Are We Overreacting to Omicron?

BY PAUL ELIAS ALEXANDER NOVEMBER 26, 2021 POLICY, PUBLIC HEALTH 7 MINUTE READ

With natural exposure immunity and early outpatient treatment, and when combined with no reports of increased lethality, the WHO's reaction of generating panic toward "Omicron" is causing needless fear and panic. So too, with the Biden administration's newly imposed travel restrictions which will achieve nothing and will once again disrupt trade and violate human rights.

The WHO has said that the Omicron variant can spread more quickly than other variants. Likely true. The virus is behaving just how viruses behave. They are mutable and mutate and, via Muller's ratchet, we expect this to be milder and milder mutations and not more lethal ones given the pathogen seeks to infect the host and not arrive at an evolutionary dead-end.

The virus will mutate downward so that it can use the host (us) to propagate itself via our cellular metabolic machinery. The Delta has shown us this: it is very infectious and mostly non-lethal. Especially for children and healthy people. So is the WHO panicking the globe needlessly? Is this Covid-19 February 2020 once again?

The problem with South Africa as is with Australia and New Zealand and even island nations like Trinidad is that it has low natural immunity to

SAR-Cov-2. This is because, as we witnessed over the last year and more, if you lock down your society too long and too hard, you deny the nation and population from inching closer to population-level herd immunity. And you have no economy or society from which to reemerge. You devastate your society for a pathogen that is largely harmless to the vast majority of people especially children.

Moreover, governments asked us for two weeks to flatten the curve to help prepare hospitals so that they can tend to surges and other non-Covid illnesses. We as societies gave our governments 2 weeks, not 21 months. They failed to tend to the non-Covid illnesses and we locked down the healthy and well (children and young and middle aged healthy persons) while failing to properly protect the vulnerable and high-risk persons such as the elderly. We failed and it was like killing fields in our nursing homes.

This failure rests on public health messaging and government. Additionally, what did our governments in the US, Canada, UK, Australia etc. do with the tax money for the hospitals and PPE etc.? Hospitals must be prepared by now. Governments have failed! Not the people. The Task Forces have failed, not the people.

These nations thought that they could stay locked down and wait for a vaccine. This is a reasonable view though I was against lockdowns as they would and did cause crushing harms on especially poor persons and children. The problem is there was an opportunity cost because the

vaccine we were waiting on was suboptimally developed without the proper safety testing or assessment of effectiveness.

We have data that the Pfizer vaccine loses 40% of antibodies per month, meaning in 3 months post-shot, you have low effective vaccinal immunity. We see it clearly playing out now whereby you got to tamp down spread with the draconian lockdowns, but you did it at the cost of natural immunity. That is the opportunity cost. So we spent on getting the vaccine and it cost us natural immunity and thus herd immunity.

For example, the vaccine has failed to stop infection and spread against Delta. We have research findings by Singanayagam et al. (fully vaccinated individuals with breakthrough infections have peak viral load similar to unvaccinated cases and can efficiently transmit infection in household settings, including to fully vaccinated contacts), by Chau et al. (viral loads of breakthrough Delta variant infection cases in vaccinated nurses were 251 times higher than those of cases infected with prior strains early 2020), and by Riemersma et al. (no difference in viral loads when comparing unvaccinated individuals to those who have vaccine "breakthrough" infections and if vaccinated individuals become infected with the delta variant, they may be sources of SARS-CoV-2 transmission to others) that reveal the vaccines have very suboptimal efficacy.

This situation of the vaccinated being infectious and transmitting the virus has also emerged in seminal nosocomial outbreak papers by Chau et al. (HCWs in Vietnam), the Finland hospital outbreak (spread among HCWs

and patients), and the Israel hospital outbreak (spread among HCWs and patients). These studies have also revealed that the PPE and masking were essentially ineffective within the healthcare setting. All of the HCWs were double-vaccinated yet there was extensive spread to themselves and their patients.

In addition, Nordström et al. (vaccine effectiveness of Pfizer against infection waned progressively from 92% day 15-30 to 47% day 121-180, and from day 211 and onwards no effectiveness), Suthar et al. (a substantial waning of antibody responses and T cell immunity to SARS-CoV-2 and its variants, at 6 months following the second immunization), Yahi et al. (with Delta variant, neutralizing antibodies have a decreased affinity for the spike protein, whereas facilitating antibodies display a strikingly increased affinity), Juthani et al. (higher numbers of patients with severe or critical illness in those who received the Pfizer vaccine), Gazit et al. (SARS-CoV-2-naïve vaccinees had a 13-fold increased risk for breakthrough infection with the Delta variant, and substantially elevated risk of symptomatic Covid and hospitalization), and Acharya et al. (no significant difference in cycle threshold values between vaccinated and unvaccinated, asymptomatic and symptomatic groups infected with Delta) collectively reveal the poor efficacy and even negative efficacy of the Covid vaccines. Levine-Tiefenbrun et al. reports that the viral load reduction effectiveness declines with time after vaccination, "significantly decreasing at 3 months after vaccination and effectively vanishing after about 6 months."

As an example, the Swedish study (retrospective with 842,974 pairs (N=1,684,958) is of interest and particularly concerning for it shows that while the vaccine provides temporary protection against infection, the effectiveness declines steadily and researchers report "Vaccine effectiveness of BNT162b2 against infection waned progressively from 92% (95% CI, 92-93, P<0·001) at day 15-30 to 47% (95% CI, 39-55, P<0·001) at day 121-180, and from day 211 and onwards no effectiveness could be detected (23%; 95% CI, -2-41, P=0·07). The effectiveness waned slightly slower for mRNA-1273, being estimated to 59% (95% CI, 18-79) from day 181 and onwards. In contrast, effectiveness of ChAdOx1 nCoV-19 was generally lower and waned faster, with no effectiveness detected from day 121 and onwards (-19%, 95% CI, -97-28), whereas effectiveness from heterologous ChAdOx1 nCoV-19 / mRNA was maintained from 121 days and onwards (66%; 95% CI, 41-80)." Researchers contend that "Vaccine effectiveness against symptomatic Covid-19 infection wanes progressively over time across all subgroups, but at different rate according to type of vaccine, and faster for men and older frail individuals."

A further example emerges from Ireland whereby reporting suggests that the Waterford city district has the State's highest rate of Covid-19 infections, while the county also boasts the highest rate of vaccination in the Republic (99.7% vaccinated). Reports are that the U.S. Covid-19 deaths for 2021 surpassed the deaths from 2020, leading some to state that "more people have died from COVID-19 in 2021, with most adults vaccinated and nearly all seniors), than in 2020 when nobody was vaccinated."

Thus these nations that locked down and stayed that way are in a quandary for they do not know what to do now. If you open you will get surges in infection. Where is the money that was to go to hospital preparation? Did governments embezzle and steal and misappropriate the money for the hospitals remain still not prepared?

We have a lot of natural immunity in the US, e.g. near 65-70% of the population. The open states (those that did not lock down too long and too hard and opened quickly) will likely do very well with this Omicron or any new variant. This also is the power of natural immunity.

And we need not forget the potency of the overlooked 'innate' immunity with the innate antibodies and innate natural killer cellular compartment. This innate response is particularly potent in children (our first line of defense against pathogens) and is what has spared children from Covid and how children typically stave off pathogens, especially young children still laying down immunological memory.

Moreover, there is no reporting of increased virulence/lethality of this new Omicron variant. As yet this will remain the case based on Delta and prior variants. There are no guarantees but we operate based on risk and all things point to the same for this new variant.

Just because there might be a wave in SA does not mean that there will be waves in the US or Israel or other places with greater natural immunity. This was the prize of letting people enjoy day-to-day living. The nations

that have ended lockdowns are likely to move past this new variant scare, and be fine. This is more of an overreaction by the WHO and governments and much ado about nothing.

Brownstone Authors and Contributors

Paul Elias Alexander

Dr Alexander holds a PhD. He has experience in epidemiology and in the teaching clinical epidemiology, evidence-based medicine, and research methodology. Dr Alexander is a former Assistant Professor at McMaster University in evidence-based medicine and research methods; former COVID Pandemic evidence-synthesis consultant advisor to WHO-PAHO Washington, DC (2020) and former senior advisor to COVID Pandemic policy in Health and Human Services (HHS) Washington, DC (A Secretary), US government; worked/appointed in 2008 at WHO as a regional specialist/epidemiologist in Europe's Regional office Denmark, worked for the government of Canada as an epidemiologist for 12 years, appointed as the Canadian in-field epidemiologist (2002-2004) as part of an international CIDA funded, Health Canada executed project on TB/HIV co-infection and MDR-TB control

(involving India, Pakistan, Nepal, Sri Lanka, Bangladesh, Bhutan, Maldives, Afghanistan, posted to Kathmandu); employed from 2017 to 2019 at Infectious Diseases Society of America (IDSA) Virginia USA as the evidence synthesis meta-analysis systematic review guideline development trainer; currently a COVID-19 consultant researcher in the US-C19 research group

READ MORE 

BROWNSTONE INSTITUTE
2028 E BEN WHITE BLVD
#240-3088
AUSTIN TX 78741