number of residents of a defined area who are hospitalized with a positive SARS-CoV-2 laboratory test divided by the total population within that defined area.
Note: Bridged-race Vintage 2018 (2010-2018) postcensal population estimates (released by NCHS on 6/25/2019). Available on CDC WONDER Online Database. Accessed at http://wonder.cdc.gov/bridged-race-v2018.html on September 1, 2020 12 PM

b. Initial estimates based on Chinese data assumed a very high 20% hospitalization rate, which led to the strategy of 'flattening the curve' to avoid overburdening hospitals. However, population-based antibody studies and data have since shown that actual hospitalization rates are under 1%, which is within the range of hospitalization rates for normal influenza (1 to 2%).

c. The CDC found that Covid-19 hospitalization rates for people aged 65 and over are, "within ranges of influenza hospitalization rates with rates slightly higher for people aged 18 to 64 and 'much lower' (compared to influenza) for people under 18."
*Source "a" and "b" above: https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html https://swprs.org/studies-on-covid-19-lethality/

According to Swiss Policy Research, an independent, nonpartisan research group, the following are the current (Sept 2020) CV19 related facts supporting the case for a return to normalized pre-CV19 social, economic and school policies:

d. The **median age** of Covid deaths in most Western countries is over 80 years – e.g. 84 years in Sweden – **and only about 4% of the deceased had no serious preconditions.** In contrast to flu pandemics, **the age and risk profile of deaths thus essentially corresponds to normal mortality.**

e. According to the latest immunological studies, the overall **lethality of Covid-19** (IFR) in the general population ranges between 0.1% and 0.5% in most countries, which is comparable to the medium influenza pandemics of 1957 and 1968.

f. For people at high risk or high exposure (including healthcare workers), early or prophylactic treatment is essential to prevent progression of the disease.

g. In countries like the UK (with lockdown) and Sweden (without lockdown), **overall mortality** since the beginning of the year is in the range of a strong influenza season.

h. In most places, the **risk of death** for the healthy general population of school and working age is comparable to a daily car ride to work. The risk was initially overestimated because many people with only mild or no symptoms were not taken into account.

i. About 80% of all people develop only mild symptoms or no symptoms. Even among 70-79 year-olds, about 60% develop only **mild symptoms**. About 95% of all people develop at most moderate symptoms and do not require hospitalization.

j. Up to 60% of all people may already have a partial **T-cell immune response** against the new coronavirus due to contact with previous coronaviruses (i.e. cold viruses). Moreover, up to 60% of children and about 6% of adults may already have cross-reactive antibodies.

k. The **median age** of Covid deaths in most Western countries is over 80 years – e.g. 84 years in Sweden – and only about 4% of the deceased had no serious preconditions. In contrast to flu pandemics, the age and risk profile of deaths thus essentially corresponds to normal mortality.

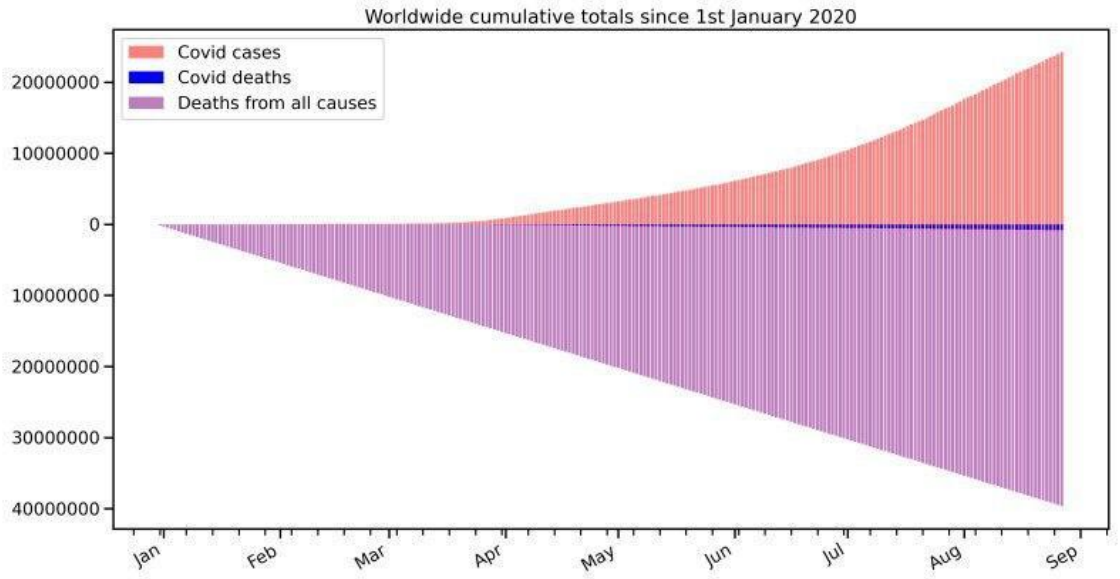
l. Numerous internationally renowned experts in the fields of virology, immunology and epidemiology, consider the measures taken to be counterproductive and recommend rapid natural immunization of the general population and protection of risk groups.

m. According to the UN, 1.6 billion people around the world are at immediate risk of losing their livelihood. Several experts predict that the measures will claim far more lives than the virus itself.

* Source "d" – "m" above: https://swprs.org/facts-about-covid-19/?fbclid=IwAR2VcLLrrJEcKMwa0NYK4WG9eb16IyaHqe_8mTLWsxwZH7nses9O--y8Rxw

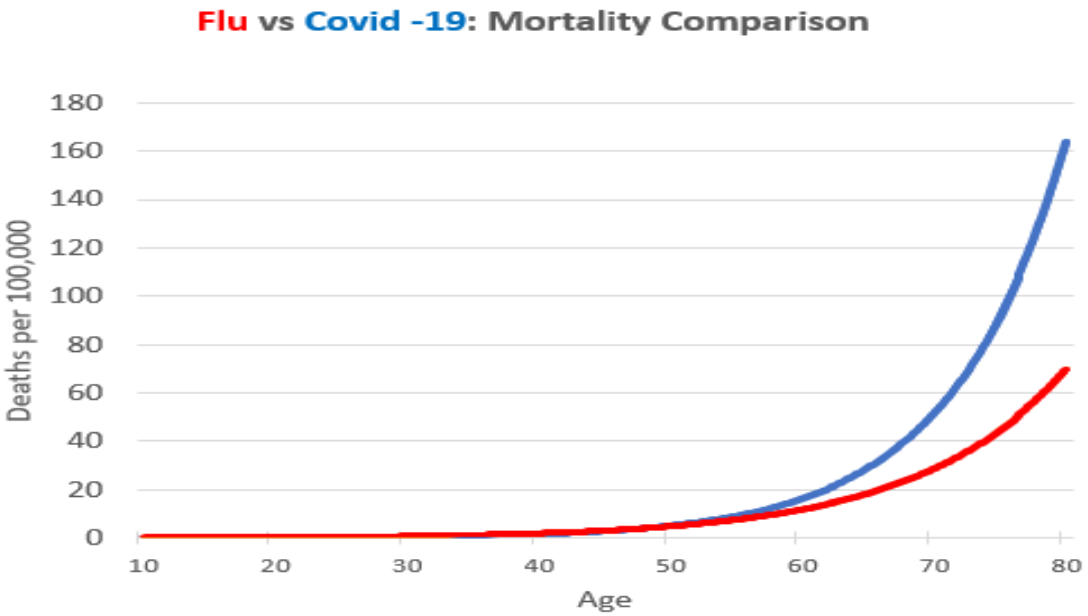
n. Via a series of just 7 charts and graphs, Swiss Policy Research presents a telling story of the skewed information consistently presented to the public. Below are a couple – we urge you to view the rest. "Chart number one (below) shows global Covid deaths* by September in blue (about 1 million) versus global all-cause deaths in purple (about 40 million). The chart also shows the cumulative number of global Covid "cases" (i.e. positive PCR tests) – the so-called "casedemic" on top of the pandemic."

** this presumes the accuracy of death counts; however, since the worldwide definition of a Covid "death" was expanded to include deaths "with" CV19, as opposed to "from" CV19, this data is highly suspect*



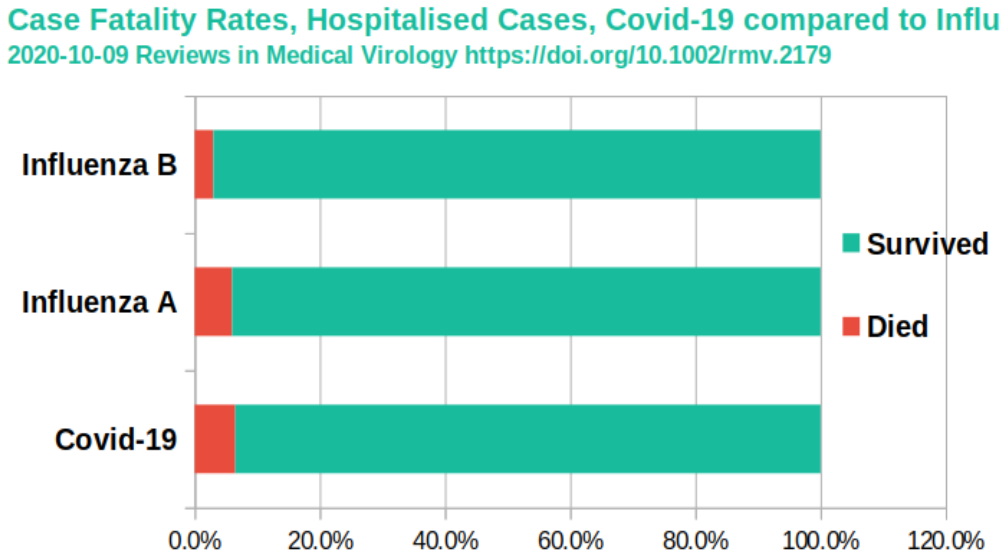

*Global Covid deaths and "cases" vs. all-cause deaths (interpolated data; source: OWD)*

Chart number two compares mortality by age for Covid and for seasonal influenza (based on US CDC data). Below 50 years, influenza is on par with influenza; above 50 years, Covid is somewhat deadlier than seasonal influenza (for which vaccines are available).




*Flu vs. Covid mortality by age (CC/CDC). **Zoom to age 50**.*

o. A recent study of nearly 200K hospitalized patients, 75K with COVID-19 infection, 113K with influenza type A infection, and 9K with influenza type B infection, analyzed Case Fatality Rate (CFR) of hospitalized patients and found the CFR to be similar: COVID-19: 6.5%; influenza type A: 6%; influenza type B: 3%



p. **On Oct 4th, 2020, over 30 world-renowned epidemiologists and public health scientists led by Harvard, Oxford, and Stanford University epidemiologists**, came together in the United States and **signed an accord** voicing their grave concerns about the damaging physical and mental health impacts of the current COVID-19 policies, and **calling for an end to the Covid-19 policies**. They conclude the policies will cause irreparable harm, leading to greater excess mortality in years to come. They recommend an approach they termed "Focused Protection", protecting the most vulnerable and high-risk, while returning those at low risk to normal pre-Covid social, work, and educational activities. As of Oct 5th, 2020, they had been joined by over 9000 additional public health experts, scientists and physicians calling for an end to current CV19 policies. Over 50,000 members of the public have also signed the accord. For those who say, "follow the science", the science demands fully reopening our State without the majority of onerous restrictions being unnecessarily imposed.

## 3. PCR TESTING - SHORTCOMINGS, PITFALLS, AND "CASES":

Arkansas and the US in general have based their CV19 response and policies on and around PCR testing. PCR tests are highly sensitive and detect bits of viral RNA in the body. They were never intended for medical diagnostics, and lack the ability to differentiate between live, contagious virus, and dead viral remnants which remain in the body long after a person has recovered from an infection. Kary Mullis, the inventor of the PCR test regarded PCR as inappropriate to detect a viral infection. While there is presently discussion of making Antigen CV19 tests available to schools, ADH cited in 10/15/2020 testimony before the Public Health, Welfare, and Labor Committee that Antigen tests had been so problematic with *false positives* that they had not been useful.

In the U.S., PCR Cycle Thresholds (Ct) vary according to PCR test manufacturer, and generally range between Ct 30 – <40. There is some correlation between Ct and viral load, with higher Ct values representing low viral load, or no live, contagious viral load at all. Generally, the higher the Ct, the greater the likelihood that "positive" results are not representative of active, contagious disease (Ref Attachment 1, PCR Testing). According to ADH, ***Arkansas currently uses a Cycle Threshold of 42. We know of no other laboratory or agency using cycle thresholds of >40 to report positive PCR test results.*** The CDC Emergency Use Instruction, and the use manual for PCR tests used by Arkansas (ElmarPerkin) establishes Limits of Detection (LOD), with mean Ct for LOD at between 31 – 37. LOD confirmation studies for tests determine the lowest detectable concentration of 2019-nCoV2 (CV19) at which approximately 95% of all (true positive) replicates test positive. Thus, results from tests using Ct greater than established LOD should be considered indeterminant. ADH appears to be ignoring Limits of Detection and reporting at the higher maximum Cycle Threshold. The Arkansas practice of using high Cycle Thresholds of <42, exceeding the mean Ct LOD is likely resulting in detection of "positive cases" in persons long-recovered from past, mild or asymptomatic CV19

infections, and/or generating a higher ratio of false positives. These "cases" are unlikely to have significant, if any, correlation to live, contagious disease, and are likely resulting in unnecessary isolation and quarantine. We urge the General Assembly to exercise oversight of ADH PCR testing practices and seek change if and as appropriate.

Some experts estimate that up to 80-90 percent of "positive" PCR tests, upon which quarantine is based, are "false positives" in the sense that the positive test subject has no active or contagious illness (Ref Attach 1, PCR Testing). The overall false positive ratio is estimated to be in the 3 – 10 percent range. However, the FDA has yet to conduct confirmation studies to demonstrate exact false positive ratios - a practice never before used by the FDA for an approved diagnostic test. When asked to cite the false positive and negative rates for Arkansas PCR testing via a 7/9/2020 FOIA request, ADH was unable to cite known rates.

While numerous scientists, medical officials, and even the press to a lesser degree, have voiced concerns about the use of PCR testing as a medical diagnostic tool and the pitfalls surrounding PCR use, those concerns have been largely ignored. The wide use of the PCR test in the asymptomatic public (also a practice never adopted prior to CV19) is presently resulting in a "casedemic" absent of any significant relationship to communicable disease, or the actual spread or advancement CV19. The following is a brief look at PCR testing concerns demonstrating a need for reevaluation of the State's use of, and dependence upon, PCR testing as a basis for policy decisions, and quarantine or isolation of citizens with no symptoms of disease or illness. Additional PCR testing information and references are contained in Attachment 2.

a. According to the authors of *PCR Positives, What Do They Mean:* "***Symptoms and signs of Covid19 are necessary to support the claim that the subject is or can be infectious. But calling PCR positives "cases" does not specify whether the persons have carried the virus for long or whether it is "active."*** This could lead to the finding of many "cases" as a function of the number of PCR tests conducted. For example, if 20% of a population are PCR positive, the number of PCR positives will depend on the size of the sample. This means that the more PCR tests that are carried out, the larger the fraction of the population that is confirmed; but, this might not speak of (active disease) changes in the population. That is, it is possible that the population was infected already long before deciding to test and PCR positives would therefore not speak of an advancing pandemic."

*Source: https://www.cebm.net/covid-19/pcr-positives-what-do-they-mean/?fbclid=IwAR3MY_71w2TfV8JjwdYHW2DnfRLMJiMKv_gfizQwzcILj-1QYwJ7kWcH2iE

b. According to the authors of *Diagnosing Covid-19: The Danger of Over-reliance on Positive Test Results*, "Unlike previous epidemics, in addressing COVID-19, nearly all international health organizations and national health ministries have treated a single positive result from a PCR-based test as confirmation of infection, even in asymptomatic persons without any history of exposure. This is based on a widespread belief that positive

results in these tests are highly reliable. However, data on PCR-based tests for similar viruses show that PCR-based testing produces enough false positive results to make positive results highly unreliable over a broad range of real-world scenarios. This has clinical and case management implications, and affects an array of epidemiological statistics, including the asymptomatic ratio, prevalence, and hospitalization and death rates. Steps should be taken to raise awareness of false positives, reduce their frequency, and mitigate effects. In the interim, positive results in asymptomatic individuals not confirmed by a second test should be considered suspect."

In closing and regarding "cases", cases have never before in other disease been defined simply by a test, which in the case of CV19, does not indicate the presence of active, live virus or contagion, to the exclusion of clinical symptoms of illness. In Arkansas, the definition of "case" has been expanded to include "probable" cases, which require neither a positive CV19 test or clinical symptoms of disease in some instances. The hyper-focus on "case" counts is misleading, and is responsible for creating an inaccurate representation of the degree of CV19 contagion in the community. It further creates undue anxiety in the public, especially our elderly, which itself may be detrimental to their mental and physical health and wellbeing. This is an egregious practice by the ADH and State officials and consideration of more accurate reporting methods should be sought and implemented.

## 4. A WORD ON MASKS:

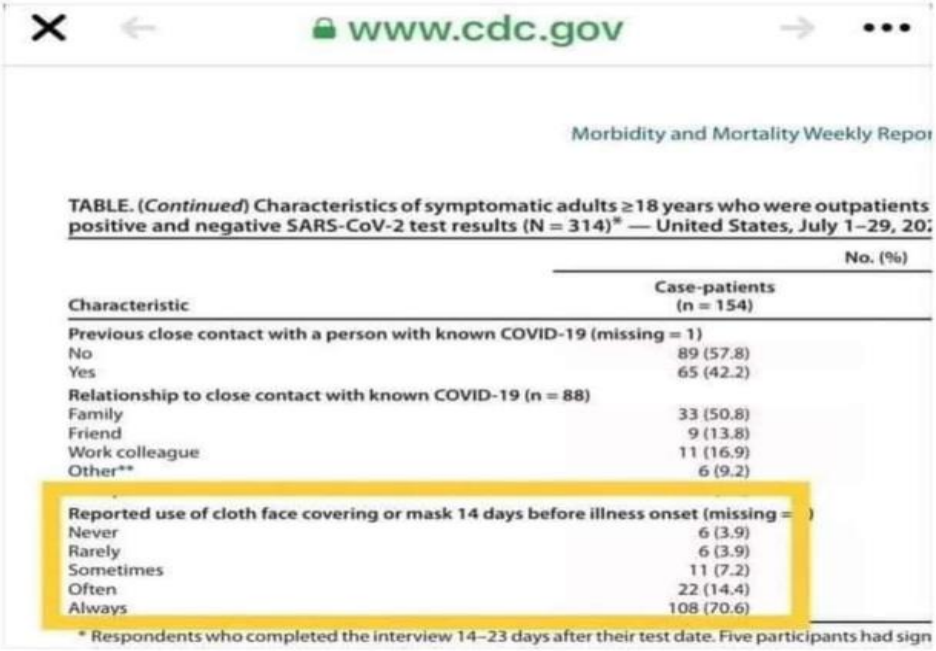
No discussion of CV19 policies or reopening would be complete without a brief discussion of the State mask mandate. The Governor's directive on mandatory mask wear was perhaps the most divisive and arbitrary of all the 47+ mandates issued by the Governor and ADH. One has only to look at the mandate itself to wonder if there was any scientific, data-based, thought in development of the mandate. For instance, mask wear is required for ages 10 and above - why 10? The examples of the arbitrary and scientifically unsupported nature of the mandate are too numerous to address herein.

The stand-out for the medically and scientifically unsupported, arbitrary, mask policy is undoubtedly the school mask wear mandates and practices. Masks are completely unnecessary in a youth population neither significantly at risk from CV19, nor believed to be spreaders of the virus. Not only are they unnecessary, significant evidence is emerging to show they are both unhealthy and dangerous. * There are numerous instances and reports of masks causing injury (unconsciousness) and illness (respiratory, bacterial pneumonia, impetigo, gum and dental disease). That is to say nothing of the adverse psychological and social effects of mask wear in youth populations, and society at large. We will not delve deeply into the science here, other than to say there is NO reliable scientific evidence supporting that mask wear in the general population reduces viral spread. There is substantial evidence that mask wear is ineffective and harmful. (*See Attachment 1, Mask Studies and Information).

The face mask requirement at schools is damaging for children's health and general well-being and should be abolished. In an open letter to the Belgian Education Minister, 70 doctors wrote in part: "Mandatory face masks in schools are a major threat to their (children's) development. It ignores the essential needs of the growing child. The well-being of children and young people is highly dependent on emotional attachment to others…. the face mask requirement makes school a threatening and unsafe environment, where emotional closeness becomes difficult." "There is no large-scale evidence that wearing face masks in a non-professional environment has any positive effect on the spread of viruses, let alone on general health." The physicians conclude: "The only sensible measure to prevent serious illness and mortality caused by Covid-19 is to isolate individual teachers and individual children at increased risk." **
*Source: https://www.brusselstimes.com/news/belgium-all-news/health/130480/face-mask-obligation-in-school-major-threat-to-childrens-development-doctors-say/?fbclid=IwAR3Uo0W3orH2wfHuuV9W_Ie4I42pTAknO9gljDMS68MGc0Q3T_EV4djatt0
** we now know that healthy children simply are not at significant risk of Covid-19

Via the medical journal article Nonpharmaceutical Measures for Pandemic Influenza in Nonhealthcare Settings-Personal Protective and Environmental Measures, May 2020, the authors reviewed the evidence base on the effectiveness of nonpharmaceutical personal protective measures and environmental hygiene measures in nonhealthcare settings. They conclude in part: "Although mechanistic studies support the *potential* effect of hand hygiene or face masks, evidence from 14 randomized controlled trials of these measures did not support a substantial effect on transmission of laboratory-confirmed influenza."

A recent study by CDC found that 70 percent of those infected with CV19 reported "always" wearing a mask, and 85% reported "always' or "often" wearing a mask:



## 5. SUMMARY/CONCLUSION:

In closing, while we hear from many elected and school officials that, “we have no power – the Governor is running everything”, that does not represent the entire picture. Often, it is from leaders who simply don’t know what to do. We offer a step in the right direction towards a solution. We urge local school boards to pursue change that returns governing back to where it should be – local and state elected representatives – not a quasi-dictatorship from the Governor’s office. Local representative government facilitates decisions at local and regional levels, responsive to local area needs. It is time to return to representative government, where our local school boards and elected officials have a voice in the CV19 response. To date, local officials have had no voice in the State declarations and directives which are adversely affecting our schools, communities, and individual liberty itself. Attached hereto is one of many steps you can take to reclaim representative government in your community and our state.

**We urge every school board and municipality to, without delay, support and adopt a resolution calling for the restoration of representative government in our State, and a return to local school board decision-making and governance. We further urge school boards and municipalities to lobby the ADH, Department of Education, and other governing entities; and, to take legal action to restore local representation and control, if and as necessary.**

Attachment 1  Sample Municipal/School Board Resolution

SAMPLE MUNICIPAL COVID-19 RESOLUTION

A RESOLUTION BY THE (CITY/COUNTY OF/SCHOOL BOARD OF) IN SUPPORT OF RESTORING FREEDOM, CHOICE, OPPORTUNITY, AND RETURN GOVERNANCE BACK TO LOCAL AND STATE ELECTED OFFICIALS

WHEREAS, the (City of _____, Arkansas) is a thriving municipality responsibly enacting ordinances and affirming resolutions for the safety, prosperity, and wellbeing of its citizens, families, students, visitors, and business; and

WHEREAS, the (City of ____, Arkansas) businesses and citizens have demonstrated tremendous courage, perseverance, restraint and outstanding decision-making capabilities; and

WHEREAS, the initial health emergency declared by Arkansas Governor Asa Hutchinson for the purpose of assuring hospitals and State emergency resources were not overwhelmed no longer exists; and

WHEREAS, the economy of the (City of _____) and the livelihoods and wellbeing of its citizens is being adversely affected by the continuing emergency executive orders, the plethora of Department of Health directives, and the excessive and inconsistent State control over local governments, schools, businesses, and citizens beyond what is reasonable and necessary; and

WHEREAS, being in a continual state of emergency since March 2020, the citizens and business of the City of _____, Arkansas feel the perpetual extensions of a state of emergency by means of the Emergency Services Act is an overreach of the spirit and intent of the law bypassing and circumventing the representative governance called for in our State constitution, and a main contributor to said damage and harms.

THEREFORE, BE IT RESOLVED THIS _____ day of _____, 2020, that

THE (CITY OF/COUNTY OF) _____ ARKANSAS strongly encourages and supports an end to the inconsistent, harmful, and damaging directives and policies against the citizens, schools, and businesses of the City of _____ Arkansas.  We call for the Governor of the State of Arkansas to restore a Representative Government of the people, by the people and for the people by ending the perpetual state of emergency without direct legislative involvement and returning governing authority back to local and state elected officials.

_____

Attachment 2
**Additional Resources and References:**

## Medical Science and Herd Immunity:

***Open letter from physicians on social crisis and no medical support for lockdowns:***
https://docs4opendebate.be/en/open-letter/?fbclid=IwAR13ifU04uSegT_LOjxw1RN6kU5tu3_euUHH14r90YO5zZrcPlyO2GYFkxc

***Dr Fauci on Herd Immunity***
https://www.andrewbostom.org/2020/09/educating-dr-fauci-on-herd-immunity-and-covid-19-completing-what-rand-paul-began/

***Graphic description of Herd Immunity***
https://www.patreon.com/posts/lets-explain-42096268

## School Information and Youth Covid-19 Risk:

***Moral case for Reopening schools***
**https://www.city-journal.org/achieving-herd-immunity#.X2qP1wlxEBJ.twitter**

***Covid-19 Medical Studies Regarding Children and Youth (Oct 2020)***
https://www.rcpch.ac.uk/resources/covid-19-research-evidence-summaries?fbclid=IwAR2puRO7Tot03xin95n5gGkgJzZJbwN73CNRzSwHKbcxHF_uwsEyAVE2uhw

***It's Not Safe to Keep Schools Closed***
https://committeetounleashprosperity.com/wp-content/uploads/2020/07/CTUP_NotSafeToKeepSchoolsClosed_Study-1.pdf

https://rationalground.com/wp-content/uploads/2020/08/472271783-Answers-to-Anti-Schoolers-on-Korea-Israel-Chicago-and-Georgia.pdf

***US DOE Questions and Answers for K-12 Public Schools In the Current COVID-19 Environment.***
https://www2.ed.gov/about/offices/list/ocr/docs/qa-covid-20200928.pdf

***Rise of Bacterial Pneumonia (due to mask wear):***
https://www.globalresearch.ca/medical-doctor-warns-bacterial-pneumonias-rise-mask-wearing/5725848?fbclid=IwAR1oneVn0Lg-qgtGoIh0fM4X7a5Af40AEob56ErVqkX6PDPFQQLGaGZ1vNs

***Masks are Ineffective and Harmful (Detailed Section, Studies/Info on harms to youth)***
https://www.meehanmd.com/blog/2020-10-10-an-evidence-based-scientific-analysis-of-why-masks-are-ineffective-unnecessary-and-harmful/?fbclid=IwAR1oyGEZtX_5Lp6tlT4m_bQAwerER7tmNu4TaegokpccCyRoi659GBjvEdE

**Higher Education Testing:**

**As of September 22nd, 2020, there were 48,299 reported COVID-19 Cases at 37 US Universities, with only 2 Hospitalizations and ZERO deaths.**

**9/22/20 update on C19 among students on campus since August, from 37 U.S. universities: Despite ~48,300 "+ C19 tests" near absence of reported C19 hospitalizations, and zero reported deaths**

| University | Reported C19+, "Cases" (N)* | Reported Hospitalizations (N)** | Reported C19 Deaths (N)*** |
|---|---|---|---|
| (1) U of Alabama sys | 2729 | 0 | 0 |
| (2) U of Georgia | 2901 | 0 | 0 |
| (3) U of Kentucky | 1645 | 0 | 0 |
| (4) Ohio State U | 2638 | 0 | 0 |
| (5) U of Dayton | 1242 | 0 | 0 |
| (6) Miami U of OH | 1372 | 0 | 0 |
| (7) Illinois State U | 1334 | 0 | 0 |
| (8) U of Iowa | 1908 | 0 | 0 |
| (9) Missouri State U | 960 | 0 | 0 |
| (10) U of Kansas | 882 | 0 | 0 |
| (11) Kansas State U | 707 | 0 | 0 |
| (12) Penn State U | 1182 | 0 | 0 |
| (13) U of Wisconsin | 2684 | 1 | 0 |
| (14) U of Miami | 394 | 0 | 0 |
| (15) U of S Carolina | 2256 | 0 | 0 |
| (16) U of Arizona | 2137 | 0 | 0 |
| (17) Notre Dame U | 688 | 0 | 0 |
| (18) Temple University | 448 | 0 | 0 |
| (19) James Madison U | 1465 | 0 | 0 |
| (20) Texas Tech U | 1332 | 0 | 0 |
| (21) U of Texas | 955 | 0 | 0 |
| (22) Texas Christian U | 917 | 0 | 0 |
| (23) Texas A & M U | 1330 | 0 | 0 |
| (24) U of Illinois | 2138 | 0 | 0 |
| (25) Iowa State U | 1021 | 0 | 0 |
| (26) East Carolina U | 889 | 0 | 0 |
| (27) U of N Carolina | 1085 | 0 | 0 |
| (28) N Carolina State U | 957 | 0 | 0 |
| (29) Auburn U | 1654 | 0 | 0 |
| (30) Arizona State U | 807 | 0 | 0 |
| (31) San Diego State U | 845 | 1 | 0 |
| (32) Ball State U | 965 | 0 | 0 |
| (33) U of N. Dakota | 712 | 0 | 0 |
| (34) U of Cent Florida | 895 | 0 | 0 |
| (35) U of Florida | 653 | 0 | 0 |
| (36) Oklahoma State U | 892 | 0 | 0 |
| (37) SUNY-Oneonta | 680 | 0 | 0 |
| Totals (N) | 48,299 | 2** | 0 |

***As of data accessed 9/22/20; ostensibly** by reverse transcriptase polymerase chain reaction amplification & detection of C19 viral RNA, or C19 nucleocapsid protein antigen detection by immunofluorescent assay(s); ****As originally noted here:** https://twitter.com/andrewbostom/status/1302438825063591936; https://bit.ly/3mHD3Be "Kansas college student hospitalized with suspected case of multisystem inflammatory syndrome", but the KS college was unidentified; However 1 of the now 845 C19+ students at SDSU was hospitalized "1st SDSU Student Among COVID-19 Surge Hospitalized as Cases Reach 440." https://www.nbcsandiego.com/news/investigations/1st-sdsu-student-among-covid-19-surge-hospitalized-as-cases-reach-440/2402332/ and 1 U-Wisc-Madison student was hospitalized out of 2684 C19+ https://wkow.com/2020/09/16/first-known-uw-madison-student-hospitalized-with-covid-19/

https://undergroundnewswire.news/2020/09/27/after-48299-covid-19-cases-at-37-us-universities-only-2-hospitalizations-and-zero-deaths/

## COVID-19 PCR TESTING:

**Clinical Utility of (PCR) Cycle Threshold**
https://www.cebm.net/study/covid-19-clinical-utility-of-cycle-threshold-values/?fbclid=IwAR1GGVkJmjk9GirNF1HRlCdN1b9G8nb_5mxooBgrb_JIAQeTmpIgUtNOj6g

**To Interpret the SARS-CoV-2 (PCR) Test, Consider the Cycle Threshold Value**
https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa619/5841456?fbclid=IwAR2k7BM7VVS5sI_J4xSq-72CGfHW8mZJyheB3vJzwcL5Q7kWFUC5ZV3Gpzw

**Up to 90% of Covid 19 Cases could be false positives**
https://westphaliantimes.com/international-experts-suggest-that-up-to-90-of-canadian-covid-cases-could-be-false-positives/?fbclid=IwAR2u9jrGv9UVy2l2IWXyOt7yDzMws1hYeIKnZKTwsnMNetLgnKdsq4-MEFE

**Why mass PCR testing of the Healthy and Asymptomatic is Counter-Productive**
https://rationalground.com/why-mass-pcr-testing-of-the-healthy-and-asymptomatic-is-currently-counter-productive/?fbclid=IwAR3Rg2GheM84eRXFL_UR0ZE1XFAw4TM44KV2J6o7Jd7ct8kokUA5lVBbpvA

**Challenges and Controversies Related to Covid-19 Testing, Mayo Clinic**
**https://jcm.asm.org/content/jcm/early/2020/08/07/JCM.01695-20.full.pdf**

## Mask Science and Information:

***Face Masks lack of safety and ineffectiveness (comprehensive compilation of scientific studies and medical journal articles) (10/10/2020)***
https://www.greenmedinfo.com/anti-therapeutic-action/face-masks-lack-safety-and-ineffectiveness-research?fbclid=IwAR2NOjfCCOkwwKOUJdWxKQkmSJbERWgWb313502vPxcIwggY_pChRthKdu0

***An Evidence Based Scientific Analysis of why Masks are Ineffective, Unnecessary, and Harmful:***
https://www.meehanmd.com/blog/2020-10-10-an-evidence-based-scientific-analysis-of-why-masks-are-ineffective-unnecessary-and-harmful/?fbclid=IwAR1oyGEZtX_5Lp6tlT4m_bQAwerER7tmNu4TaegokpccCyRoi659GBjvEdE

***Masks Note Effective and Harmful to your Health***
https://www.primarydoctor.org/masks-not-effect?fbclid=IwAR0DbaKuEJAdewL_ZfISFo31BQSY3Jm2VvrYBqUy4YgS0Xm4-PiGEtFh6NE

***Masks Don't Work:  A review of Science Relevant to Covid 19***
From Denis G. Rancourt, PhD, Canadian research scientist
https://www.rcreader.com/commentary/masks-dont-work-covid-a-review-of-science-relevant-to-covide-19-social-policy?fbclid=IwAR0tKtYT5RV_IrYZfrLfgMKKf45s9wjxA8XnAXy0BFXhWrn5jz8OZM9NhOc

***Uncompromised Science on Masks*** (last updated 10 Sept. 2020)
https://docs.google.com/document/d/13Xt6pN_VASGOd3abMafH2Jj3Y2MMnj9NYF512KJLJ2M/edit

***Face Masks, Lies, Damn Lies, and Public Health Officials: "A Growing Body of Evidence***"
From Denis G. Rancourt, PhD, Canadian research scientist
https://www.researchgate.net/publication/343399832_Face_masks_lies_damn_lies_and_public_health_officials_A_growing_body_of_evidence

***Why Masks are Ineffective and Harmful:*** https://www.meehanmd.com/blog/2020-10-10-an-evidence-based-scientific-analysis-of-why-masks-are-ineffective-unnecessary-and-harmful/?fbclid=IwAR1oyGEZtX_5Lp6tlT4m_bQAwerER7tmNu4TaegokpccCyRoi659GBjvEdE

## Government Responsibility:

***Could unchecked gov't power be more dangerous than the threat of infectious disease?*** https://standforhealthfreedom.com/blog/coronavirus/

"… it's crucial that any measures government officials take are supported by science and are proportional to the threats they are trying to mitigate."

"… Experts believe the coronavirus primarily endangers the elderly and those with underlying health conditions. As such, we believe that policy makers should focus their efforts on reducing risks for that population while evaluating the effects widespread quarantines will have — on our nation's economy and our citizens' physical and emotional wellbeing. **No one should ever be collateral damage in a war against infectious disease."**

"… **In addition to safeguarding the public's health, elected officials have an obligation to uphold the civil liberties and constitutional rights of their constituents. One cannot be sacrificed or exchanged for the other.**"