Covid-19 Response Information for Arkansas Legislators

The Case for a Return to Representative Governance and Fully Reopening Arkansas Schools, Businesses, and Communities

Presented By: Reopen Arkansas
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EXECUTIVE SUMMARY: This paper is presented by the grassroots citizens' group Reopen Arkansas as a service to Arkansas legislators. It offers an overview of current Covid-19 (CV19) related information and discusses the need for a return to policy development and control by state elected officials, and an end to perpetual "emergency" declarations. Herein we examine the need for return to representative governance, and for an end to the CV19 "emergency" and the many over-reaching, arbitrary, and medically/scientifically unsupported Arkansas Department of Health (ADH) CV19 directives. This paper includes information on CV19 risk by demographic, mask wear, CV19 testing, school policy recommendations, and other CV19 related information.

CV19, which began as a health crisis and "two weeks to flatten the curve," has devolved into a political and social crisis. The latest medical data and science show CV19 is about as dangerous to the vast majority as the common flu, and our youth are at almost no risk. The state response is doing more damage than CV19 itself. Despite significant lobbying and persuasion attempts, the Arkansas Governor and the Arkansas Dept. of Heath (ADH) solely control the state response through perpetual "emergency" declarations. The Governor has declared he sees no end in sight, and is sustaining the "emergency" through what could be called a "casedemic," bearing no relationship to actual, communicable disease. Cases are not infections – more on that below.

While the emergency has passed, we have failed to adjust the state response and CV19 policies according to what we have learned about CV19 and its actual risk. Hundreds, if not thousands**,** of Arkansas small businesses have been lost for good, affecting tens of thousands of business owners, families, and workers; yet we continue to impose unnecessary policies that restrict and harm our citizens, businesses, livelihoods, and liberty. Students, including those in higher education, are at a much greater risk of serious harm from the trip to campus than they are from CV19, yet we've instituted state education policies that risk significant and lasting social, emotional, health, and educational harm, all in the name of a virus which represents little to no risk to our youth.

The emergency is over. It is time to return to the representative governance and adjust our CV19 response policies to adopt a focused, risk-based approach. That approach should be centered on recommendations and advisories – not mandates – and focused on those actually at risk of serious adverse outcomes from CV19.

1. COVID-19 AT PRESENT – 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 over 2000 CV19 "related" deaths to date, according to the ADH via various FOIA responses, 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. 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 actually contracted CV19 following isolation orders due to contact with a probable case, ADH admitted they did not track this data.

a. According to an ADH FOIA response on 7/9/2020, 42.8 percent of CV19 hospitalizations were FIRST hospitalized for reasons other than Covid-19. The below ADH data, from a recent ADH FOIA response, show the relative risk and rate of hospitalization in various demographic groups in Arkansas, and the rates of Covid-19 exposure from visiting various public places. As you can see, the hospitalization rate is 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	0.19%
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	0.26%
45-64 years	244	32.4	1970	261.6	0.49%
65+ years	449	87.7	2510	490.4	
With underlying condition	315	10.5	2828	93.8	
Vent	139	4.6	715	23.7	0.02%
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	

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	0.1%
Bar	359	11.9	0.01%
Outdoor venues	418	13.9	0.01%
Gym/Indoor athletic facility	641	21.3	0.02%
Casino	127	4.2	
Church	2695	89.4	0.09%
Outdoor athletic facility (sports)	444	14.7	
Retail Stores	7538	250.1	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 "b" and "c" 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.

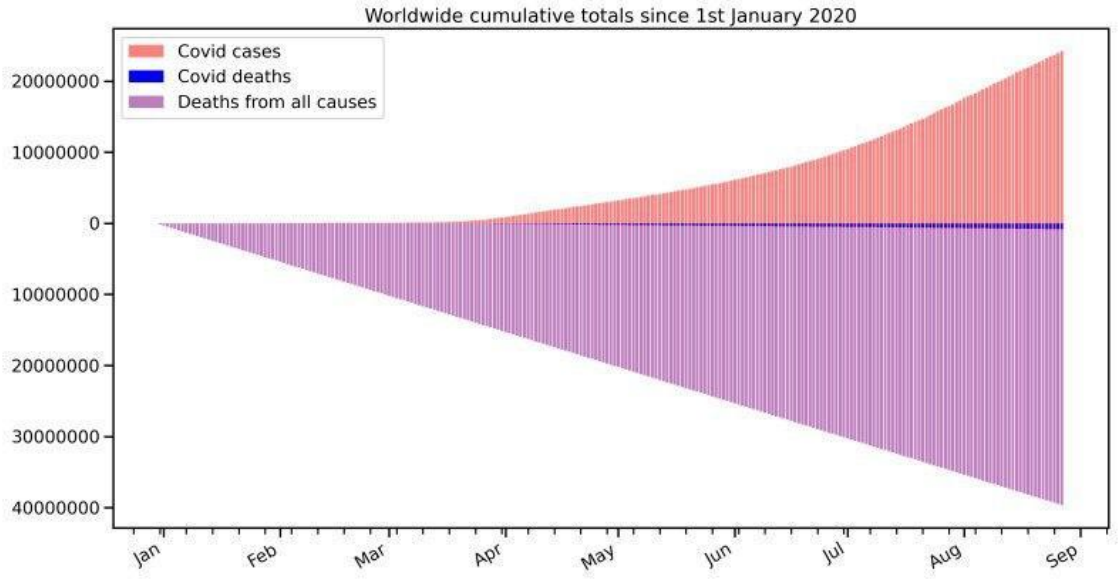
k. Numerous internationally renowned experts in the fields of virology, immunology, and epidemiology consider the measures taken to be counterproductive and recommend rapid natural immunization of the general population along with protection of high-risk groups.

l. 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.

m. 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 examples – we urge you to view the rest.

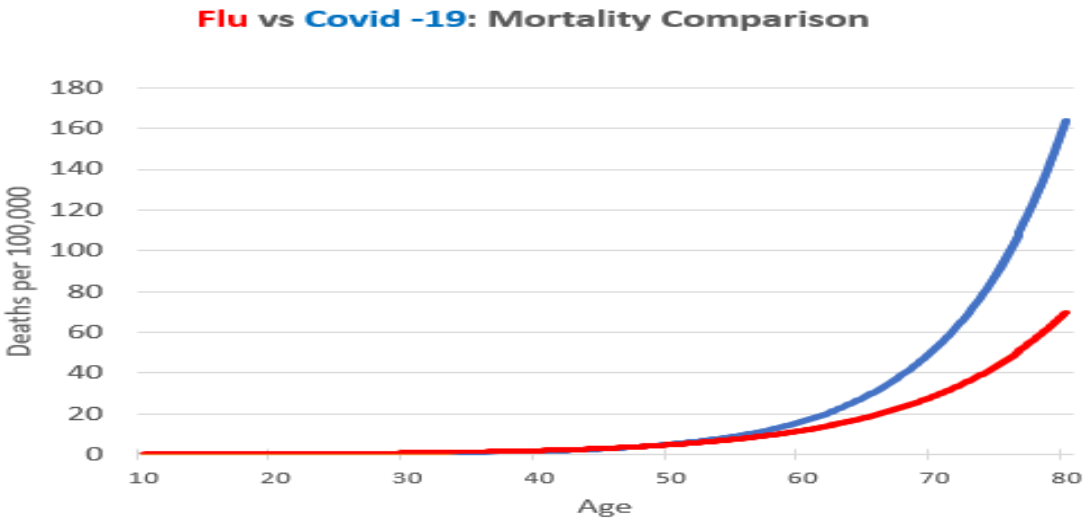
“Chart number one (below) shows global Covid deaths* by September in blue (about 1 million) versus global all-cause deaths in purple (about 40 million). The chart also shows the cumulative number of global Covid “cases” (i.e. positive PCR tests) – the so-called ‘casedemic’ on top of the pandemic.”

** 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 number is likely inflated.*



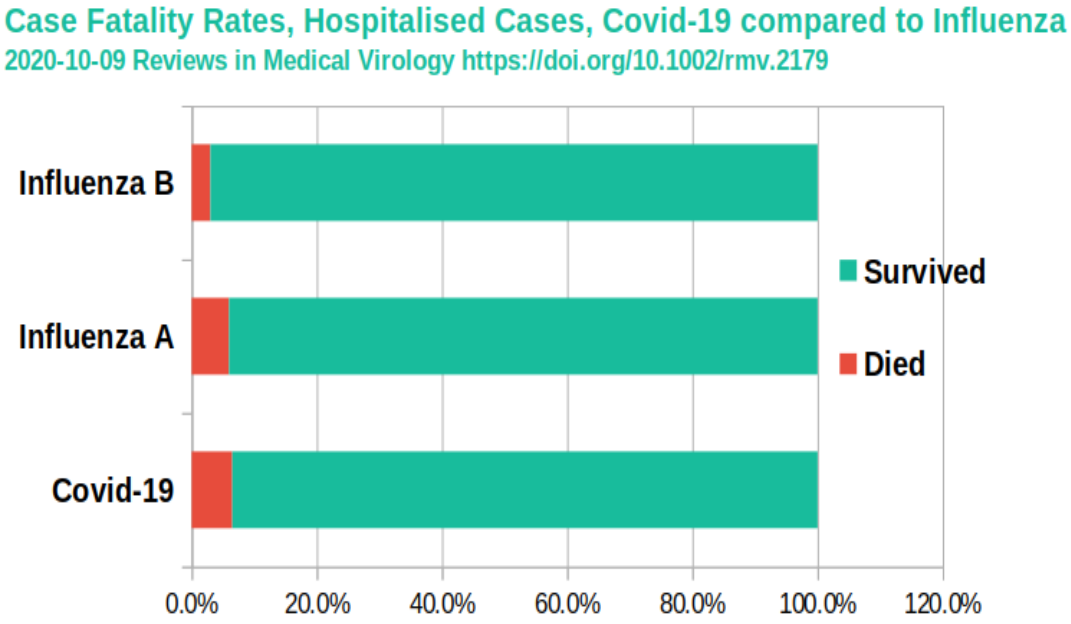
Global Covid deaths and “cases” vs. all-cause deaths (interpolated data; source: OWD)

Chart number two compares mortality by age for Covid-19 and for seasonal influenza (based on US CDC data). Below 50 years, Covid-19 is on par with influenza; above 50 years, Covid-19 is somewhat deadlier than seasonal influenza (for which vaccines are available).



*Flu vs. Covid-19 mortality by age (CC/CDC). **Zoom to age 50**.*

n. 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 the case fatality rate (CFR) of hospitalized patients and found the CFRs to be similar: COVID-19: 6.5%; influenza type A: 6%; influenza type B: 3%



o. **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 many current Covid-19 policies**. They conclude the policies will cause irreparable harm, leading to greater excess mortality in years to come. They recommend an approach 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 5000 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 and ending the onerous restrictions that are being unnecessarily and counterproductively imposed.

2. COVID-19 TESTING – SHORTCOMINGS, PITFALLS, AND "CASES"

Arkansas and the US in general have based their CV19 response and policies around Reverse-transcription polymerase chain reaction (RT-PCR) testing, hereafter referred to as "PCR". 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.

In addition to PCR testing, rapid antigen testing has been available and in use for screening in other parts of the country, and to a lesser degree in Arkansas, where we are just beginning to explore the wide use of Antigen testing. While there is presently discussion of antigen CV19 testing widely in Arkansas, making it available in schools and other settings, antigen testing has been plagued with significant high false negative and high false positive problems. 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*." While Arkansas has purchased newer, Binex brand, antigen tests, those tests remain of unknown reliability and it is unknown if they will be plagued by the same false result problems as prior Antigen tests. Extreme caution should be used in basing policy decisions such as "positive" reporting or quarantine on the basis of antigen tests.

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 relationship to communicable disease, or the actual spread or advancement of 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:

a. In the U.S., PCR cycle thresholds (Ct) vary according to PCR test manufacturer, and generally range from 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 section). 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 the PCR tests used by Arkansas (ElmarPerkin), establish Limits of Detection (LOD), with a mean Ct for LOD between Ct 31 – 37. LOD confirmation studies for tests determine the

lowest detectable concentration of 2019-nCoV2 (CV19) at which approximately 95% of all true positives test positive***.*** Thus, results from tests using Ct greater than established LOD should be considered indeterminate. ADH appears to be ignoring limits of detection and reporting tests higher than the maximum cycle threshold. The Arkansas practice of using high cycle thresholds of up to 42, thereby 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 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.

b. 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 section). The overall false positive ratio is estimated to be in the 3-10% range. However, the FDA has yet to conduct confirmation studies to demonstrate exact false positive ratios – an omission never before allowed 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**.

c. 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."

d. 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 any other illness been defined simply by a laboratory test – much less by a test which 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, nor 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.

In addition to the above information on PCR testing, additional PCR studies and informational resources are contained in Attachment 2.

3. 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 1, 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 and urgently pursue revision of Arkansas Covid 19 policies regarding our youth populations and schools.

According to an on-going, real-time study by Brown University, which looks 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** and NPR, 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 only slightly higher, at just 0.24 percent.** This data in no way supports the stringent mask, isolation, and quarantine policies and practices that have been instituted in our public schools.

A look at national and world-wide evidence from nations that never closed schools shows:

a. According to Swiss Policy Research, 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.

b. According to a study by the Netherlands' National Institute for Health (RIVM) "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." Ruters reported that "transmission between children, or from children to adults, as is known in influenza, appears to be less common."

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."

d. Importantly, The Moral Case for Opening Schools tells us: "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, 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?"

e. 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 Damaging an Entire Generation of Kids.

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:
"According 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

4. SOCIO-ECONOMIC INFORMATION – REOPEN BUSINESSES UNRESTRICTED

While specific data detailing the total adverse economic impact in Arkansas is difficult to assess at this point, CV19 has created a significant economic crisis. Arkansas unemployment indicators are significantly higher compared to 2019. According to government data, the Arkansas leisure and tourism industry alone has lost nearly 17.5K jobs since 2019, resulting in approximately $200K in lost tax revenue in the tourism sector alone. The Little Rock Convention Center has had 325 events cancelled, resulting in $36 million of economic impact. There are countless other anecdotal examples of the devastating economic effects that the CV19 policies, not the virus, have had on the Arkansas economy.

According to the Brookings Institute, the following adverse economic impacts are due to the CV19 response:

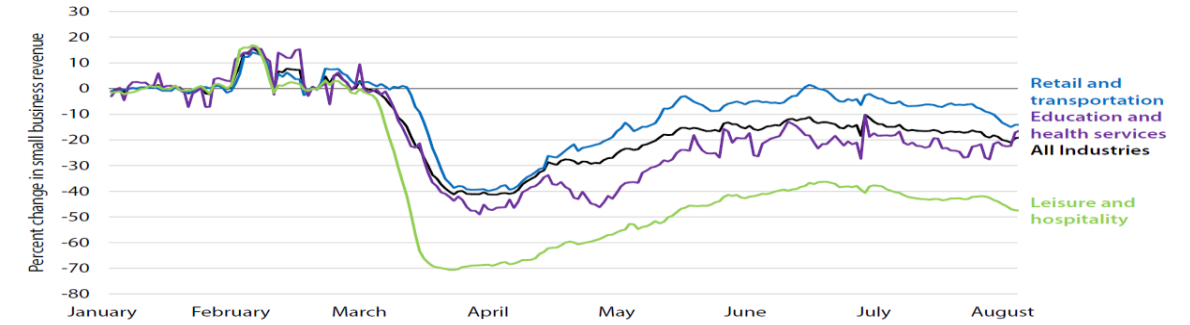
Fact 1: Small business revenue is down 20 percent since January.

"The COVID-19 pandemic has been particularly damaging for small businesses, which represent the majority of businesses in the United States and employ nearly half of all private sector workers (Bartik, Bertrand, Cullen, et al. 2020; Small Business Administration 2012). Figure 1 below shows how the different small business sectors have been affected by this downturn, highlighting severe declines in revenue among the leisure and hospitality as well as education and health services sectors. Compared to

January 2020, average daily revenue as of August 9 was down by 47.5 percent in the leisure and hospitality sector; aggregate small business revenue across all industries had fallen by 19.1 percent."

FIGURE 1.

Change in Small Business Revenue for Selected Industries Relative to January 2020, January–August 2020



Source: Chetty et al. 2020.
Note: Data are for January 10, 2020 to August 9, 2020. Raw data are collected from Womply, a firm-based panel data set of small business revenue. "Revenue" is defined as the sum of all credits (generally purchases) minus debits. Data are seasonally adjusted, calculated as a seven-day moving average, and indexed to January 4–31, 2020. Chetty et al. (2020) analyze Womply data at the two-digit industry level and then aggregate using NAICS supersector codes. "All industries" includes both the shown supersectors as well as the other supersectors (e.g., manufacturing, financial services, etc.). For more on supersectors, see BLS 2019.

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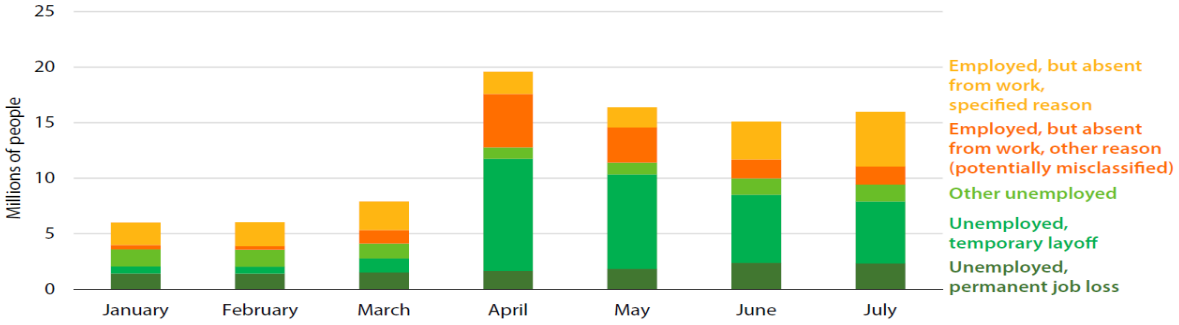
Fact 2: The decline in business revenue has caused many firms to become insolvent. Hamilton (2020) estimates that by July nearly 420,000 small businesses had failed since the start of the pandemic, the number of failures typically seen in an entire year.

Fact 3: The number of labor force participants not at work quadrupled from January to April.

FIGURE 5.

Prime-Age Population by Selected Labor Force Statuses, January–July 2020



Source: U.S. Bureau of Labor Statistics (Current Population Survey [CPS]) 2020; authors' calculations.
Note: "Employed, not at work" refers to workers who are employed but were not at work during the reference work for a specific reason (e.g., illness, vacation, etc.). "Misclassified" refers to workers who reported as employed, but absent from work due to other reasons; for more on why these workers are misclassified, see Bauer et al. (2020). "Unemployed, temporary layoff" refers to job losers who expect to get their job back. "Unemployed, permanent job loss" refers to job losers who either finished a temporary job or do not expect to get their job back. "Other unemployed" refers to people who quit their jobs, new entrants to the labor force, and re-entrants to the labor force.

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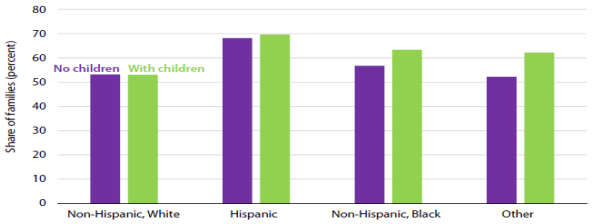
Fact 4: The number of people not in the labor force who want a job spiked by 4.5 million in April and has remained elevated.

Fact 5: Low-income families with children were most likely to experience an income shock.

FIGURE 8A.

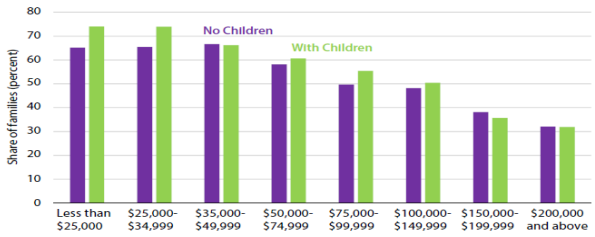
Share of Families Experiencing an Income Shock by Race and Presence of Children



Source: U.S. Census Bureau (Household Pulse Survey) 2020b; authors' calculations.
Note: The Household Pulse Survey asks individuals about their experiences with employment, spending, food security, housing, and health during the COVID-19 pandemic. It is designed to be both state-level and longitudinal, a short-turnaround instrument to aid in post-pandemic recovery. These data were taken from Week 12 of the survey, representing July 16–21. The sample is restricted to prime-age adults, aged 24–54.

FIGURE 8B.

Share of Families Experiencing an Income Shock by Household Income and Presence of Children



Source: U.S. Census Bureau (Household Pulse Survey) 2020b; authors' calculations.
Note: The Household Pulse Survey asks individuals about their experiences with employment, spending, food security, housing, and health during the COVID-19 pandemic. It is designed to be both state-level and longitudinal, a short-turnaround instrument to aid in post-pandemic recovery. These data were taken from Week 12 of the survey, representing July 16–21. The sample is restricted to prime-age adults, aged 24–54.

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Fact 6: In 26 states, more than one in five households was behind on rent in July.

Fact 7: From 2018 to mid-2020, the rate of food insecurity doubled for households with children.

5. A WORD ON MASKS:

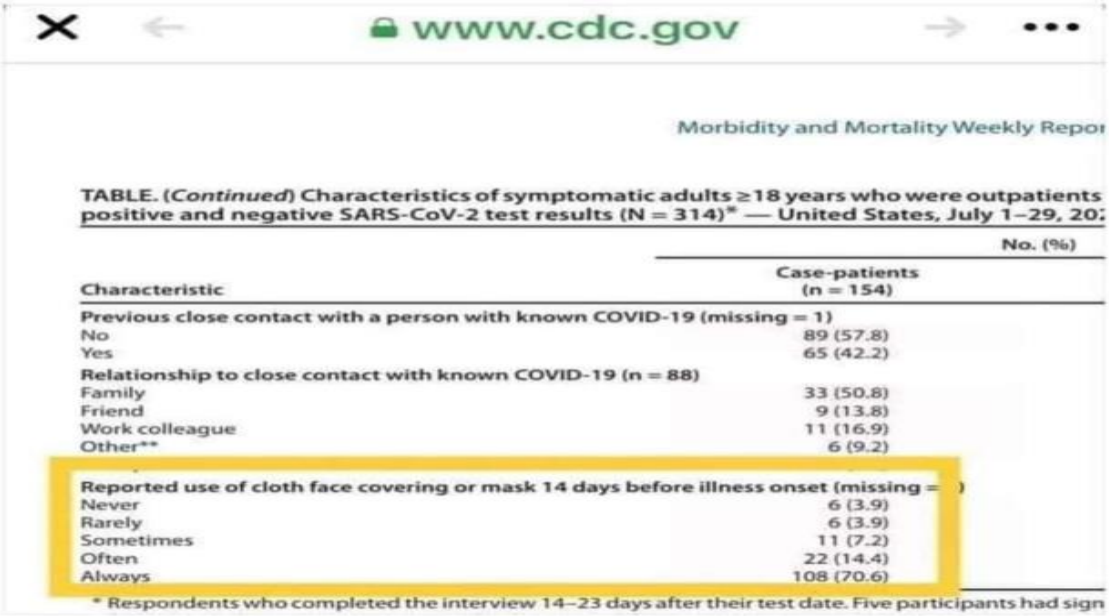
No discussion of CV19 policies or reopening would be complete without a brief discussion of the state mask mandate. The Governor's directive on mandatory mask wear was perhaps the most divisive and arbitrary of all the 47+ mandates issued by the Governor and ADH. One has only to look at the mandate itself to wonder what data, science, or logic went into development of the mandate. For instance, mask wear is required for ages 10 and above – why the arbitrary age of 10? Mask wear is required in a restaurant while standing/walking, but not while seated. Additional examples of the arbitrary and scientifically unsupported nature of the mandate are too numerous to address herein.

The most egregious of the medically and scientifically unsupported, arbitrary mask policies is undoubtedly the school masking mandates and policies. 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, and 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. **There is no reliable scientific evidence supporting that mask wear in the general population reduces viral spread.** There is, however, substantial evidence that mask wear is ineffective and harmful, and numerous studies show no reduction in community viral spread from mask wear. **(*See Attachment 1, Mask Science, Studies, and Information)**.

The face mask requirement in 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 [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 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."

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 the CDC found that 70 percent of Covid-19 patients reported "always" wearing a mask, and 85% reported "always" or "often" wearing a mask:


www.cdc.gov

Morbidity and Mortality Weekly Repor

TABLE. (*Continued*) Characteristics of symptomatic adults ≥18 years who were outpatients positive and negative SARS-CoV-2 test results (N = 314)* — United States, July 1–29, 20

No. (%)

Characteristic	Case-patients (n = 154)
Previous close contact with a person with known COVID-19 (missing = 1)	
No	89 (57.8)
Yes	65 (42.2)
Relationship to close contact with known COVID-19 (n = 88)	
Family	33 (50.8)
Friend	9 (13.8)
Work colleague	11 (16.9)
Other**	6 (9.2)
Reported use of cloth face covering or mask 14 days before illness onset (missing =)	
Never	6 (3.9)
Rarely	6 (3.9)
Sometimes	11 (7.2)
Often	22 (14.4)
Always	108 (70.6)

* Respondents who completed the interview 14–23 days after their test date. Five participants had sign

We note that the State Emergency Services Act, under which the Governor's declarations and ADH directives have been promulgated, as well as ADH statutes and rules, require that any policies be based on the best reasonably available science and information. We believe the best reasonably available science and information in no way supports the Governor's mask directive specifically, nor the ADH recommendations on mask wear in general. We urge you to challenge the state directives on mask wear (especially school mask wear) policies, which are at best ineffective in reducing CV19 spread, and at worst harmful or dangerous to our citizens – especially our youth.

6. SUMMARY/CONCLUSION:

In closing, we urge all Arkansas legislators to call for and pursue an immediate end to the Governor's perpetual "emergency" declarations, and seek restoration of representative government in our state. We further urge all legislators to immediately pass a concurrent resolution ending the Governor's declared emergency, as provided for in the Emergency Services Act. While we have heard some legislators contend that such a resolution cannot be accomplished because the legislature is not in session, we do not believe this is accurate. Such contention is not supported by the plain language of the Emergency Services Act, and the Governor himself has publicly voiced that the legislature may end the Emergency Declaration at any time via concurrent resolution.

It is time to restore representative governance and end the quasi-dictatorship of the Governor and his ADH Director. Representative government facilitates decisions at local and regional levels that are responsive to local area needs. For over 8 months now, the citizens of Arkansas have suffered under the Governor's emergency declarations and directives. Those unilateral declarations and directives, purported by the Executive Branch to be law, have significantly and adversely affected Arkansans' businesses, livelihoods, communities, schools, and individual liberty and freedom. The citizens of Arkansas deserve to have a voice in the State CV19 response, via you, their elected representatives.

Arkansans are capable of making their own informed health decisions. We urge legislators to call for an end to the declared CV-19 "emergency," and immediately pursue a concurrent resolution ending the state of emergency and restoring representative government. We further urge a return to a pre-Covid-19 policy and practice of advisory health recommendations to the general public; and, the adoption of policy which focuses on protection of those most at risk of serious, adverse Covid-19 outcomes. Lastly, we recommend legal action if and as necessary to bring an end to the Governor's perpetual emergency declarations.

Presented by: Reopen Arkansas; Prepared by: C. Stafford, updated 12/1/2020. Contact us at: reopenar@gmail.com, on Facebook, or at our website, http://wwww.reopenarkansas.org

Attachment 1
Additional Resources and References

MASK SCIENCE, STUDIES, AND INFORMATION:

Effectiveness of Adding a Mask Recommendation to Other Public Health Measures to Prevent SARS-CoV-2 Infection – A Randomized Controlled Trial (Nov 2020)
https://www.acpjournals.org/doi/10.7326/M20-6817?fbclid=IwAR0eWTm1T1rfmQCMgmGT9QOUH7xUJ7nkvUS6Bx0cDTs_mq4zLWtpqf_WdCQ&

Face Masks Lack Safety and Effectiveness (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

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/

Masks Not Effective and Harmful to Your Health
https://www.primarydoctor.org/masks-not-effect

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

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

COVID-19 PCR TESTING:

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

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

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/

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/

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

MEDICAL SCIENCE AND HERD IMMUNITY:

Open letter from physicians on social crisis and lack of medical evidence for lockdowns:
https://docs4opendebate.be/en/open-letter/

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 Demonstration 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

Royal College: Covid-19 Medical Studies Regarding Children and Youth (Oct 2020)
https://www.rcpch.ac.uk/resources/covid-19-research-evidence-summaries

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

Answers to Anti-School Arguments
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/

Masks are Ineffective and Harmful (Detailed section of 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/

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 0 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/

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

Government Responsibility:

Could Unchecked Government 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.**"

ATTACHMENT 2:
Arkansas Department of Heath FOIA Response Regarding Covid 19 Related Deaths and Comorbidities

[redacted]

From: [redacted]
Sent: Monday, October 5, 2020 9:56 AM
To: [redacted]
Cc: Lynda [redacted]
Subject: RE: FOIA Response for legislative request

Shirley,

In response to Request #2:

We used the CDC online source to answer this question. We are not in position now to be able to group comorbidities and we depend on NCHS classifications. The counts below reflect the certificates that are coded by NCHS at time of reporting. At the time of reporting there were 1,166 certificates where COVID-19 was listed in the cause of death. The table below is conditions contributing to deaths involving COVID-19. Based on the way the data is provided there is not a way to distinguish when COVID-19 was the underlying cause, versus when it was only a contributing factor on the death certificate.
CDC website: https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm?fbclid=IwAR3-wrp3tTKK5-9tOHPGAHWFVO3DfslkJ0KsDEPQpWmPbKtp6EsoVV2Qs1Q

Condition	Age Group	Total
Diabetes	0-24	0
Diabetes	25-34	**
Diabetes	35-44	**
Diabetes	45-54	**
Diabetes	55-64	34
Diabetes	65-74	44
Diabetes	75-84	43
Diabetes	85+	29
Diabetes	All Ages	172
Obesity	0-24	**
Obesity	25-34	**
Obesity	35-44	**
Obesity	45-54	**
Obesity	55-64	10
Obesity	65-74	**
Obesity	75-84	**
Obesity	85+	0
Obesity	All Ages	33
Hypertensive diseases	0-24	0
Hypertensive diseases	25-34	**
Hypertensive diseases	35-44	**
Hypertensive diseases	45-54	**
Hypertensive diseases	55-64	29
Hypertensive diseases	65-74	40
Hypertensive diseases	75-84	71
Hypertensive diseases	85+	67
Hypertensive diseases	All Ages	219
Ischemic heart disease	0-24	**
Ischemic heart disease	25-34	0
Ischemic heart disease	35-44	0
Ischemic heart disease	45-54	**
Ischemic heart disease	55-64	10
Ischemic heart disease	65-74	23
Ischemic heart disease	75-84	40
Ischemic heart disease	85+	33
Ischemic heart disease	All Ages	113
Heart failure	0-24	0
Heart failure	25-34	0
Heart failure	35-44	**
Heart failure	45-54	**
Heart failure	55-64	14
Heart failure	65-74	10
Heart failure	75-84	21
Heart failure	85+	40
Heart failure	All Ages	90
Cerebrovascular diseases	0-24	0
Cerebrovascular diseases	25-34	0
Cerebrovascular diseases	35-44	0
Cerebrovascular diseases	45-54	**
Cerebrovascular diseases	55-64	**
Cerebrovascular diseases	65-74	**
Cerebrovascular diseases	75-84	12
Cerebrovascular diseases	85+	10