

# *Self-Selected COVID-19 “Unvaccinated” Cohort Reports Favorable Health Outcomes and Unjustified Discrimination in Global Survey*

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## ABSTRACT

Self-reported data collected independently by the UK-based Control Group Cooperative between September 2021 and February 2022, inclusive, from a self-selected international COVID-19 “unvaccinated” population are discussed. Data come from a cohort of 18,497 participants who provided questionnaire responses monthly. The largest numbers are from Europe, North America, and Australasia. Data were skewed towards the 40-69y age range and included 60% female respondents. Reasons for avoiding COVID-19 “vaccines” were: a preference for natural medicine, distrust of pharma, distrust of government information, poor/limited trial data, and fear of long-term adverse reactions. During the survey period, the greatest incidence of COVID-19 disease was reported in the 50-69y range, peaking at 12.3%, in January 2022. Persons at 70y and above were least affected (1.3%), with 10.7% and 3.8% in the 20 to 49y band, and in the 1 to 19y group, respectively. Most rated their symptoms as “mild” (14.4%), with 2% reporting “severe” disease. Fatigue, cough, muscle/body aches, and fever were the four most common. Just 0.4% of the cohort reported hospitalization (as in- or out-patients). Nearly two-thirds reported taking vitamin D, C, zinc, quercetin, or a combination, for prevention, with 71% using vitamin D, C, and zinc for treatment. Nearly 45% reported “moderate” to “severe” mental health issues (depression) during the survey period. Menstrual abnormalities were reported by 36% of women in the 20-49y age band. Reported job losses were greatest in Australia and New Zealand at 29%, followed by 13% in North America. Between 20% and 50% reported being personal targets of hate because of their vaccination status. Between 57% and 61% of respondents in Southern Europe and Western Europe, Australia/New Zealand and South America, reported being targets of governmental victimization. The cohort may not be representative of wider populations given its reliance on self-care. The findings suggest that opting out of the world’s largest medical experiment, relying on natural immunity, self-care with supplements, and/or ivermectin or hydroxychloroquine, appeared to contribute to low incidences of severe disease, hospitalization, or death. The results imply the urgent need for prospective studies of “unvaccinated”, “partially vaccinated”, and “fully vaccinated” persons investigating long-term outcomes, behaviors, choices, and discriminatory responses by the state, institutions, or employers based on “vaccination” status. Public dialogue about the touted “safety and effectiveness” of vaccines, contrasted with strategies to enhance immune resilience, all in the context of authoritarianism versus autonomy, self-care, personal responsibility, and freedom of choice is needed.

**Keywords:** control group ID card, depression, discrimination, hydroxychloroquine, ivermectin, mass formation (group hypnosis), mental health issues, quercetin, self-reported data, stigmatization of the unvaccinated, vitamin C, vitamin D, zinc

## Introduction

In this paper, we provide an independent analysis and interpretation of a subset of data from an ongoing survey of participants in a project operated by the UK-based Control Group Cooperative (CGC). While there are some 305,000 current “unvaccinated” participants in the project, this analysis pertains to a subset of the data including 18,497 participants that was considered representative. Although COVID-19 “genetic vaccines” (relying on mRNA and adenoviral vector technologies) were widely authorized, released, and later even mandated around the world after December 2020, there have been few studies evaluating health outcomes, choices, reasons for declining vaccination, and potential discrimination of the widely maligned “unvaccinated”. In fact, so-called “fact checkers” (e.g. Gore, 2021), health authorities (e.g. Ellis, 2022) and governments have consistently exposed the public to messaging that claims the “unvaccinated” pose a risk to the COVID-19 “vaccinated” (see McLeod et al., 2022). As early as November 2021, there was a preponderance of data to show that such views, which have led to stigmatization of the COVID-19 “unvaccinated” were unjustified scientifically (Kampf, 2021), yet the controlling health authorities, and the mainstream media, seem not to have changed their COVID-19 narrative to reflect the scientific data.

A study published in the preprint server *MedRxiv* found less severe outcomes among “fully vaccinated” COVID-19 patients requiring hospitalization, compared with those not “vaccinated”, yet the risk of in-hospital death was greater among the “vaccinated” than “unvaccinated” (Mielke et al., 2022; Oller & Santiago, 2022). A global study (68 countries) by Subramanian and Kumar (2021) found a slight negative association between the extent of COVID-19 “vaccine” coverage and the number of cases of COVID-19 per person in the population.

The UK REACT study (DHSC, 2021) is widely reported to justify COVID-19 vaccination. It found that of 98,000 volunteers studied, those who were double “vaccinated” for COVID-19 were three times less likely to test positive by PCR than those who were “unvaccinated” (1.21% vs 0.4%, respectively). However, the data on which such findings are based cannot demonstrate a causal relationship with vaccination owing to numerous behavioural and other confounding factors between the two groups. There is also a potential measurement problem owing to the tendency for the “unvaccinated” to be more likely to be subjected to testing on the assumption that those who are “vaccinated” need the testing less. Furthermore, some data on cases and deaths relied upon by UK authorities have been shown to be spurious owing to mis-categorization of vaccination status (Fenton et al., 2021).



Figure 1. CGC control group ID card (example).

## *THE CONTROL GROUP COOPERATIVE<sup>1</sup>*

The Control Group Cooperative (*controlgroup.coop*) was formed in July 2021 in response to concerns over the marginalization and stigmatization of COVID-19 unvaccinated communities. It represents the interests of individuals and families around the world who have chosen to not receive COVID-19 “vaccines.” One of the features of joining the CGC “control group” or gaining membership has been the issue of an ID card (Figure 1), in the relevant language. The card includes the statement that the individual is part of a SARS-CoV-2 Control Group and “must not be vaccinated”. Many members have reported that these ID cards have been successful in preventing forced vaccination (vaccination without informed consent) or loss of liberties, such as access to venues, by virtue of their COVID-19 “vaccination” status.

When joining or becoming a member of the CGC, subscribers are asked to participate in a survey (see **Methods**). It is the survey findings from a specific cohort of subscribers to the CGC over the first five months of the CGC’s operation that forms the primary subject of this paper.

### *INDEPENDENT ANALYSIS*

We, the authors of the present work, are entirely independent of the CGC and have received no funding to undertake this analysis, reporting and interpretation of findings. Since mid-2021, we have collaborated on a diverse range of scientific and medical issues as part of our ongoing work with the Health & Humanities Committee (co-chaired by Naseeba Kathrada, MBBS, and Robert Verkerk, PhD) of the non-profit World Council for Health (*worldcouncilforhealth.org*).

## **Methods**

This survey is based on self-reported data among self-selected individuals from around the world who have subscribed to the CGC project (*controlgroup.coop*). All respondents on which the present analysis is based completed an online survey (see Supplementary Information) on the CGC website monthly over 5 consecutive months (October 2021 to February 2022, inclusive). This period included the time during which, in most parts of the world, Omicron replaced the Delta variant as the dominant, circulating strain of SARS-CoV-2.

The cohort ( $n = 18,497$ ) that is the subject of this analysis is a sub-group comprising 6.2% of the 297,618 people who had registered on the website by the end of February 2022 and provided data monthly over the first 5 consecutive months of the survey. Comparison of selected parameters from this cohort (blood group proportions, age and biological sex distributions) with available data from the less complete but entire survey data set of CGC (that includes some 305,000 respondents from around the world at the time of writing) suggests that this smaller data set is likely to be representative of the full dataset.

The online survey includes some initial profile questions (Supplementary Information; Annex 1), that were answered at registration, followed by a further series of questions (Supplementary Information; Annex 2) answered by respondents on a monthly basis thereafter. Recruitment of respondents depended entirely on

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<sup>11</sup> Not to be confused with the Control Group Survey (2019-2021) operating out of California (<https://www.thecontrolgroup.org/>) aiming to compare outcomes of persons who avoided childhood vaccines, estimated at about 0.26% of the cohort. Both online surveys suggest a growing distrust by the general public of governmental pronouncements about the “safety and efficacy” of vaccines in general.

self-selection and relied on respondents being made aware of the CGC project through largely alternative media outlets, given widespread censorship on mainstream media and social media channels.

The ongoing survey aims primarily to gather insights about health outcomes, choices and discrimination experienced by this specific marginalized sub-population of people from diverse socio-economic backgrounds, ethnicities, cultures and geographic locations who have elected to exercise their right to refuse COVID-19 “genetic vaccines”.

This paper focuses primarily on the responses, choices and viewpoints of this specific self-selected, “unvaccinated” population. Accordingly, central to this “look and see” approach is the provision of data summaries that show the proportion of respondents who have given particular responses to the questions provided to them in the survey questionnaires.

Not all questions were answered by all respondents. Therefore, the denominators for the proportional analyses vary according to how many relevant answers have been provided in each instance. Where these are notably different from expectations, explanations for the denominator in question appears in the respective table, figure, or text. Some analyses involve just a subset of the respondents (e.g. those who have declared their biological sex; menstruating, menopausal and post-menopausal women aged 20 to 69).

**Table 1**  
**Continental Distribution of Respondents in Cohort**

Region	<i>n</i>	% of Total
Africa	171	0.9%
Asia	555	3.0%
Europe	7,442	40.5%
North America	4,657	25.3%
Oceania	4,982	27.1%
South America	576	3.1%
Unknown	114	0.6%
<b>TOTAL (N)*</b>	<b>18,383</b>	<b>100.0%</b>

\*Less the 114 respondents (0.6%) who did not

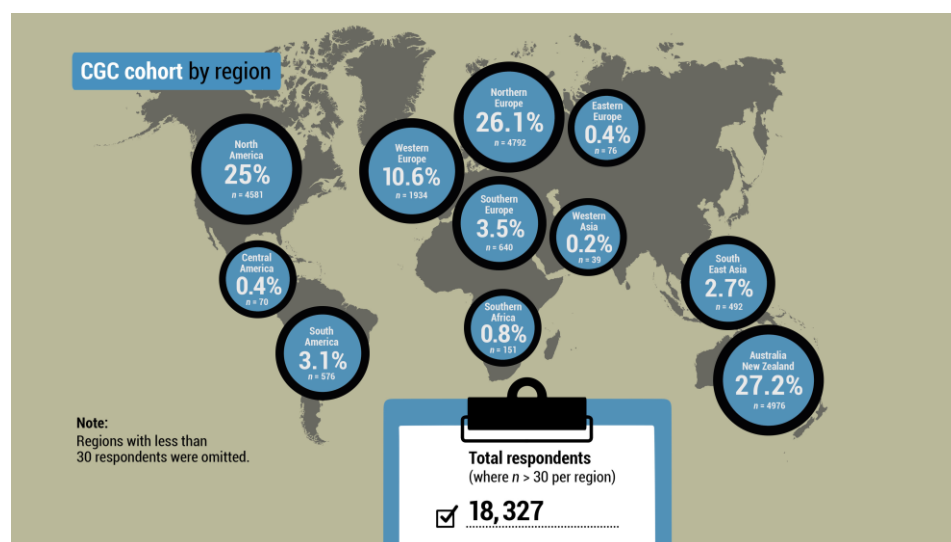


Figure 2. Regional distribution of the Control Group Cooperative (CGC) survey cohort.

## Survey Findings: Beginning with the Cohort

This section summarizes findings from data collated from respondents during their registration in October 2021 (Supplementary Information; Annex 1).

### GEOGRAPHIC LOCATION

The vast majority (98.8%) of non-COVID-19 injected participants were from 6 major continents or regions (Table 1), most being from Europe (40%), with the next largest constituents from Oceania (principally Australia and New Zealand) and North America (USA and Canada), 27% and 25%, respectively. Europe, Oceania, or North America accounted for about 92% of the cohort of interest in this paper. The regional geographical distribution of respondents in the self-selected cohort is summarized in Figure 2.

### ***REPORTED AGE GROUPS AND BIOLOGICAL SEX***

The age distribution of the cohort is shown in Figure 3. Overall, of the respondents who disclosed their biological sex (96.3%), 57% of respondents were female and 43% male. The greatest numbers of respondents were in the 50 to 69 age range, and accordingly would generally be regarded by health authorities as highly susceptible to COVID-19 disease.

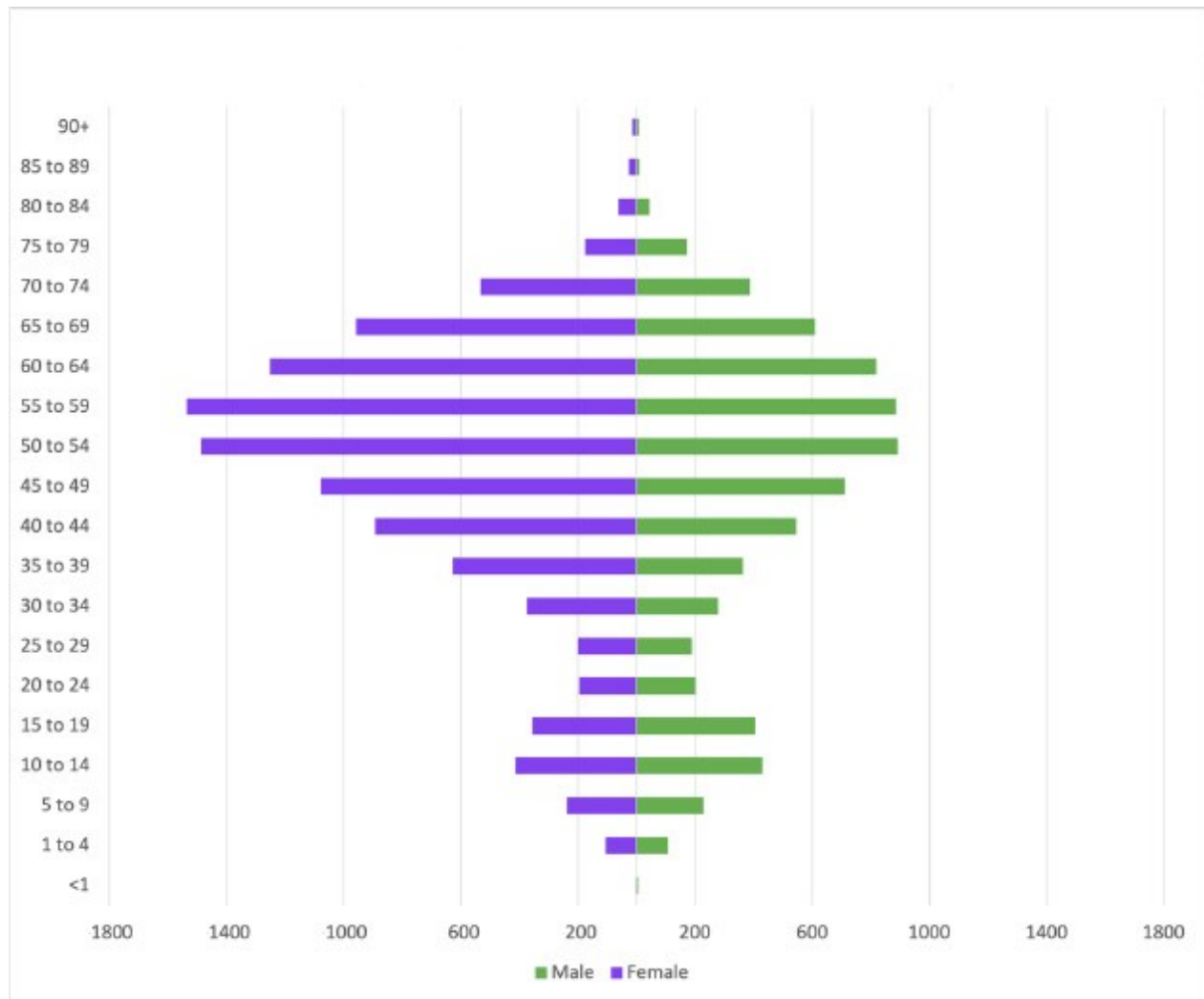


Figure 3. Age and biological sex distribution of cohort.

### ***BLOOD GROUP***

The blood groups and rhesus factors were reported by 51% of respondents, with expected variations between regions and almost twice as many females rather than males disclosing data (Table 2). Given prevalence of Caucasian ethnicities, the relative order of blood groups (most common to least common) was as expected, as follows:

O+ > A+ > O- > B+ > A- > AB+ > B- > AB.

**Table 2**  
**Blood Group by Biological Sex of Cohort**

Blood Group	Females		Males		Undisclosed		Total
	<i>n</i>	% of Total	<i>n</i>	% of Total	<i>n</i>	% of Total	
A-	436	7%	182	6%	6	9%	<b>624</b>
A+	1,778	29%	901	28%	24	34%	<b>2,703</b>
AB-	71	1%	33	1%	0	0%	<b>104</b>
AB+	265	4%	141	4%	2	3%	<b>408</b>
B-	145	2%	56	2%	0	0%	<b>201</b>
B+	598	10%	294	9%	5	7%	<b>897</b>
O-	665	11%	359	11%	5	7%	<b>1,029</b>
O+	2,235	36%	1,196	38%	28	40%	<b>3,459</b>
<b>Total Known Blood Group*</b>	<b>6,193</b>		<b>3,162</b>		<b>70</b>		<b>9,425</b>
<b>Not Disclosed</b>	<b>1,383</b>		<b>1,289</b>		<b>538</b>		<b>3,210</b>
<b>Unknown</b>	<b>2,946</b>		<b>2,842</b>		<b>74</b>		<b>5,862</b>

\*Respondents of undisclosed and unknown blood groups not included.

**PRIMARY REASON FOR NOT ELECTING TO RECEIVE COVID-19 “VACCINE”**

Table 3 lists, in descending order of frequency, the reasons judged most important by cohort respondents for deciding against COVID-19 injection. Respondents were able to select multiple reasons if they felt them to be of equal importance, so the denominator is larger than might be expected at 54,152.

The survey results suggest that five reasons were of almost equal significance (within a narrow range of only 1.4%), namely preference for natural medicine interventions, distrust of pharmaceutical

companies, distrust of government information, insufficient trial data, and concerns over long-term adverse

**Table 3**  
**Frequency Among Cohort Where the Listed Reason Was Reported to Be the Single Most Important for Declining COVID-19 “Vaccination”**

Reasons for Not Being “Vaccinated” for COVID-19	Respondents Who Judged This Reason Most Important	% of Total
Prefer natural medicine interventions	9,084	16.78%
Distrust of pharmaceutical interventions	8,896	16.43%
Distrust of government information	8,888	16.41%
Poor/limited trial study data	8,841	16.33%
Fear of long-term adverse reactions	8,348	15.42%
Fear of short-term adverse reactions	6,216	11.48%
Medical complications	2,376	4.39%
Previous vaccine injuries	1,503	2.78%
<b>Total</b>	<b>54,152</b>	<b>100.0%</b>

**Table 4**  
**Vaccination History for Cohort**

Reported Vaccination	<i>n</i>	% of Total
As a child	5,405	29.2%

reactions. Only 7% of respondents gave either medical complications or concerns stemming from previous vaccine injuries as the primary reason for COVID-19 “vaccine” avoidance.

In last 12 months	912	4.9%
Less than 5 years ago	2,837	15.3%
More than 5 years ago	6,246	33.8%
Never vaccinated	782	4.2%
Rather not disclose	2,315	12.5%
<b>Total</b>	<b>18,497</b>	<b>100.0%</b>

**HISTORY OF PAST VACCINATION**

Approximately one-third of the cohort reported having been vaccinated as children, while another one-third reported having not received any vaccine within the last 5 years (Table 4). The age groups from 20 years through to 84 years had the smallest proportions (2.0% to 2.9%) reporting that they had never been vaccinated. Conversely, as seen in Table 5, the youngest age group (0 to 19 years) reportedly were the least vaccinated (15.9%), this likely reflecting a growing distrust of vaccines among parents or/guardians within this cohort.

**Table 5  
Reported Vaccination History by Age Group**

<b>Age Range and % of Subtotal in that Particular Range</b>	<b>0-19</b>	<b>%</b>	<b>20-49</b>	<b>%</b>	<b>50-64</b>	<b>%</b>	<b>65-84</b>	<b>%</b>	<b>85+</b>	<b>%</b>
As a child	494	20.0%	1,957	33.5%	2,131	30.0%	810	26.8%	11	17.5%
More than 5 years ago	313	12.7%	1,956	33.4%	2,755	38.8%	1,200	39.8%	19	30.2%
Less than 5 years ago	567	23.0%	858	14.7%	967	13.6%	436	14.4%	9	14.3%
Rather not disclose	492	20.0%	671	11.5%	811	11.4%	327	10.8%	12	19.0%
In last 12 months	206	8.4%	238	4.1%	273	3.8%	185	6.1%	9	14.3%
Never vaccinated	392	15.9%	170	2.9%	157	2.2%	60	2.0%	3	4.8%
<b>Total</b>	<b>2,464</b>		<b>5,850</b>		<b>7,094</b>		<b>3,018</b>		<b>63</b>	

**FUTURE VACCINATION CHOICES**

Nearly two-thirds of the cohort (64.2%) reported that they would refuse all future vaccines of any type, with about one-fifth (22.5%) choosing not to disclose their choices (Figure 4). Only 1.3% reported an interest in receiving flu vaccinations and less than 5% reported that they would receive “holiday vaccinations”. The choices were generally similar regardless of age group.

**WILLINGNESS TO DONATE BLOOD**

Around 60% of COVID-19 “unvaccinated” respondents, regardless of their blood group, indicated their willing to donate blood, these numbers being approximately three times greater than those who were either unwilling to do so, or who did not disclose any preference about giving blood (Figure 5). As might be

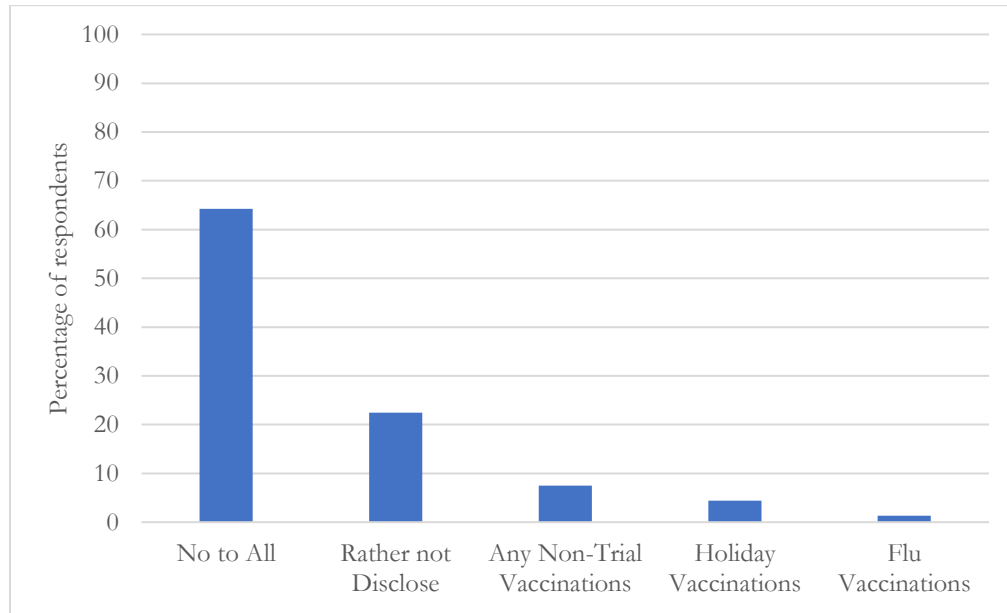


Figure 4. Responses to future vaccination choices for all age groups in cohort.

expected, given the random selection of respondents of any particular blood-type, there were no striking contrasts in willingness to donate blood across the various blood-types.

**RESPONDENTS REPORTING PRIOR COVID-19 DISEASE AT SURVEY COMMENCEMENT**

On average, 16% of the respondents who declared their biological sex ( $n = 2,845/17,802$ ) indicated they had experienced COVID-19 symptomatic disease. Respondents between the ages of 20 and 49 years

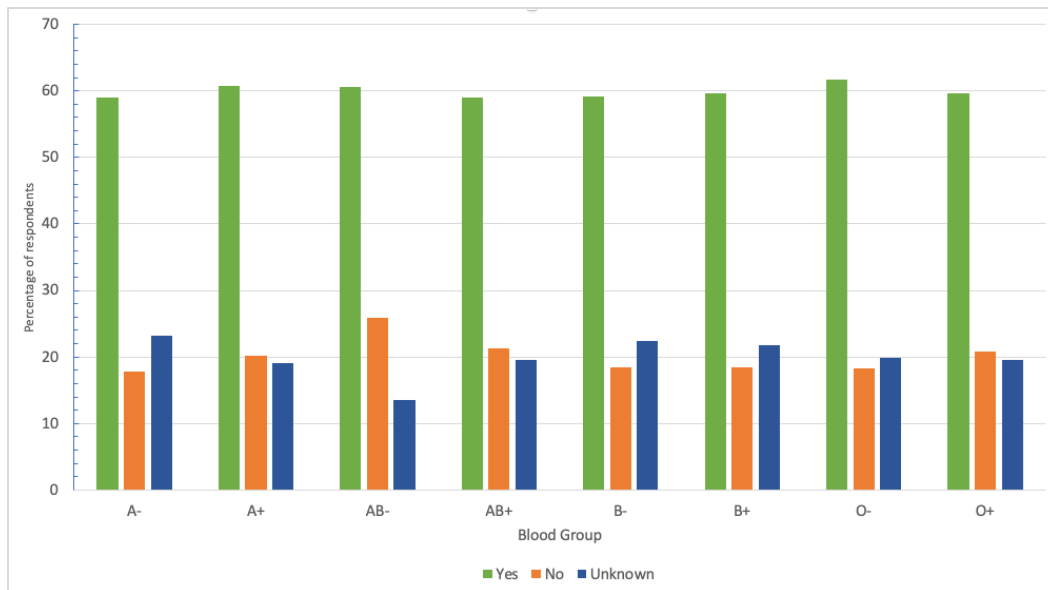


Figure 5. Percentage of respondents reporting willingness or otherwise to donate blood.

reported the greatest incidence of COVID-19 disease (19.6% females, 17.2% males) prior to the start of the survey (between February 2020 and September 2021), with females consistently reporting illness more often



than males regardless of age (Figure 6). Those at 70 and over reported the lowest incidence of COVID-19 disease (11.7% females, 11.2% males) prior to the survey period (Figure 6).

**REPORTED COVID-19 ANTIGEN TESTING OUTCOMES**

Nearly 20% of respondents aged 50 to 69 reported having received one or more positive tests while also experiencing symptoms, with only 1.9% in this same age range reporting positivity in the absence of symptoms (Figure 7). Those over 70 reported the lowest rate of positive tests, with all age groups reporting much greater rates of positivity with symptoms, rather than without (Figure 7).

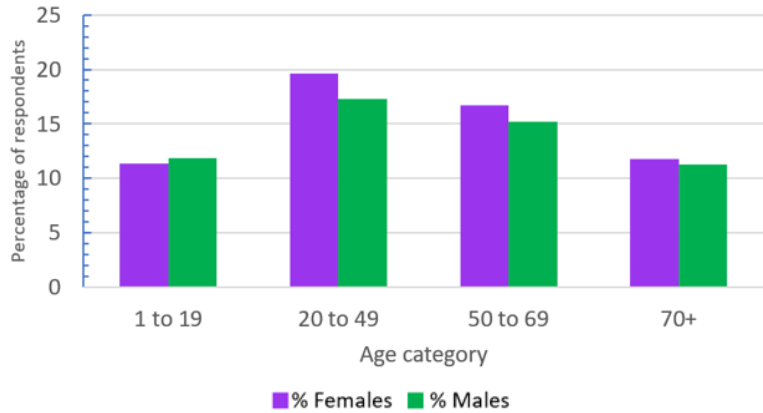


Figure 6. Percentage of respondents by age band reporting COVID-19 disease prior to survey, where *n* is the number of declared females and males in each age band. Total number of males plus females per age band was 0y to 19y, 2,283; 20y to 49y, 5,656; 50y to 69y, 8,432; 70y+, 1,432.

**SARS-COV-2 NEUTRALIZING ANTIBODIES**

Over 1 in 5 (23.5%) respondents in the survey cohort between the ages of 50 and 69 reported having been “positive” for SARS-CoV-2 (neutralizing) antibodies at the time of registration, although only 8.3% of these were confirmed with serology assays (measuring IgG antibodies specific to the nucleocapsid protein, most commonly in the 50 to 69 year age band (Figure 8).

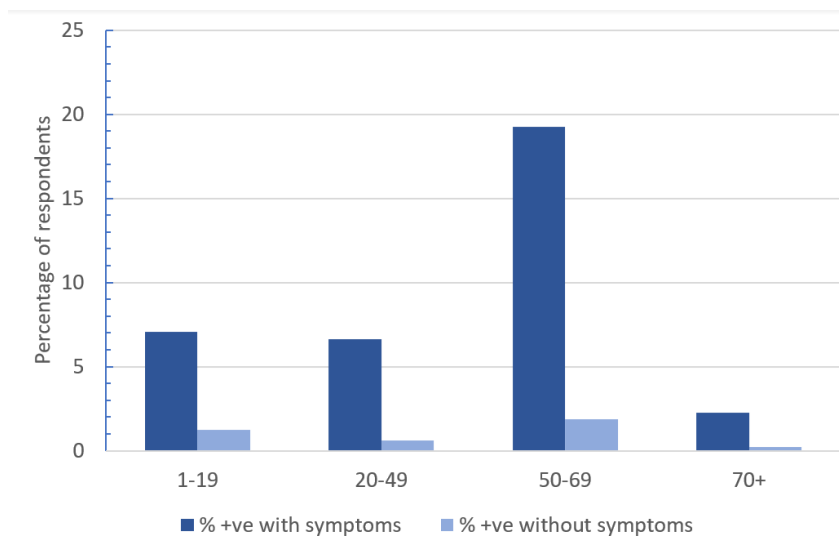


Figure 7. Percentage of respondents reporting positive antigen tests both with and without COVID-19 symptoms. Total number (*n*) of male + female per age band: 1y to 19y, 2283; 20y to 49y, 5656; 50y to 69y, 8432; 70+y, 1432.

## Survey findings: Reported Outcomes, Choices and Attitudes

This section summarizes findings from data collated from respondents during the ongoing monthly survey responses (Supplementary Information; Annex 2).

### REPORTED COVID-19 DISEASE BY AGE GROUP AND MONTH

The greatest incidence of reported COVID-19 disease was in January 2022, with a clear escalation which mirrors the generalized, global displacement of the dominant circulating SARS-CoV-2 variant from Delta to Omicron, especially during the European winter (where respondent numbers were greatest). Most respondents reporting COVID-19 during the survey were in the

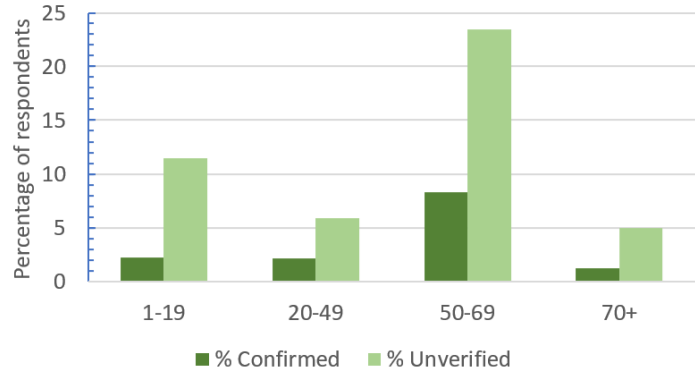


Figure 8. Reported “positive” serology (SARS-CoV-2 neutralizing antibodies) by age group. Total number (n) of male + female per age band: 1-19y, 2283; 20-49y, 5656; 50-69y, 8432; 70+y, 1432.

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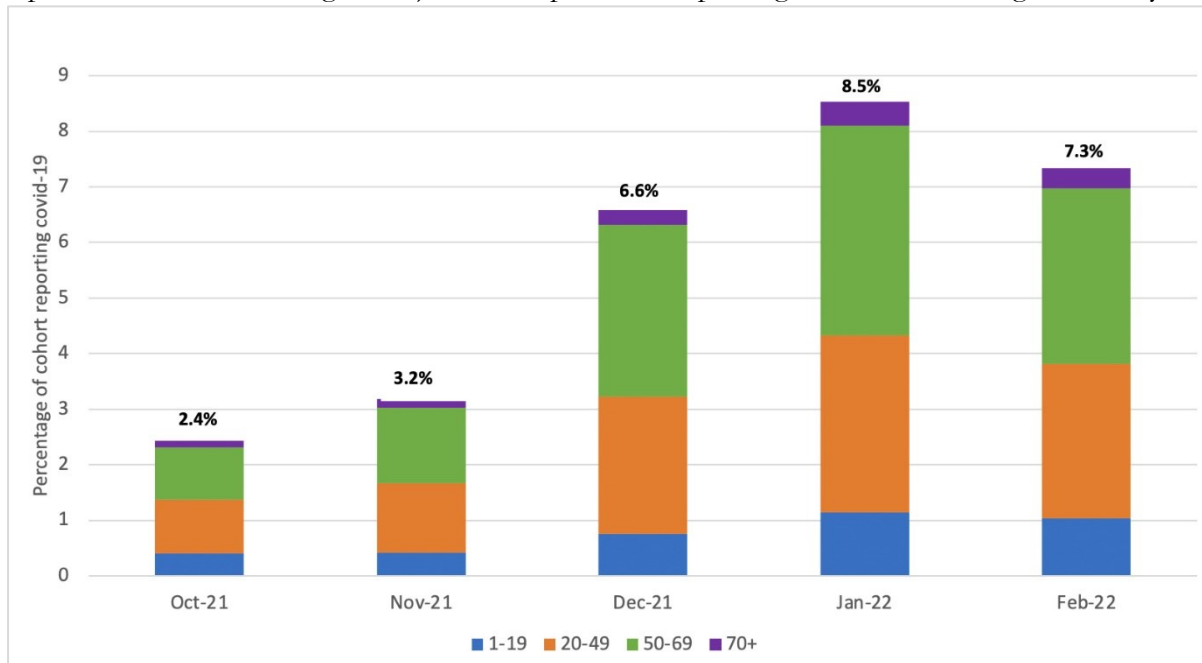


Figure 9. Monthly distribution of respondents reporting COVID-19 disease in cohort including age band distribution (note: some respondents will have reported disease in two consecutive months (13% reporting COVID-19 disease were symptomatic for more than 3 weeks; 64% for less than 1 week).

middle age bands (20 to 69 years inclusive) (Figure 9). In terms of age bands, the 50 to 69 years age range reported the highest incidence of COVID-19 disease (12.3% of respondents), followed by the 20 to 49 year group (10.7%), with considerably lower reporting (1.3% to 3.8%) of suspected or confirmed COVID-19 disease among both the youngest and oldest age bands (Figure 10).

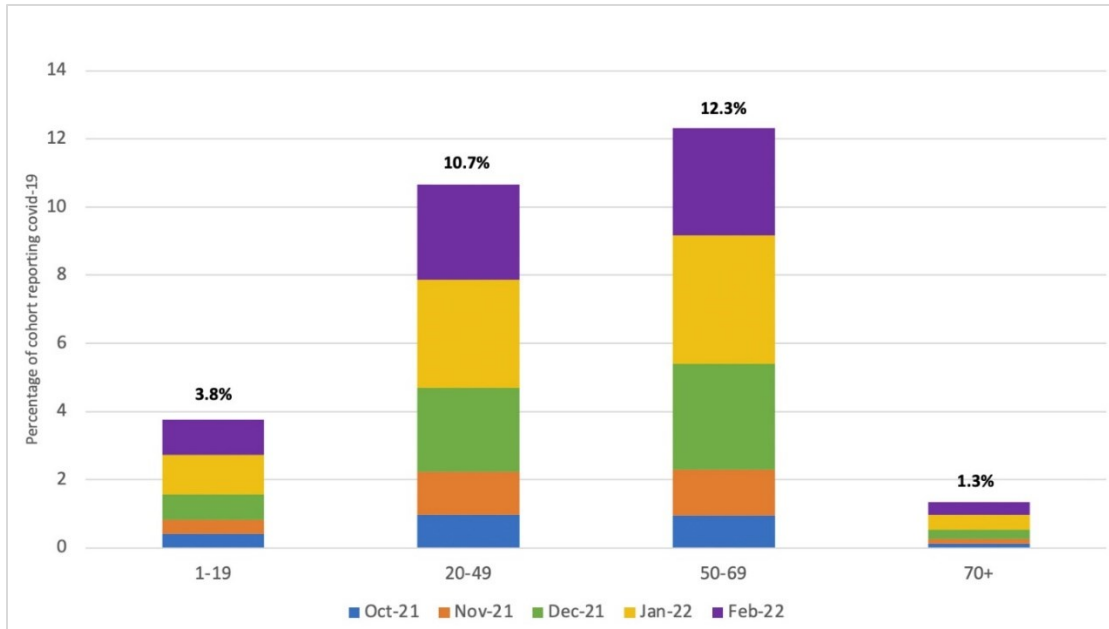


Figure 10. Incidence of reported COVID-19 disease by age band with proportion affected in each month of survey.

### SEVERITY OF COVID-19 SYMPTOMS

On average, one quarter (25.1%) of the survey cohort reported symptomatic disease ( $n = 4,636$ ) at some

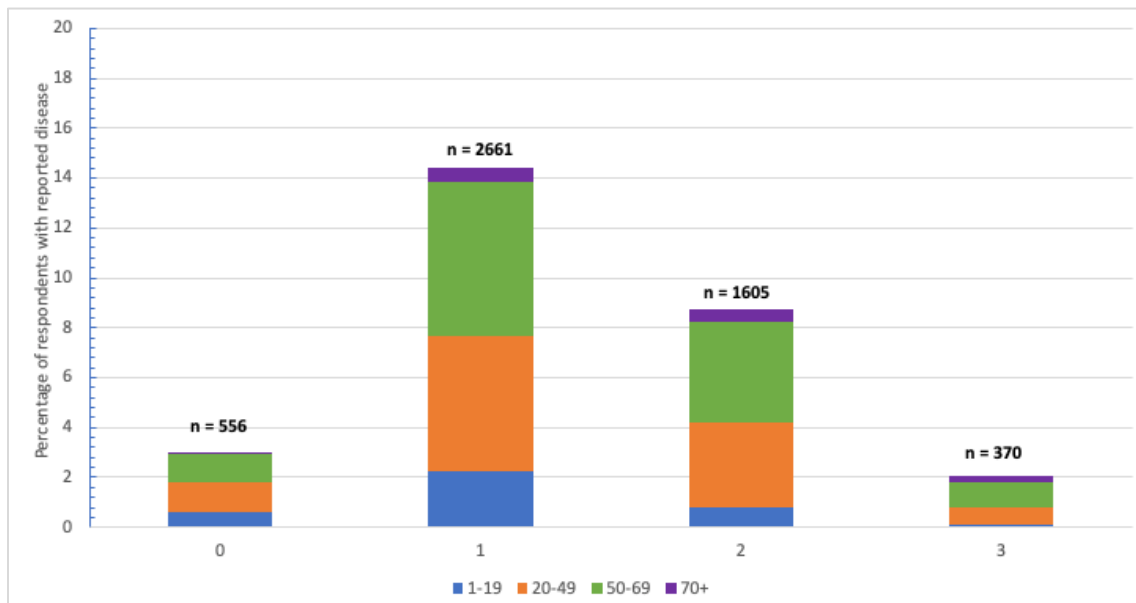


Figure 11. Reported severity of COVID-19 disease among those with known or suspected SARS-CoV-2 as a proportion by age band: 0 = asymptomatic, 1 = mild symptoms, 2 = moderate symptoms, and 3 = severe.

stage during the survey period. Most of the reported symptoms were rated as mild (14.4%), 8.7% were reportedly moderate and just 2% were reported as severe (based on raw data shown in summary form in

Figure 11). Some 3% reported asymptomatic disease. The 50 to 69 age band reported the highest incidences of disease of all severity levels (Figure 11). Please bear in mind, however, that self-reported severity of symptoms may have been over-reported (see Table 6) by the largely lay participants and so should not be regarded as directly comparable with data from health authorities, clinical trials, or hospital data. Of those with reported symptomatic COVID-19 disease, nearly half

(44.6%) were in the age band 50 to 69 years, COVID-sick or 54% 20% than 3

“Fatigue”

COVID-19 disease, closely followed by “cough” and “muscle or body aches”. Symptom ranking by frequency of reports is shown in Table 7. Most symptoms were reported among the 50 to 69 year age band, with between 1 and 3 symptoms being most commonly reported in all age classes. In the youngest age class (1 to 19 years), there were proportionately fewer respondents reporting 4 to 6 symptoms compared with the other three age classes (Figure 12). There was relatively little variation in the frequency of reporting of the 8 different symptoms, as shown in Figure 13.

#### **REPORTED WITHIN-HOUSEHOLD TRANSMISSION**

More than twice (2.2 times) the number of respondents with suspected or known SARS-CoV-2 infection indicated that other family members within the same household had also suffered COVID-19 disease, compared with those who did not report disease. However, of these, nearly one-third (31%,  $n = 1,435$ ) indicated that no other family members in the same household had become ill.

**Table 6**  
**Reported Duration of Sickness Following Suspected or Known SARS-CoV-2 Infection**

Health status	<i>n</i>	%
Generally well	649	14.4%
Sick less than 1 week	2,440	54.3%
Sick 1-2 weeks	902	20.1%
Sick 3 weeks or more	505	11.2%
<b>Total</b>	<b>4,496</b>	

years, followed by 37.8%, 12.5% and 5.1% for bands 20 to 49 years, 1 to 19 years, and 70+ respectively. When patients reporting 19 symptoms were asked how long they were unwell, of those who answered ( $n = 4,496$ ), indicated they were sick for less than a week, between 1 and 2 weeks, and 11% for more weeks (Table 6).

#### **SYMPTOMS IN RELATION TO AGE**

was the most commonly reported symptom of

**Table 7**  
**Ranking Symptoms by Report Frequency During Survey Period**

Symptom	Number Reporting	Rank
Fatigue	4,786	1
Cough	4,305	2
Muscle or body aches	4,296	3
Fever	3,613	4
Loss of taste	1,846	5
Loss of smell	1,791	6
Difficulty breathing	1,346	7
Diarrhea	915	8

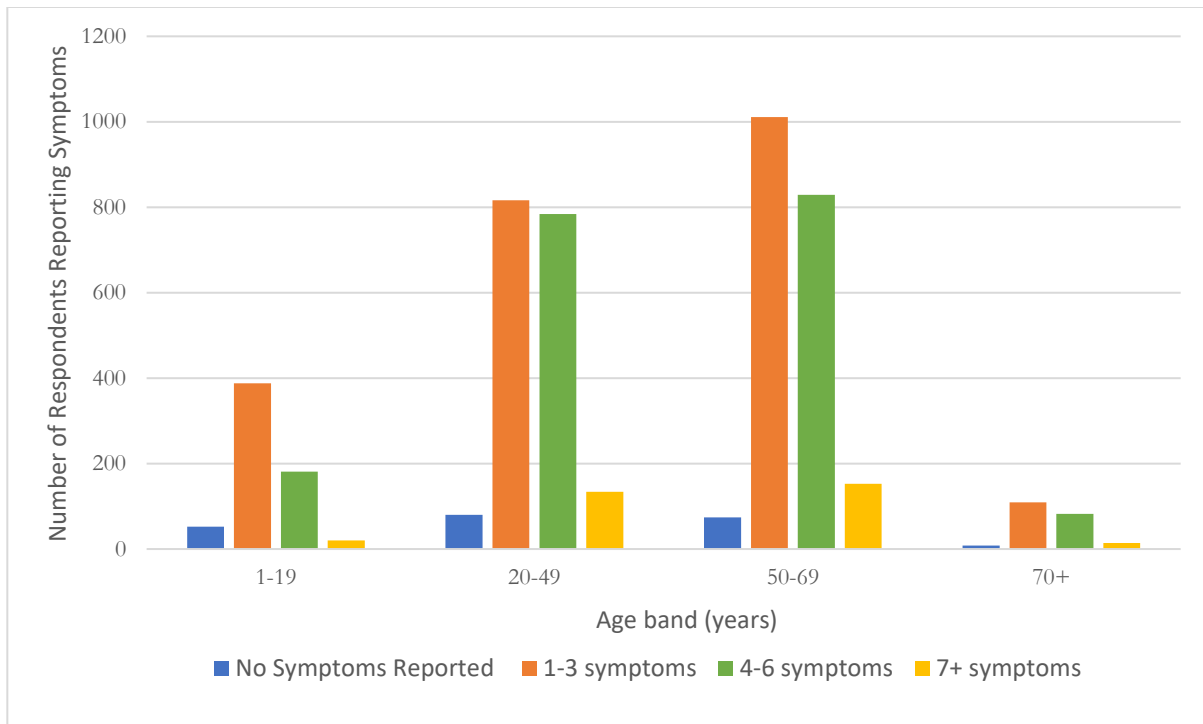


Figure 12. COVID-19 symptoms reported by age band in those with suspected or known COVID-19.

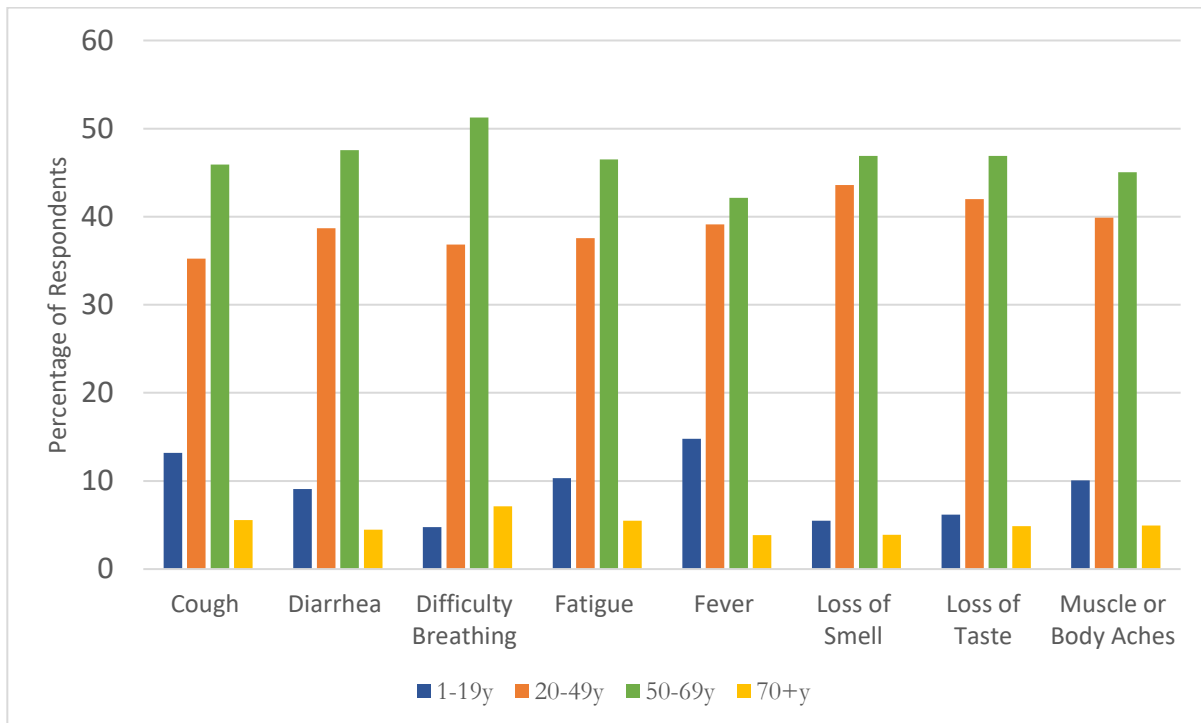


Figure 13. Symptoms reported by respondents in 4 age bands (color coded) with known or suspected COVID-19.

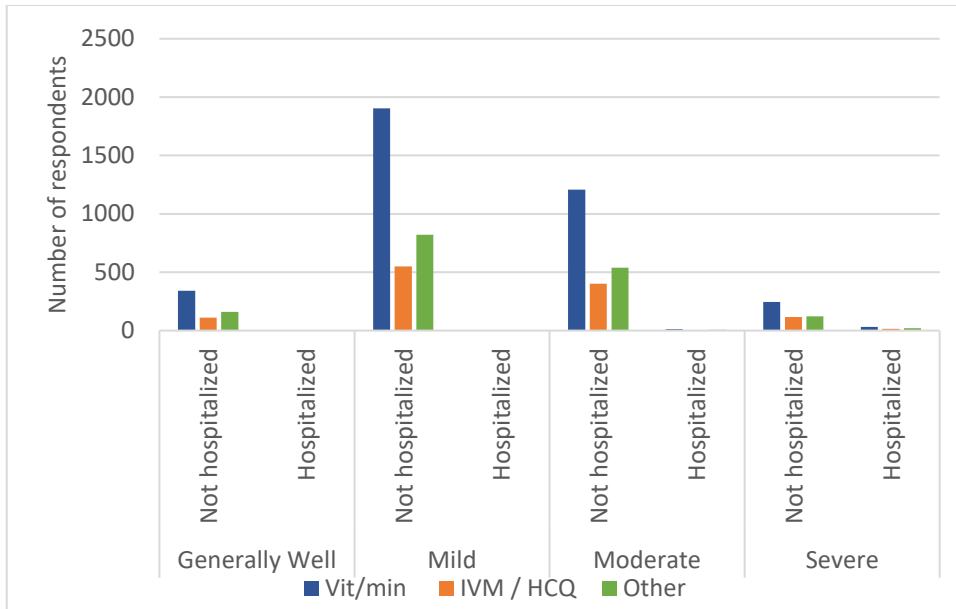


Figure 14. Respondents reporting COVID-19 disease who self-administered vitamins C and D and zinc (=Vit/min), off-label medications (ivermectin [IVM] or hydroxychloroquine [HCQ]) (=IVM/HCQ), or other products or medications (=Other) during the survey period.

### HOSPITALIZATIONS

Only 74 respondents out of the 5,196 (1.4%) who reported suspected or known SARS-CoV-2 infection also reported that they were hospitalized following infection. Therefore, outpatient or inpatient hospitalization was reported in just 0.4% of the full survey cohort. Of these, 15 were outpatient only, another 15 were hospitalized for less than 3 days, 26 were hospitalized between 3 and 7 days, 11 for between 7 and 14 days, and only 10 for more than 14 days. These numbers are overestimated because, in some cases, a single individual made more than one visit to the hospital.

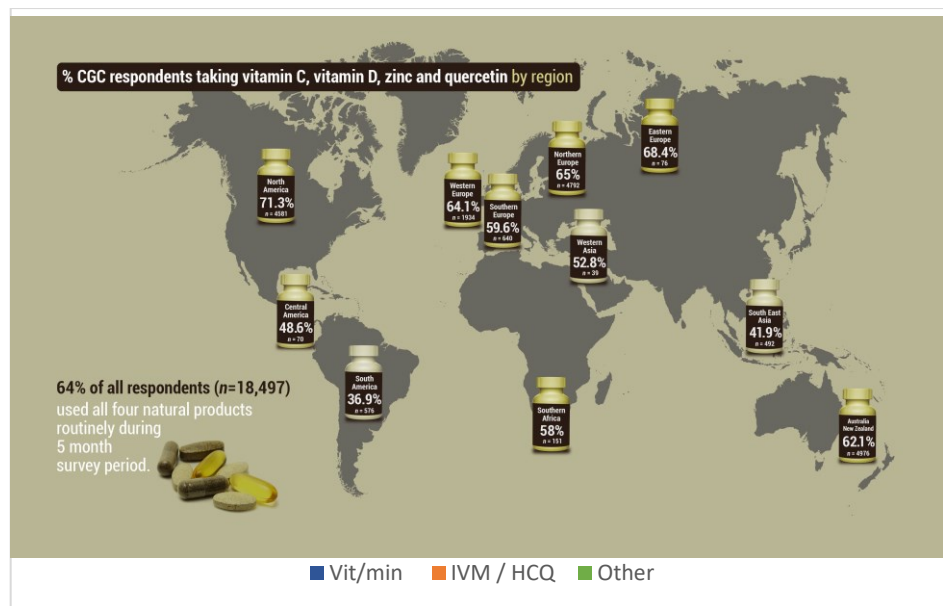


Figure 15. Respondents reporting COVID-19 disease who self-administered vitamins C and D and zinc (=Vit/min), off-label medications (ivermectin [IVM] or hydroxychloroquine [HCQ]) (=IVM/HCQ), or other products or medications (=Other) during the survey period.

### ***SELF-ADMINISTERED TREATMENTS AMONG COVID-19 PATIENTS***

The majority of respondents with suspected or confirmed COVID-19 engaged in self-administered treatments using vitamins (C, D), minerals (zinc) and off-label medications (Ivermectin [IVM] and Hydroxychloroquine [HCQ]) during the 5-month survey period. Vitamins C, D, and zinc were the most common self-administered treatments reported by those with COVID-19 disease, with some 71% of the survey cohort ( $n = 3,701$  out of 5,196) reporting consumption. Self-administration of these treatments or supportive nutrients was much lower in a hospital setting than at home and declined in frequency as symptom severity increased (Figure 14).

### ***DIETARY SUPPLEMENT USE AMONG COHORT***

Sixty-four percent of all respondents reported taking vitamin C, vitamin D, zinc or quercetin, or any combination of these, routinely during the survey period for preventative purposes (Figure 15). Among those taking supplements routinely, vitamin D was the most commonly consumed (53.3% of respondents), closely followed by vitamin C (51.7%), in turn followed by zinc (42.4%), with quercetin being the least used (15.5%) of the four. Supplement used in North America (USA and Canada) exceeded their use in other parts of the world (Figure 15).

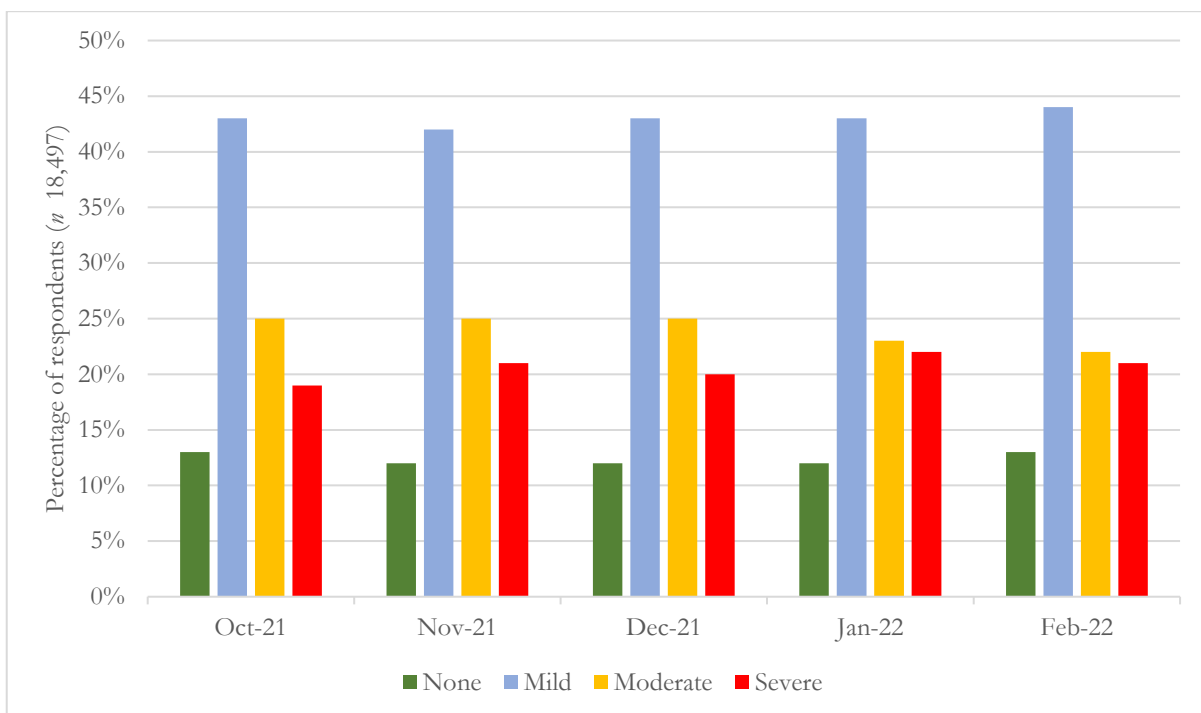


Figure 16. Percentage of cohort reporting no, mild, moderate or severe mental issues during each month of the survey based on a subjective scale (1 to 10), where severity of mental issues was categorized as follows: 10 = none; 7 to 9 = mild; 4 to 6 = moderate, and 1 to 3 = severe.

### ***MENTAL HEALTH***

Mental health status was self-assessed monthly on a subjective scale of 1 to 10. A rating of 10 was assigned the meaning that “life is great” (i.e., no mental health issues) and 1 meant the opposite, “feeling there is no hope”. Over the 5 months, on average only 12% of the participants selected 10 (the “life is great” level).

There was little change in responses during the survey period (Figure 16). While more than 4 in 10 participants reported mild mental health issues, more than 2 in 10 reported moderate issues, and nearly 2 in 10 severe issues (Figure 16).

During the 5-month survey period, around half the respondents reported sustained mild mental health issues, the reports being highest for the oldest and youngest age bands. Reports of moderate mental health issues dropped to around 3 to 4 in 10, with reports then being higher among the intermediate age bands. About 2 in 10 in each age band reported severe, sustained discouragement, i.e., feeling there was no hope (Figure 17).

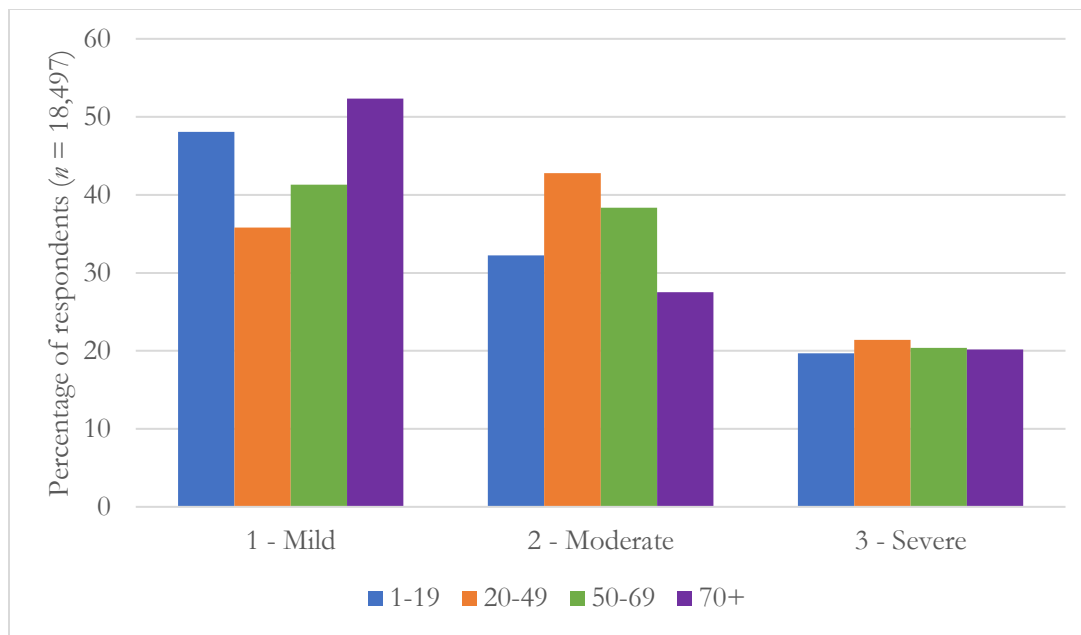


Figure 17. Proportion of respondents reporting mental health issues by age band.

### ***BLEEDING ABNORMALITIES***

There were significant numbers of reports of unusual bleeding among the non-COVID-19 “vaccinated” women in the cohort, particularly those in the age band, representing the highest proportion of menstruating women, ages 20 to 49 (Figure 18). The most commonly reported named menstrual abnormality was irregular periods (1,210 reports) among the 20 to 49 year age band, this representing 36% of women in the age band.



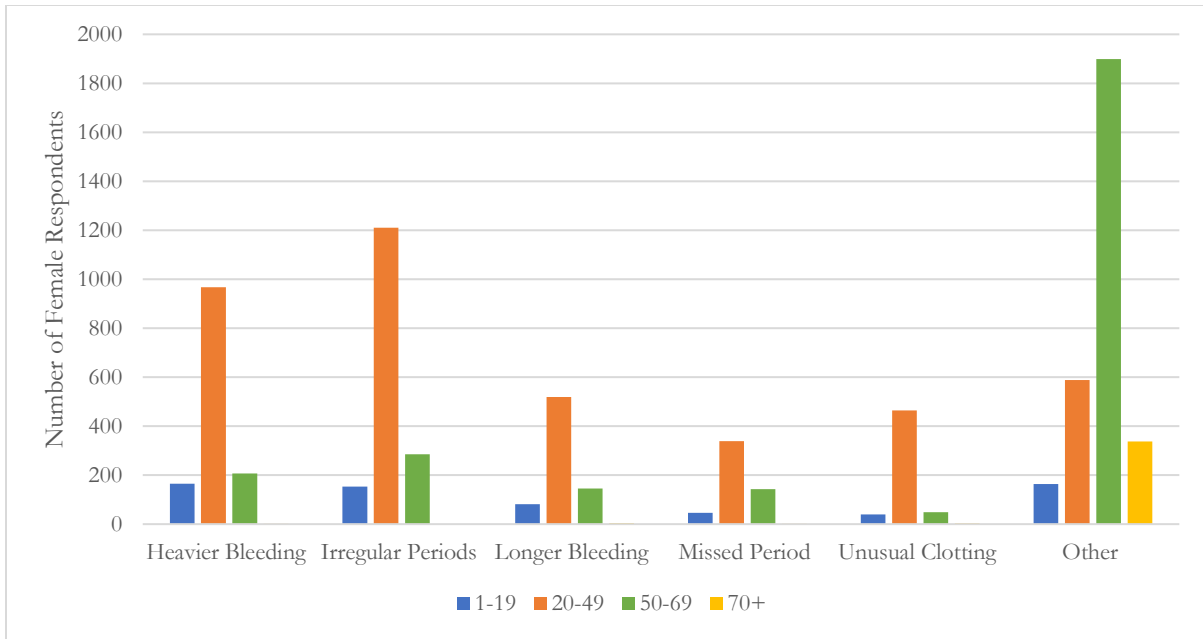


Figure 18. Number of female respondents reporting menstrual or other bleeding abnormalities.

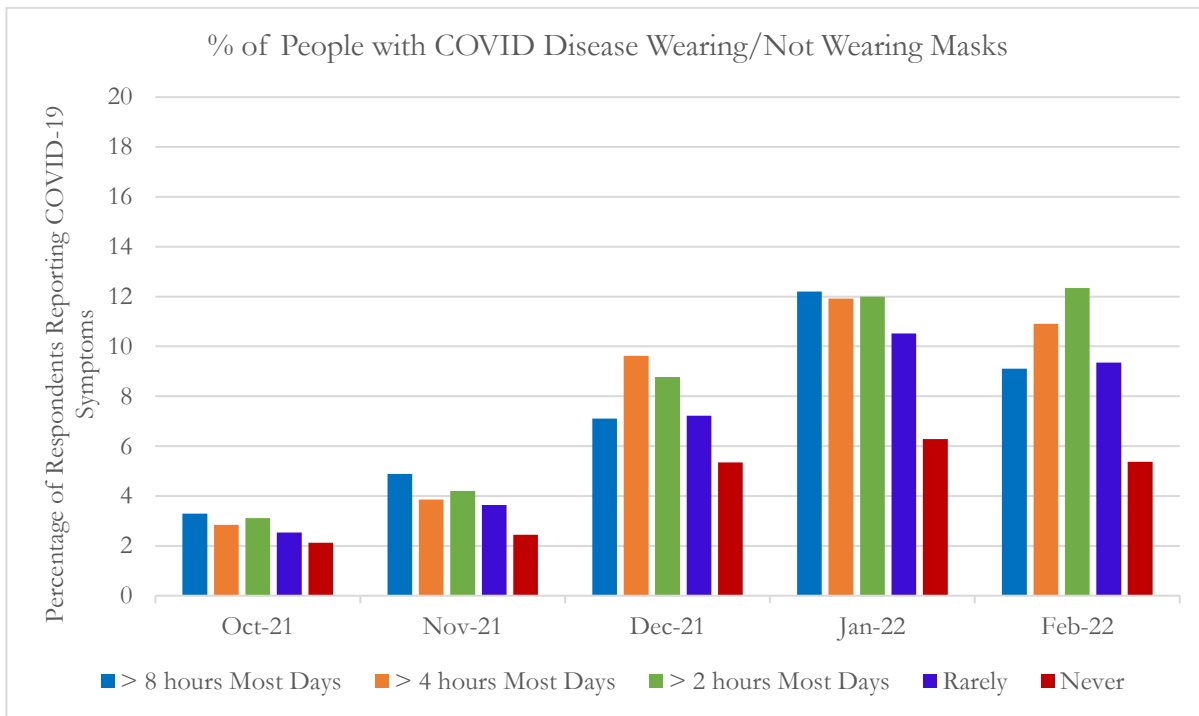


Figure 19. Percentage of respondents with known or suspected COVID-19 disease according to their mask wearing habit over the 5 months of the survey. Number of female respondents reporting menstrual or other bleeding abnormalities.

Additionally, 12.0% of female respondents reported unusual nosebleeds during the course of the survey, compared with 4.7% of men. This difference between females and males was even more pronounced for reports of unspecified unusual bruising, which was reported by 12.7% of females, but just 1.7% of males (all age groups).

## WEARING OF MASKS OR FACE COVERINGS

In October and November 2021 (before the Omicron variant surged around the world) there were only slight variations associated with different durations of wearing masks or face coverings (Figure 19). The only consistent trend revealed throughout the survey period was that those who reported never wearing a mask or face covering, consistently reported the lowest incidence of COVID-19 symptoms. These data do not provide information on any causal association between mask wearing and COVID-19 disease incidence given the wide range of uncontrolled behavioral and other factors known or suspected of being involved as confounding variables.

## JOB LOSSES

For our estimates of the proportion of persons who reported a job loss, we focused on the ages of 20 to 69, inclusive, as the primary working age range (Figure 20). The greatest reported job losses were reported in Australia and New Zealand ( $n = 1,097$ ; 29% of respondents). This rate was more than double that reported in North America ( $n = 467$ ; 13%), and much greater than that from the areas with the next highest losses, namely Southern Europe ( $n = 73$ ; 13%) and South East Asia ( $n = 39$ ; 12%).

Among the occupations affected by job losses, teachers were the most common, followed by nurses, those declared as self-employed, support workers, and social workers.

## DISCRIMINATION

The survey requested information about whether respondents had faced discrimination personally by members of society, or by their state (country).

Between 20% and nearly 50% of respondents,

depending on region, reported being personal targets of hate, implying victimization, owing to their COVID-19 vaccination status (Figure 21). Proportionately, rates of such victimization were highest in Southern Europe and South America and lowest in Western Asia and Southern Africa (although the number of respondents in the latter regions were also substantially lower).

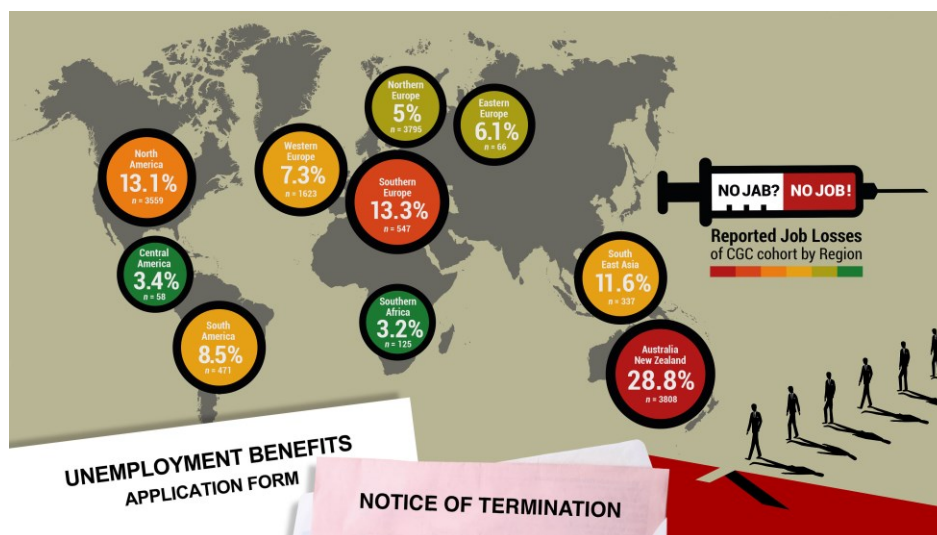


Figure 20. Job losses in different regions among the COVID-19 unvaccinated survey cohort as a proportion of respondents of working age (20 to 69 years).

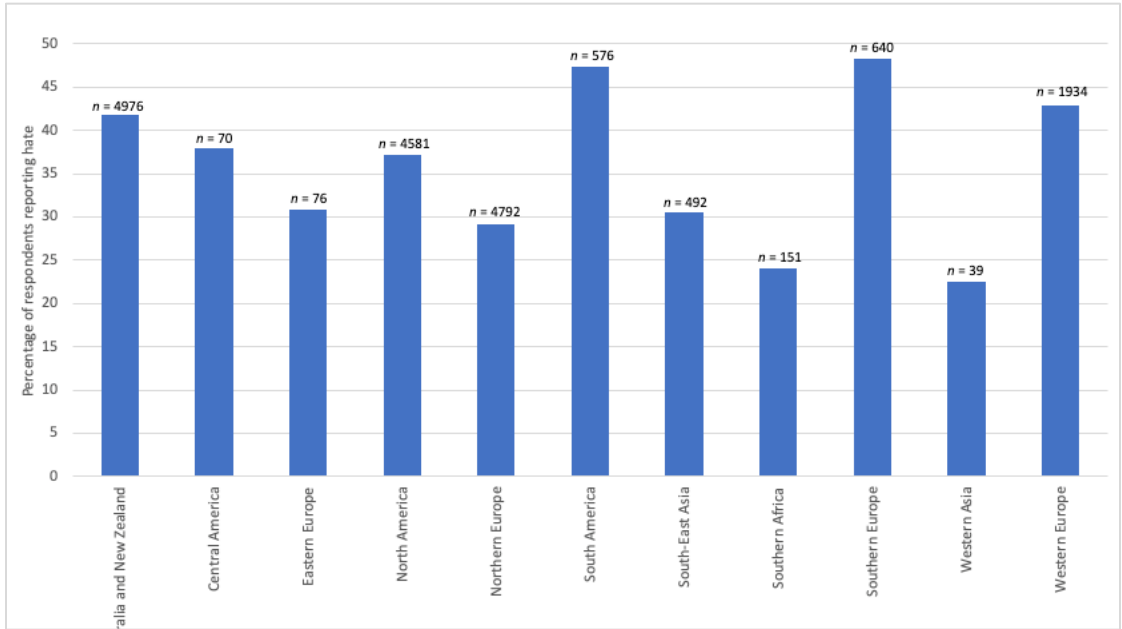


Figure 21. Percentage of respondents by region reporting hate or victimization during the 5-month survey period.

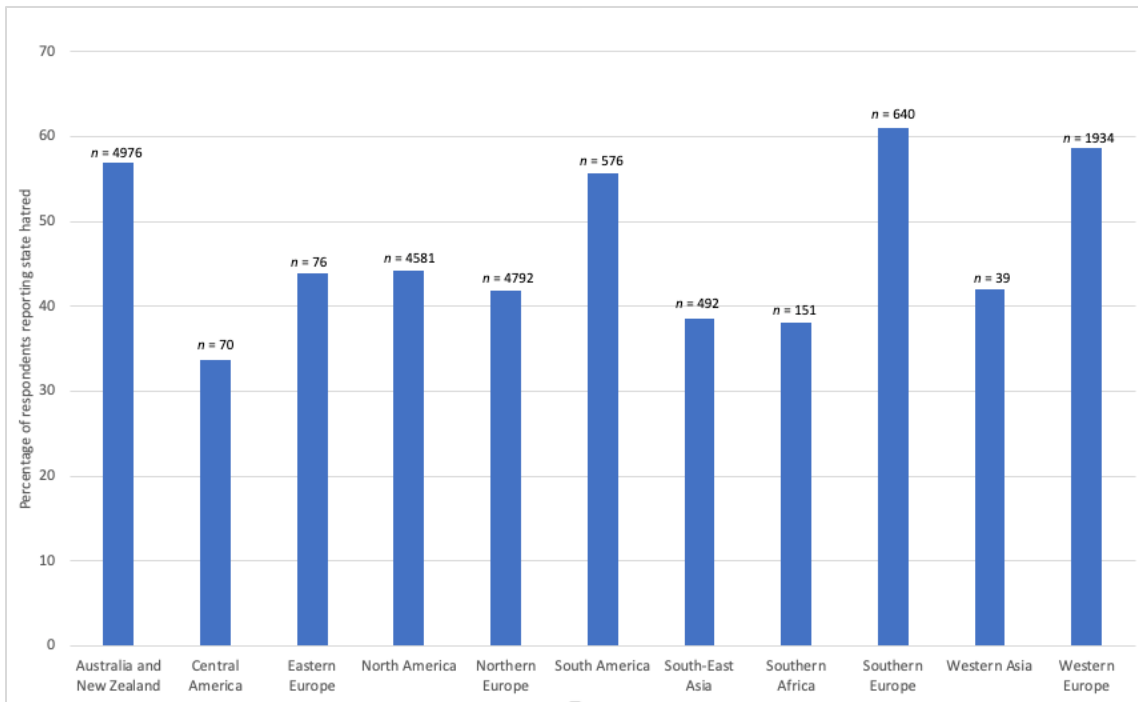


Figure 22. Reported state victimization of “unvaccinated” respondents.

As seen in Figure 22, respondents reported feeling even more victimized by the respective government authorities than by the non-state entities. Rates of perceived discrimination were greatest among respondents in Southern Europe (61%), Western Europe (59%), Australia and New Zealand (57%), and South America (57%).

## Discussion

As soon as COVID-19 intra-muscular genetic injections were issued with emergency use authorization by national regulatory authorities towards the end of 2020, coercive and pervasive pressure was placed on populations to receive them, starting with the oldest and most vulnerable, despite evidence from influenza vaccination programs that immunosenescent people and those with multiple comorbidities are those least able to mount an effective immune response (Anderson et al., 2020). The novel “genetic vaccines” all relied exclusively on an mRNA (e.g. Pfizer, Moderna) or indirectly on mRNA spike protein through an adenoviral vector (e.g. AstraZeneca, Institute of Virology, Johnson & Johnson) platform (Heinz & Stiasny, 2021; see also Oller & Santiago, 2022 in this issue, and their sources).

Large numbers of people in different parts of the world have chosen to avoid COVID-19 injections. Such dissenters have been stigmatized and marginalized by mainstream society, being referred to variously, as “anti-vaxxers”, “conspiracy theorists” or “refuseniks”. At the time of writing, Our World in Data (2022) reveals that 35% of the world population has yet to receive any COVID-19 injections, this number rising to 84% in low-income countries. The same database suggests 77% of the population of the African continent, equating to over 1 billion people, and nearly 31% of Europeans, equating to some 232 million people, have not received any COVID-19 injections. The proportion (and population sizes) not yet COVID-19 “vaccinated” in other regions are as follows: USA 22% (73 million); Canada 14% (5.3 million), and Australia 13% (3.3 million) (data source: Our World in Data compiled by Ritchie et al., 2022). As noted earlier, to account for their rejection of COVID-19 injections, the CGC participants in the present survey most frequently reported distrust of health authorities, governments or the pharmaceutical industry, insufficient evidence of safety or effectiveness, and concerns over injuries or potential adverse reactions.

Since the mass roll-out of experimental products was initiated in late 2020, the products have been found to deliver very little protection against transmission of the current, dominant, circulating, Omicron variant (Amanatidou et al., 2022; Hachmann et al., 2022). These and similar findings have led to mounting distrust by the public. The underlying reasons seems to be the reluctance of government authorities and the mainstream press to make the narrative consistent with emerging consensus of actual scientific information.

There is a substantial and growing body of evidence suggesting that individuals relying on naturally-acquired immunity develop broader and more robust immunity to SARS-CoV-2 and its variants than those relying on the experimental genetic “vaccines” (Gazit et al., 2021; Turner et al., 2021; Cohen et al., 2021). Such naturally-acquired immunity is likely to play a key role in dampening the host-pathogen population dynamics of the novel virus, as well as reducing the evolutionary pressure on the development of potentially more virulent and transmissible variants (Koyama et al., 2022).

There is also no currently relevant scientific evidence suggesting that COVID-19 vaccines can achieve herd immunity. The World Health Organization (WHO) updated its definition of herd immunity on 31 December 2020, with the aim of prioritizing vaccination over granting naturally-acquired immunity:

WHO supports achieving “herd immunity” through vaccination, not by allowing a disease to spread through any segment of the population, as this would result in unnecessary cases and deaths (World Health Organization, 2020).

This redefinition is misleading in relation to COVID-19 given that currently available vaccines would need to be able to sterilize infection and stop transmission.

Not only do current variants escape vaccine-induced, IgG neutralizing antibodies (Hachmann et al., 2022), immunologic effectiveness against infection was found to wane rapidly, within a few weeks or months at most (Israel et al., 2022; Ferdinands et al., 2022). Such waning has encouraged health authorities to

recommend regular administration of COVID-19 injections, for example at 6-month intervals, in the absence of any prior safety trials.

The lack of a scientific basis for COVID-19 vaccination means that stigmatizing individuals who exercise their right to informed choice is unethical (Kampf, 2021). Jonathan Pugh and colleagues from the Faculty of Philosophy at the University of Oxford, argued the following in the *Journal of Medical Ethics*:

Without compelling evidence for the superiority of vaccine-induced immunity, it cannot be deemed necessary to require vaccination for those with natural immunity (Pugh et al., 2022).

It follows, therefore, that discrimination against individuals who have elected to invoke natural immunity, in place of vaccine-induced immunity, is unjust.

The data from the first 5 months of the CGC survey suggest that COVID-19 “unvaccinated” populations have not placed a significant additional burden on healthcare systems in their respective countries. In the UK, official data reveal that 33% of the population tested positive via either PCR or lateral flow tests during the whole pandemic to-date, with the highest case rates occurring in late 2021 and early 2022 during the period of the CGC survey (GOV.UK, 2022a). While some 25% of CGC survey respondents reported symptomatic COVID-19 disease during the 5 months of the survey, the incidence of disease does not itself indicate the burden on healthcare systems or society; the latter are better assessed by hospitalization rates and mortality (there were no CGC data available for the latter). However, UK data (GOV.UK, 2022b) for hospitalizations reveals that 189,525 patients were hospitalized during the survey period, this equating to 0.3% of the UK population.

The COVID-19 disease burden for the USA was estimated by the US Centers for Disease Control and Prevention (CDC) for the period February 2020 to September 2021 (CDC, 2022). The estimate included 124 million cases of symptomatic illness, 7.5 million hospitalizations and 921,000 deaths. This equates, following a *pro rata* adjustment to include mean data over a 5-month period to match the survey period of CGC, an average of 10.4% of the US population had symptomatic disease, 0.6% of the US population was hospitalized, and 0.3% died with COVID-19 on their death certificate. By comparison, 25% of the self-selected, self-reported, CGC population sample reported symptomatic disease (suspected or confirmed), with just 0.4% of the cohort (one-third less than the adjusted CDC estimate) reporting one or more visits to hospital (as inpatients or outpatients). The CGC survey could not report on mortality given the self-reporting nature of data collection.

The adjusted CDC estimates and the CGC survey data should be compared with caution as they originate from different regions of the world: they have been derived from different time periods, and the CDC includes different proportions of “vaccinated” and “unvaccinated” over the 19 months of its collection, and both datasets relied on different reporting systems. However, it is of interest that the CGC cohort included a period (October 2021 to February 2022, inclusive) with the highest rates of SARS-CoV-2 infection in many parts of the world, including North America and Europe, during the first Omicron wave.

Based on an analysis of UK case data for the survey reporting period (GOV.UK, 2022a), some 15% of the UK population were defined as COVID-19 “cases” based on antigen testing, this figure likely being an under-estimate of the real figure given it includes only those cases assessed by an antigen test.

While the number in the CGC cohort reported to have experienced symptomatic disease is substantially greater than the UK figure of 15% for the same period as the survey, the difference was likely magnified because the majority of the CGC cases were suspected, rather than confirmed, cases, and so were more likely to have been reported. Most cases resolved rapidly as reflected by the 64% of those who reported COVID-19 disease indicating that they were symptomatic for less than one week. Cases manifesting as

symptomatic disease among the CGC cohort were greatest among people in the age band from 50 to 69 years, which likely reflects age-dependent manifestation of disease (Omori et al., 2020), as well as shielding among the oldest, potentially most vulnerable, age group.

Almost 3 out of 4 CGC respondents who had COVID-19 engaged in self-care using vitamins (D and C), minerals (notably zinc) and/or quercetin. Reported self-administration of these micronutrients, as well as Ivermectin and Hydroxychloroquine, dropped off dramatically for those who were hospitalized, presumably at least in part because of lack of support for use of natural products in hospital settings (a phenomenon that has been widely reported to the authors anecdotally). The percentage of populations engaging in preventative self-care using dietary supplements containing vitamins C, D, zinc, or quercetin was highest in the USA at 71% of respondents, and somewhat lower, but still high (60% to 65%), in Europe, Australia and New Zealand.

These data compare favourably with the 47% of UK users of the Zoe app in the COVID-19 Symptom Study ( $n = 372,720$ ) who reported using dietary supplements (Louca et al., 2021). This latter study found modest reductions in risk of infection (9% to 14%) among those routinely using vitamin D, multivitamins, omega-3 fatty acids, or probiotics.

Among the most surprising findings in this COVID-19 unvaccinated cohort were the commonly reported instances of menstrual disturbances and bleeding abnormalities in women. Such disturbances have been reported in the literature in association with COVID-19 disease (e.g. Sharp et al., 2021), lifestyle changes associated with the pandemic (Bruinvels et al., 2021), and particularly following COVID-19 vaccination (e.g. Alvergne et al., 2021; Trogstad, 2022). The disturbances reported in the survey are likely to be related to COVID-19 disease, but other factors such as shedding exposure, chronic stress and changes to lifestyles caused by restrictions and related measures, as well as chronic spike protein exposure (“spikopathy”) in domestic and occupational settings, could also have been involved.

A high proportion (around 40%) of respondents reported mental health issues during the reporting period. This was in line with the effects of ongoing chronic, psychological stress associated with the pandemic results, as found in other studies, 66 of which have been pooled as part of a comprehensive, global, systematic review and meta-analysis carried out by a group of Chinese researchers (Wu et al., 2021). Despite the avoidance of COVID-19 vaccines, the CGC cohort reported a surprisingly high mental health burden, comparable with the wider, largely “vaccinated” population (Dragioti et al., 2021). Given the reported discrimination in the workplace, by peers or by family members, as well as victimization by states (governments/health authorities) owing to “unvaccinated” status, the contribution of marginalization by mainstream society to the mental health burden of this COVID-19 unvaccinated cohort could be significant.

Contributory factors to this discriminatory treatment must also include: widespread misunderstandings about, and over-stated benefits of, COVID-19 “vaccines”; false claims over societal risks posed by the unvaccinated; misleading or plainly false media or state propaganda; coercion to ensure high rates of COVID-19 vaccination; institutional mandates; and the desire for in-group identity as explained by social identity theory (Scheepers & Derks, 2016).

In line with the scapegoating of those who have not consented to COVID-19 injection, it was also relevant that those respondents in the CGC survey who reported never wearing facial coverings or masks also experienced the lowest incidence of suspected or confirmed COVID-19 disease.

The scientific basis for the continued pressure on populations to receive COVID-19 “vaccines” and boosters remains elusive. There is still inadequate governmental and health authority recognition of the breadth and depth of injuries which are underreported to the Vaccine Adverse Event Reporting System

(VAERS) in the USA (refer to OpenVAERS [[www.openvaers.com](http://www.openvaers.com)] for summaries), the Medicines and Healthcare products Regulatory Agency (MHRA) Yellow Card system in the UK, EudraVigilance in Europe, and similar national reporting systems elsewhere.

Research by a German insurance company, BKK ProVita, suggested in February 2022 following its own analysis of available data that there is already a “violent alarm signal” in Germany which implies substantial underreporting of injection injuries by the responsible health authority, the Paul Ehrlich Institute. The findings suggest that between 4% and 5% of those to whom COVID-19 injections have been administered are engaging, or have engaged, with treatments to deal with COVID-19 injection injuries (Deutsche Wirtschaft Nachrichten, 2022), amounting to 2.5 to 3 million people in Germany (Phillips, 2022).

Unfortunately, given the desire to uphold the mainstream narrative that wrongly asserts that mass roll-out of COVID-19 “vaccines” is the only means of resolving the pandemic, the executive responsible for disclosing these findings, Andreas Schöfbeck, was sacked by BKK (Deutsche Wirtschaftsnachrichten, 2022). This is another stark reminder of “mass formation” also known as “group hypnosis” (Desmet, 2022) which includes the discriminatory consequences of speaking out against the mainstream narrative even where ample supporting data are available and the communication is in the public interest. Findings from Israel also suggest the scale of COVID-19 injection injuries, and the need for medical support for those affected, is much greater than has been reported (Guetzkow, 2022).

Thus, when comparing health system burdens between COVID-19 “vaccinated” and ever more constrained “unvaccinated” (control) populations, the short- and long-term impacts of injection-related injuries needs to be taken into account. It seems there has been a coordinated effort by vaccine manufacturers and by the associated Phase 3 clinical-trial-study-teams to remove data that allows comparison of outcomes between COVID-19 injected and un-injected (control) populations. The release of Pfizer data (322 documents at the time of writing) following the successful legal action in the USA by Public Health and Medical Professionals for Transparency ([phmpt.org](http://phmpt.org)), with which the authors are associated, we expect will over the course of time confirm the misleading nature of the “safety and effectiveness” claims made by health authorities and vaccine manufacturers for the COVID-19 injections.

The findings from the present survey have four main limitations; 1) the respondents are self-selected and therefore not randomly selected; 2) there has been no attempt to collect similar data from “control” populations that contain individuals who have consented to one or more COVID-19 vaccines of different types; 3) the data are self-reported and therefore have not been verified independently, and; 4) the questionnaire design is limited and does not account for multiple variables that affect health status, such as socioeconomic status, urban, peri-urban or rural residence, cultural differences, diet, or lifestyle.

## Conclusions

Overall, the survey findings suggest there is no adequate basis to believe that the CGC cohort and, by extension, other health-aware populations who have elected to avoid COVID-19 injections and have prioritized self-care, have inflicted a disproportionate burden on health systems. Nor is, or was, there any robust scientific evidence that even suggests such COVID-19 “unvaccinated” populations place “vaccinated” populations at disproportionately greater risk. The survey data provide preliminary evidence that the CGC COVID-19 “unvaccinated” cohort prioritizes self-care, has faced low rates of hospitalization or severe disease, yet has also suffered a considerable mental health burden, while also being exposed to risks from COVID-19 “vaccinated” individuals, especially among women of reproductive age in the survey. It should be of considerable concern to those responsible for COVID-19 health policies, that essential workers, such as teachers, nurses, and care workers, have been among the most impacted by job losses that result from “unvaccinated” status.

It follows, then, that the marginalization, stigmatization, coercion of, or discrimination against, this mass formation/hypnosis resistant “outgroup”, consisting of those who exercised their right of refusal of products known to be “unavoidably unsafe” according to *Bruesenitz et al. v. Wyeth LLC, FKA Wyeth, Inc., et al. 2011*, and/or defective in design (Goldberg, 2022), and all of which were known to be experimental medical products at their time of release on the public, is neither valid nor ethical. Such discrimination and restriction of liberties based on a medical choice may fall foul of relevant national anti-discrimination laws and international treaties, such as the United Nation’s International Covenant on Economic, Social and Cultural Rights (UN Office of Public Information, 1966), which includes fundamental rights to liberty and security of person, freedom of movement, privacy, religion and belief, freedom of expression, and peaceful assembly. Finally, the findings amplify the need for high quality prospective observational studies to compare outcomes, choices, and potential discrimination, among COVID-19 “unvaccinated” (control) populations and those who have elected to be “vaccinated” with different products and doses.

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## Declaration of Conflicts of Interest

None of the authors have any competing interests.

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CGC is a membership organization and accordingly receives subscription fees, as well as donations, to help conduct research and provide support for COVID-19 “vaccine”-free communities, as well as COVID-19 “vaccinated” individuals who have decided to opt out of ongoing COVID-19 “vaccination” programs. The authors are independent of CGC and received no funding to undertake the present work.

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# ***ANNEX 1: Profile Questionnaire (Completed on Registration)***

- 1. MEDICAL CONDITIONS**
  - a. Condition
  - b. Month/Year diagnosed
  - c. Further details
- 2. VACCINATIONS RECEIVED**
  - a. Vaccinations received
  - b. Date received
  - c. Informed consent given
- 3. TREATMENTS RECEIVED**
  - a. Treatment received
  - b. Reason for treatment
  - c. Duration of treatment
  - d. Further details
  - e. Month/Year received
- 4. ALLERGIES**
  - a. Allergy
  - b. Date diagnosed
- 5. DISCRIMINATION EXPERIENCED**
  - a. Type of discrimination
  - b. Discrimination Body/Org
  - c. Location (Town/City)
  - d. Further details
  - e. Date (dd/mm/yyyy)
- 6. PERSONAL INFORMATION**
  - a. Have you had covid-19?
7. Please choose your reasons for joining the Vaccine Control Group?
  - a. Rather not disclose
  - b. Fear – short-term adverse reactions
  - c. Fear – long-term adverse reactions
  - d. Poor trial study data
  - e. Distrust pharma
  - f. Distrust of Government
  - g. Prefer natural medicines
  - h. Previous vaccine injuries
8. Which future vaccination programmes are you likely to opt into?
  - a. Rather not disclose
  - b. Any non-trial vaccinations
  - c. Flu vaccinations
  - d. Holiday vaccinations
  - e. No to all
9. When did you last have a vaccination?
  - a. Rather not disclose

- b. In last 12 months
  - c. Less than 5 years ago
  - d. More than 5 years ago
  - e. As a child
  - f. Never vaccinated
10. Which blood group are you?
- a. Rather not disclose
  - b. Unknown
  - c. A+
  - d. A-
  - e. B+
  - f. B-
  - g. AB+
  - h. AB-
  - i. O+
  - j. O-
11. Would you be happy to give blood if it was categorized as without SARS-CoV-2 vaccination?
- a. Unknown
  - b. Yes
  - c. No
12. What is your biological sex?
- a. Female
  - b. Male
13. In which month were you born?
14. What is your occupation?
15. In which year were you born?
16. In which state or county do you live?
17. Which is the closest town or city to where you live
18. In which country do you live?

# ***ANNEX 2: CGC Online Survey Monthly Questionnaire***

## **1. WELLNESS**

### **2. Have you had any of the following ailments?**

- a. No, I have generally been well
- b. Tiredness/Fatigue
- c. Common Cold
- d. Vomiting and Diarrhoea (not food poisoning)
- e. Bronchitis
- f. Pneumonia
- g. Whooping Cough
- h. Shingles
- i. Flu
- j. Herpes outbreak
- k. More headaches than usual
- l. Other

## **3. SUPPLEMENTS**

### **4. Which of the following supplements have you taken regularly?**

- a. Vitamin C
- b. Vitamin D
- c. Zinc
- d. Quercetin
- e. Ivermectin (prophylactically)
- f. Hydroxychloroquine
- g. Other
- h. None

## **5. MASKS**

### **6. Are masks mandated in your work?**

- a. Yes
- b. No
- c. N/A

### **7. How frequently do you wear a face mask?**

- a. Never
- b. Rarely
- c. >2 hours most day
- d. >4 hours most days
- e. >8 hours most days

## **8. TESTING**

### **9. Have you EVER had a PCR test?**

- a. No
- b. Yes

### **10. Have you EVER had a LATERAL FLOW test?**

- a. No
- b. Yes

### **11. How frequently have you had a PCR Test this month?**

- a. Not Tested
- b. Daily
- c. Weekly Testing
- d. 2+ times per week
- e. Special occasions only

**12. ILLNESS**

**13. Do you think you have had Covid-19 during this month?**

- a. No
- b. Yes

**14. If you have tested positive for COVID-19, how was it diagnosed?**

- a. Not tested positive
- b. Self-diagnosed
- c. PCR test
- d. Lateral flow test
- e. Antibody test
- f. LAMP/LamPORE test

**15. What if any Symptoms did you have?**

- a. No symptoms
- b. Cough
- c. Fever
- d. Muscle or body aches
- e. Shortness of breath/difficulty breathing
- f. Loss of taste
- g. Loss of smell
- h. Fatigue
- i. Diarrhoea
- j. Other

**16. On a scale of 1 to 10 with 1 being very mild and 10 being seriously ill, how ill were you?**

- i. Not ill with covid-19
- ii. 1
- iii. 2
- iv. 3
- v. 4
- vi. 5
- vii. 6
- viii. 7
- ix. 8
- x. 9
- xi. 10

**17. Did other family members of your household become ill?**

- a. Not applicable
- b. Yes, before me
- c. Yes, after me
- d. Yes, before and after me
- e. Not at all

**18. What treatments did you use?**

- a. Not applicable
- b. No treatments taken
- c. Ivermectin
- d. Hydroxychloroquine (HCQ)
- e. Vitamin C
- f. Zinc
- g. Vitamin D
- h. Dexamethasone
- i. Prescribed antibiotics
- j. Zelenko protocol
- k. Other

**19. Other treatments taken**

**20. EXPOSURE**

**21. Are you currently living with covid-19 vaccinated individual(s)?**

- a. Yes
- b. No

**22. Do you spend more than 2 hours per day inside alongside covid-19 vaccinated individuals?**

- a. Yes
- b. No

**23. BLEEDING**

**24. What changes if any, have you noticed to your menstrual cycle?**

- a. No changes
- b. Rather not disclose
- c. Heavier bleeding
- d. Longer bleeding
- e. Unusual clotting
- f. Irregular periods
- g. Missed period
- h. Other

**25. Other menstrual changes**

**26. Have you had any more nosebleeds than usual?**

- a. No
- b. Yes

**27. Comments about nosebleeds**

**28. Have you had any more bruising than usual?**

- a. No
- b. Yes

**29. Comments about bruises**

**30. LIFESTYLE**

**31. Due to declining the COVID-19 vaccination:**

**32. Are you finding it difficult to buy food?**

- a. No
- b. Yes

**33. Are you finding it difficult to play sports?**

- a. No
- b. Yes

c. N/A

**34. Are you finding it difficult to access restaurants, theatres, museums etc..?**

- a. No
- b. Yes
- c. N/A

**35. Other comments on how your lifestyle is being impacted**

**36. MENTAL HEALTH**

a. **How is your mental health on a scale of 1 to 10, if 10 is “Life is great” and 1 is “Feeling there is no hope”?**

- i. 1
- ii. 2
- iii. 3
- iv. 4
- v. 5
- vi. 6
- vii. 7
- viii. 8
- ix. 9
- x. 10

**37. PERSONAL SAFETY**

**38. Are you concerned that your unvaccinated status may cause you to be a target of hatred?**

- a. No
- b. Yes
- c. N/A

**39. Comments on feeling targeted**

**40. Are you concerned that being unvaccinated is making you a target of the state?**

- a. No
- b. Yes
- c. N/A

**41. EMPLOYMENT**

**42. Due to declining the COVID-19 vaccination:**

**43. Have you been pressured into leaving your job?**

- a. No
- b. Yes
- c. N/A

**44. Have you been suspended from your job?**

- a. N/A
- b. No
- c. Yes – with pay
- d. Yes – without pay

**45. Have you been dismissed from your job?**

- a. No
- b. Yes
- c. N/A



**46. Is your employment under threat?**

- a. No
- b. Yes
- c. N/A

**47. Is it becoming difficult to do your job because of people's attitude towards you?**

- a. No
- b. Yes
- c. N/A

**48. Are you finding it difficult to find employment?**

- a. No
- b. Yes
- c. N/A

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