August 10, 2020

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Mr. Wilson Masilingi, Ambassador
Embassy of Tanzania
1232 22nd St. NW
Washington D.C 20037
202-884-1080

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Mr. Wilson Masilingi, Ambassador
Embassy of the United Republic of Tanzania
1232 22nd St. NW
Washington D.C 20037
202-884-1080

Subject: Letters to Dr. Anthony Fauci, and First Lady of the United States Melania Trump
Reference: SARS-Cov-2 and COVID-19

Dear Ambassador Masilingi:

Please share the enclosures with your good president, Dr. John Magufuli. Please note that I mention President Magufuli in my letter to Dr. Fauci (page 11 of 36).

Please note that these materials are already in-receipt, including my alma mater Cornell University. Please feel free to share with anyone. The links for doing so electronically:

http://pvsheridan.com/sheridan2fauci-1-21july2020.pdf
http://pvsheridan.com/Sheridan2Melania-3-23July2020.pdf

In the latter, my letter to the First Lady, I am essentially asking if she is aware of precisely what is being proposed as a "vaccine." An mRNA based vaccine has never been deployed, due to its implicit dangers. As Dr. Fauci is fully aware, the mRNA based injection is so dangerous that the so-called *'Operation Warp Speed'* is skipping the animal trials . . . instead, the trials will be conducted on humanity; make no mistake about it.

Regarding alternatives to mRNA-based human trials, I have attached pages 1-5 of a 56 page study entitled:


Early treatment with hydroxychloroquine: a country-randomized controlled trial

Covid Analysis, August 5, 2020 (updated August 6, 2020)

@CovidAnalysis

I ask Dr. Fauci questions regarding hydroxychloroquine (see pages 4 – 8). Note that as of 6 August 2020, **the chances of avoiding death (due to infection by SARS-CoV-2) increase by 79.1% with the prophylactic dispensing of that 65+ year old pharmaceutical;** a value which improves when corrected for 'compounding factors." The entire 56 page report is available at: https://hcqtrial.com/ .

Respectfully yours,

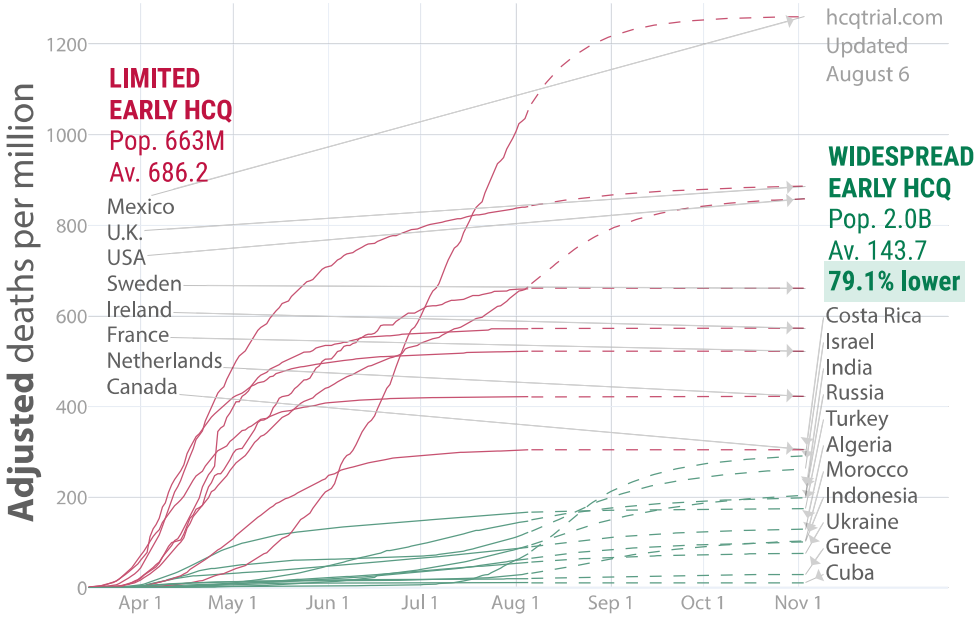
Paul V. Sheridan

Enclosures/Attachment

cc: Cornell University President Martha Pollack

Early treatment with hydroxychloroquine: a country-randomized controlled trial

Covid Analysis, August 5, 2020 (updated August 6, 2020)
@CovidAnalysis



Many countries either adopted or declined early treatment with HCQ, forming a large country-randomized controlled trial. 2.0 billion people were assigned to the treatment group, and 663 million to the control group. As of August 6, 2020, an average of 38.5/million in the treatment group have died, and 440.2/million in the control group, relative risk 0.087. After adjustments, treatment and control deaths become 79.6/million and 630.0/million, relative risk 0.13. Confounding factors affect this estimate, including varying degrees of spread between countries. Accounting for predicted changes in spread, we estimate a relative risk of 0.21. **The treatment group has 79.1% lower chance of death**. We examined diabetes, obesity, hypertension, life expectancy, population density, urbanization, testing level, and intervention level, which do not account for the effect observed.

Trial Setup

Treatment. We investigate early or prophylactic treatment for COVID-19 with hydroxychloroquine (HCQ), which has been adopted or declined in different countries. Since the severity of COVID-19 varies widely based on age and comorbidities, treatment was generally only initiated in higher risk individuals. The primary endpoint was death.

Treatment groups. Entire countries were assigned to either the treatment or control group. Countries have made different decisions regarding treatment with HCQ. For the purposes of this study, selection into the treatment or control group was based on the same information and is essentially random.

We focus here on countries that chose and maintained a clear assignment to one of the groups for a majority of the duration of their outbreak, either adopting widespread use, or highly limiting use. Some countries have very mixed usage, and some countries have joined or left the treatment group during their outbreak. We searched government web sites, Twitter, and Google, with the assistance of several experts in HCQ usage, to confirm assignment to the treatment or control group, locating a total of 194 relevant references, shown in Appendix 12. We excluded countries with <1M population, and countries with <0.5% of people over the age of 80. COVID-19 disproportionately affects older people and the age based adjustments are less reliable when there are very few people in the high-risk age groups. We also excluded countries that adopted early widespread use of masks because these countries tend to have significantly lower spread, which we discuss in detail below.

Collectively the countries we identified with stable and relatively clear assignments account for 34.7% of the world population (2.7B of 7.8B). Details of the groups and evidence, including countries identified as having mixed use of HCQ, can be found in Appendix 12.

Analysis. We analyze deaths per capita with data from *[Our World in Data]*. To determine the effectiveness of treatment we could compare the death rates for the entire populations in the treatment and control groups, however we use the average of the individual country rates in each group in order to minimize effects due to differences between countries.

Since randomization was done at a coarse country level, we adjust for differences between countries and analyze confounding factors. We analyze deaths rather than cases because case numbers are highly dependent on the degree of testing effort, criteria for testing, the accuracy and availability of tests, accuracy of reporting, and because there is very high variability in case severity, including a high percentage of asymptomatic cases.

Results

2.0 billion people were assigned to the treatment group, and 663 million to the control group. As of August 6, 2020, an average of 38.5/million in the treatment group have died, and 440.2/million in the control group, relative risk 0.087. After adjustments, treatment and control deaths become 79.6/million and 630.0/million, relative risk 0.13. Confounding factors affect this estimate, including varying degrees of spread between countries. Accounting for predicted changes in spread, we estimate a relative risk of 0.21. The treatment group has 79.1% lower chance of death. We examined diabetes, obesity, hypertension, life expectancy, population density, urbanization, testing level, and intervention level, which do not account for the effect observed. Figure 1 shows cumulative demographic adjusted death rates by country and trial group. Adjustments are detailed in the next section. Some analyses adjust graphs for the date since a specific milestone was reached, such as 0.1 deaths per million. We do not do this because an effective treatment will alter the time that such a milestone is reached.

For comparison, if we use the median of country death rates in each group rather than the mean, the relative risk is 0.12 (before prediction of future spread). If we combine all countries into single treatment and control groups, the relative risk is 0.13. Since the sample sizes are very large, $p < 0.0001$, however it is more important to analyze confounding factors.

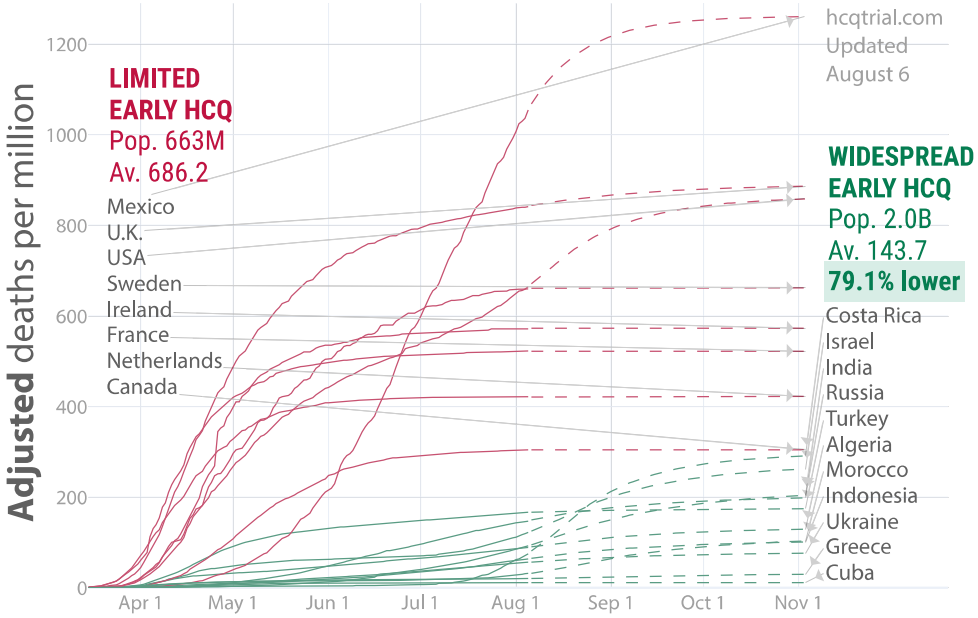


Figure 1. *Adjusted deaths per million for countries using widespread early HCQ versus those that do not, with a prediction for the following 90 days. As of August 6, 2020, countries using early HCQ are predicted to have a 79.1% lower death rate after adjustments.*

Confounding Factors

A number of confounding factors affect the results, which we investigate here. For reference, the results before adjustments are shown in Figure 2.

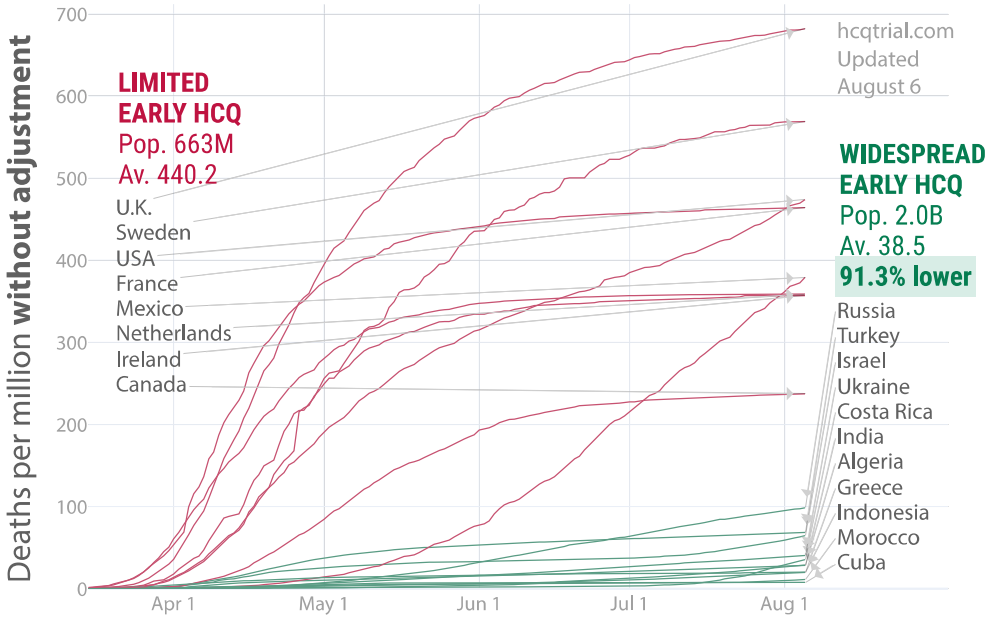


Figure 2. *Deaths per million for countries using widespread early HCQ versus those that do not,* ***before adjustments****.*

Age. The COVID-19 IFR varies around four orders of magnitude depending on age. Since the proportion of older adults varies significantly between countries, this is likely to have a significant effect on the results *[Leffler]*. We approximate the relative risk based on age using the infection fatality rates provided in *[Verity]*, and shown in Figure 3. Due to the distribution, simple adjustment based on the median age, the proportion of people over 65, or similar may not be very accurate. We obtained age demographics from *[United Nations]* which provides a breakdown within 5 year age groups. Using the 9 age groups provided by *[Verity]*, we computed an age adjustment factor for each country to normalize the observed deaths to the predicted number of deaths if the country's age distribution matched that of the country with the oldest population. The age distributions and computed age factors are provided in Appendix 1. These adjustments are relatively significant as in *[Leffler]*.

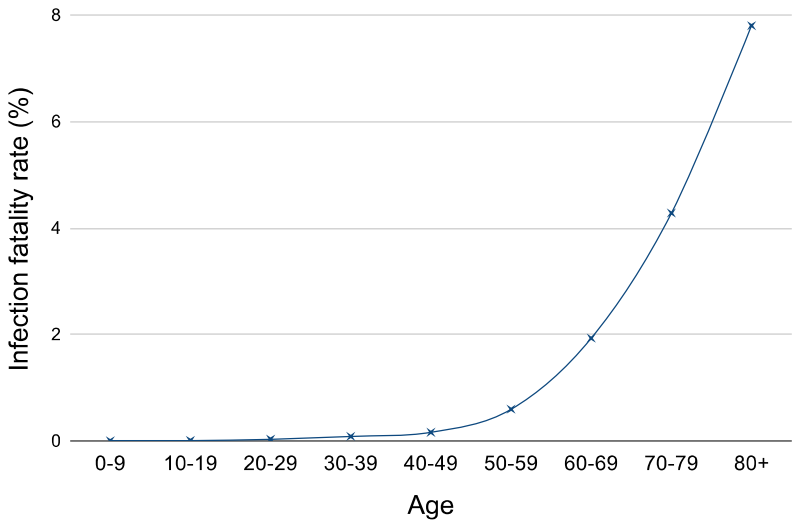


Figure 3. *Infection fatality rates from* ***[Verity]****.*

Gender. Risk differs significantly based on gender ***[Gebhard]***, so we also normalized for this in a similar fashion. Data is from ***[United Nations]***, and using the hazard ratio of 1.78 from ***[Williamson]*** the resulting adjustment factors are shown in Appendix 1. These adjustments are relatively minor as in ***[Leffler]***. After adjusting for age and gender we obtain the results in Figure 4. Adusted mean treatment and control deaths become 79.6/million and 630.0/million, relative risk 0.13.

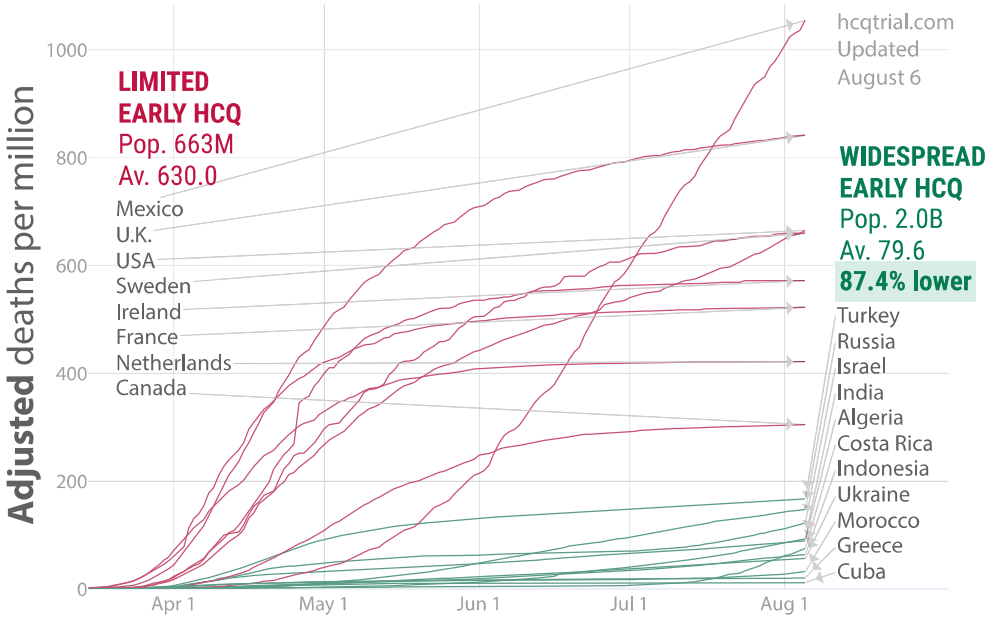


Figure 4. *Deaths per million for countries with widespread early HCQ versus those that do not, after adjustment for differences in demographics.*