

Hidden Costs of the Military COVID-19 Mandate

Mandatory vaccination of the U.S. military undermines force readiness and national security. Since the announcement of the mandates, COVID-related military deaths have grown exponentially with no correlated civilian increase. COVID-19 vaccines do not stop the vaccinated from contracting the disease or spreading the virus to others. Adverse reactions to the COVID-19 vaccines are statistically significant, and Pfizer acknowledges numerous medical risks, which have not been evaluated to determine the potential for harm. For those previously infected, natural immunity provides greater protection than COVID-19 vaccines. As an alternative to vaccination, multiple highly-effective preventative and early treatment options have been identified, many of which have been studied in depth and used safely for decades, thus questioning the need for divisive and unconstitutional vaccine mandates.

Since late 2019, the SARS-CoV-2 (COVID-19) pandemic has challenged global health. Although the U.S. military has not been immune, military COVID-19 deaths have been limited.

- To date, 70 military members have died from COVID-19. Of the 248,865 COVID-19 cases among active duty, reserve, and National Guard members, less than 0.03% succumbed to the disease and less than one percent were hospitalized.¹ Stated in clearer terms, over 99.97% of military members infected by COVID-19 survived.^[1]
- On 9 August 2021, the U.S. Secretary of Defense announced his intention to impose a military-wide COVID-19 vaccine mandate.^[2] At the time only 28 military had died of COVID-19.^[3] In two months, military COVID-19 deaths have more than doubled. This shocking increase in mortality is absent from the civilian population.^[4] Although it is unclear whether the deceased were unvaccinated or had received one or more COVID-19 injections prior to passing away, this phenomenon should be investigated immediately and reported to the public to ensure transparency.

Historically, vaccines have been administered to prevent disease and gain immunity. A recent review of domestic and international COVID-19 cases showed no correlation between the percentage of a population that is vaccinated and prevalence of COVID-19 infections.^[5] Since May 2021, the Centers for Disease Control and Prevention (CDC) has only collected data on COVID-19 cases occurring in vaccinated individuals, also known as “breakthrough cases,” that result in hospitalization or death. Unlike unvaccinated cases, positive COVID-19 tests of vaccinated individuals that do not result in hospitalization or death are not tracked by the CDC,^[6] resulting in incomplete data sets. As a result, there is no way to validate actual vaccine effectiveness and viral spread due to vaccinated individuals with a confirmed “breakthrough case.” However, several studies provide useful insight and indicate **“breakthrough cases” are common among fully vaccinated individuals.**

- During July 2021, 469 Massachusetts residents contracted COVID-19 at summer events and large public gatherings. Despite 69% of residents being fully vaccinated, 74% of the positive cases during the outbreak were among the fully vaccinated. Four of the five individuals hospitalized were also fully vaccinated.^[7]
- In England, recent reporting indicates 44% of COVID-19 cases are among fully vaccinated individuals.^[8] 70% of deaths and 49% of overnight hospitalizations attributed to the Delta variant were among people who had received one or more COVID-19 inoculations.^{[9] ii}
- In Singapore, a recent study indicated 33% of COVID-19 cases were among fully vaccinated individuals; an additional 5% of cases were partially vaccinated.^[10]

COVID-19 vaccines do not stop transmission of the virus.^[10] In fact, peak viral load is similar for vaccinated individuals with “breakthrough cases” and unvaccinated individuals who have contracted the Delta variant of COVID-19.^[11] This is disconcerting, considering the prevalence of “breakthrough cases.” Additionally, vaccinated individuals may be more likely to have a high viral load when asymptomatic than unvaccinated individuals.^[12] This is particularly concerning for confined workplaces where social distancing may not be possible, such as aboard ships or aircraft, particularly when vaccinated crews incorrectly perceive their risk of transmission is low.^[11]

Adverse reactions to COVID-19 vaccines are well documented and statistically significant.

- One in every 333 males aged 16-25 years of ageⁱⁱⁱ required medical care in an emergency room or hospital within a week of receiving the Pfizer-BioNTech COVID-19 vaccine.^[13]
- There is also an increased risk of heart problems, to include myocarditis and pericarditis, particularly among males under 40 years of age.^[14] Pfizer’s initial vaccine studies were insufficient to identify this risk,^[14] however the CDC has found the rate of myocarditis or pericarditis increases as age decreases. Male vaccine recipients aged 18-24 years^{iv} are impacted at a rate of 56.3 cases per million.^[13] This disproportionately impacts the U.S. military population since 45.7% of the active duty force and 32.8% of reservists and National Guard are 25 years old or younger.^{[15][16]} **These vaccine-induced cardiac problems result in reduced quality of life, heart failure, and/or shortened life expectancy.**^[17]
- The U.S. Department of Health and Human Services’ (HHS) Vaccine Adverse Event Reporting System (VAERS) cites over 3.6 million adverse reactions, to include over 9,000 deaths, associated with COVID-19 vaccines.^[18]
- The World Health Organization’s (WHO) VigiAccess website cites over 5 million adverse reactions, to include over 11,500 deaths, associated with COVID-19 vaccines.^[19]
- Although data from VAERS and VigiAccess have limitations, the systems assist in detecting unusual or unexpected patterns of adverse event reporting. The quantity of adverse reports and death likely indicate safety concerns that warrant further investigation.

Pfizer’s product information highlights the risk of carcinogenicity, genotoxicity, and impairment of male fertility, which have not been evaluated to determine the potential for harm. Pfizer also identifies sub-populations of concern due to the lack of long-term research and associated safety data, to include: pregnant women, breastfeeding women, and infants who are breastfed by women who have received the COVID-19 vaccine.^[14] The CDC’s Advisory Committee on Immunization Practices specifically addressed vaccination in pregnant and breastfeeding women, stating “there are no data on the safety and efficacy of COVID-19 vaccines in these populations to inform vaccine recommendations.”^[20] Despite the lack of safety data, portions of the military do not permit medical waivers for pregnant and breastfeeding service members to defer COVID-19 vaccination.

Recent military guidance requires COVID-19 vaccination, regardless of **medically proven immunity through natural infection.**^[21] This guidance is inconsistent with long-standing military medical regulations^v, wastes critical resources, and exposes the military to unnecessary risk.^[22]

- **Vaccination does not reduce the risk of COVID-19 among those previously infected.**^[23]
- Numerous credible studies have indicated COVID-19 infection, to include asymptomatic and mild cases, induces robust, long-lived natural immunity in humans.^{[24][25][26]} As such, at least 13.1% of the military has natural immunity.^{vi}

- Natural infection significantly reduces the risk of reinfection, ^[27] providing greater than 90% protection against COVID-19. ^{[28] [29]}
- An Israeli study determined fully vaccinated individuals are 6-13 times more likely to experience “breakthrough infections” than individuals with natural immunity. Natural immunity confers longer lasting and stronger protection against COVID-19 infection, symptomatic disease, and hospitalization caused by the Delta variant than Pfizer-BioNTech vaccine-induced protection. ^[30]
- It is worth noting that individuals with natural immunity have an increased risk of adverse reactions to the COVID-19 vaccines. ^[31] This will impact over 13% of our military.

There are also **numerous preventative and early treatment options**, which can improve force readiness by preventing the spread of COVID-19 and reducing the incidence of COVID-related hospitalization and death. Several of these alternatives include:

- Monoclonal antibodies (Sotrovimab): Use of monoclonal antibodies results in 85% relative reduction in hospitalizations or death. ^[32]
- Inhaled budesonide (asthma medication): Reduces clinical deterioration by 90%. ^[33]
- Vitamin D: There is a strong correlation between vitamin D deficiency and COVID-19 infection. ^{[34] [35]} Military members are at a higher risk of vitamin D deficiency because of unique environmental conditions and uniform requirements. ^[36] Dietary options high in vitamin D and appropriate doses of vitamin D supplements can reduce this additional risk. ^[37]

In addition to medical considerations, military vaccine mandates have paved the way for unconstitutional civilian vaccine mandates. ^[38] Military members have a sworn duty to protect and defend the Constitution. These mandates are creating a two-tier society, inciting division, ^[39] and resulting in significant job losses, which undermine domestic stability and economic recovery. Civilians working for the healthcare industry who were fired for lack of COVID-19 vaccination are particularly troubling, as they undermine our domestic ability to respond to the COVID-19 pandemic. ^[40]

In conclusion, between the aforementioned concerns and the number of service members who will be forced out of the military, the benefit of mandatory COVID-19 vaccination on force readiness and mission execution is negligible at best. Natural immunity and preventative/early treatment options are effective and should be authorized as alternatives to vaccination. Demand for a robust military force is increasing worldwide due to countries such as China and Russia, which are actively undermining the international order and engaging in increasingly aggressive military activities. Should COVID-19 vaccination be linked with long-term health problems, vaccine mandates have the potential to cripple our military. That potential alone should be sufficient to halt the mandate.

References

- [1] US Department of Defense, "Spotlight – Coronavirus: DoD Response," 2021. [Online]. Available: <https://www.defense.gov/Explore/Spotlight/Coronavirus-DOD-Response/>. [Accessed 23 October 2021].
- [2] Lloyd J. Austin III, US Secretary of Defense, "Memorandum for all Department of Defense Employees: Message to the Force," US Department of Defense, Washington, D.C., 09 August 2021.
- [3] US Department of Defense, "Spotlight - Coronavirus: DoD Response," 2021. [Online]. Available: <https://www.defense.gov/Spotlights/Coronavirus-DOD-Response/>. [Accessed 05 August 2021].
- [4] Centers for Disease Control and Prevention, "COVID Data Tracker: COVID-19 Weekly Cases and Deaths per 100,000 Population by Age, Race/Ethnicity, and Sex," 10 October 2021. [Online]. Available: <https://covid.cdc.gov/covid-data-tracker/#demographicsovertime>.
- [5] S. V. Subramanian and A. Kumar, "Increases in COVID-19 are unrelated to levels of vaccination across 68 countries and 2947 counties in the United States," *European Journal of Epidemiology*, 30 September 2021.
- [6] Centers for Disease Control and Prevention, "Vaccines and Immunizations - COVID-19 Vaccine Breakthrough Case Investigation and Reporting," 29 September 2021. [Online]. Available: <https://www.cdc.gov/vaccines/covid-19/health-departments/breakthrough-cases.html>. [Accessed 02 October 2021].
- [7] Centers for Disease Control and Prevention, "Morbidity and Mortality Weekly Report: Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021," 06 August 2021. [Online]. Available: <https://www.cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm>.
- [8] P. Elliott, D. Haw, H. Wang, O. Eales, C. E. Walters, K. E. C. Ainslie, C. Atchison, C. Fronterre, P. J. Diggle, A. J. Page, A. J. Trotter, S. J. Prosoblek, The COVID-19 Genomics UK (COG-UK) Consortium, D. Ashby, C. A. Donnelly, W. Barclay, G. Taylor, G. Cooke, H. Ward, A. Darzi and S. Riley, "REACT-1 round 13 final report: exponential growth, high prevalence of SARS-CoV-2 and vaccine effectiveness associated with Delta variant in England during May to July 2021," United Kingdom, 10 September 2021.
- [9] Public Health England, "SARS-CoV-2 variants of concern and variants under investigation in England (Technical briefing 23)," United Kingdom, 17 September 2021.
- [10] P. Y. Chia, S. W. X. Ong, C. J. Chiew, L. W. Ang, J.-M. Chavatte, T.-M. Mak, L. Cui, S. Kalimuddin, W. N. Chia, C. W. Tan, L. Y. A. Chai, S. Y. Tan, S. Zheng, R. T. P. Lin, L. Wang, Y.-S. Leo, V. J. Lee, D. C. Lye and B. E. Young, "Virological and serological kinetics of SARS-CoV-2 Delta variant vaccine-breakthrough infections: a multi-center cohort study," Singapore, 31 July 2021.

- [11] K. B. Pouwels, E. Pritchard, P. C. Matthews, N. Stoesser, D. W. Eyre, K.-D. Vihta, T. House, J. Hay, J. I. Bell, J. N. Newton, J. Farrar, D. Crook, D. Cook, E. Rourke, R. Studley, T. Peto, I. Diamond, A. S. Walker and the COVID-19 Infection Survey Team, "Impact of Delta on viral burden and vaccine effectiveness against new SARS-CoV-2 infections in the UK," United Kingdom, 24 August 2021.
- [12] K. K. Riemersma, B. E. Grogan, A. Kita-Yarbro, P. Halfmann, A. Kocharian, K. R. Florek, R. Westergaard, A. Bateman, G. E. Jeppson, Y. Kawaoka, D. H. O'Connor, T. C. Friedrich and K. M. Grande, "Shedding of Infectious SARS-CoV-2 Despite Vaccination when the Delta Variant is Prevalent - Wisconsin, July 2021," Madison, WI, 11 August 2021.
- [13] T. Shimabukuro, "COVID-19 Vaccine Safety Update," Center for Disease Control and Prevention Advisory Committee on Immunization Practices, 23 June 2021.
- [14] BioNTech Manufacturing GmbH and Pfizer Inc., "Comirnaty Package Insert," 2021.
- [15] Department of Defense (DoD), Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy (ODASD (MC&FP)), "2019 Demographics Profile of the Military Community," August 2020.
- [16] J. Montgomery, M. Ryan, R. Engler, D. Hoffman, B. McClenathan, L. Collins, D. Loran, D. Hrcir, K. Herring, M. Platzer, N. Adams, A. Sanou and L. T. Cooper Jr., "Myocarditis Following Immunization With mRNA COVID-19 Vaccines in Members of the US Military," *JAMA Cardiology*, 29 June 2021.
- [17] L. A. Blauwet and L. T. Cooper, "Myocarditis," *Progress in Cardiovascular Diseases*, vol. 52, no. 4, pp. 274-288, 2010.
- [18] U.S. Department of Health and Human Services, "Vaccine Adverse Event Reporting System," [Online]. Available: <https://vaers.hhs.gov/>. [Accessed 09 October 2021].
- [19] The World Health Organization, "VigiAccess," [Online]. Available: <http://www.vigiaccess.org/>. [Accessed 09 October 2021].
- [20] Centers for Disease Control and Prevention, "Vaccine Recommendations and Guidelines of the ACIP: Interim Considerations for COVID-19 Vaccination of Healthcare Personnel and Long-Term Care Facility Residents," 23 August 2021. [Online]. Available: <https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19/clinical-considerations.html>. [Accessed 03 October 2021].
- [21] Lloyd J. Austin III, US Secretary of Defense, "Mandatory Coronavirus Disease 2019 Vaccination of Department of Defense Service Members," US Department of Defense, Washington, D.C., 24 August 2021.
- [22] Headquarters Departments of the Army, the Navy, the Air Force, and the Coast Guard, "Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases," Washington, DC, 07 October 2013.
- [23] N. K. Shrestha, P. C. Burke, A. S. Nowacki, P. Terpeluk and S. M. Gordon, "Necessity of COVID-19 vaccination in previously infected individuals," Cleveland, OH, 19 June 2021.

- [24] J. S. Turner, W. Kim, E. Kalaidina, C. W. Goss, A. M. Rauseo, A. J. Schmitz, L. Hansen, A. Haile, M. K. Klebert, I. Pusic, J. A. O'Halloran, R. M. Presti and A. H. Ellebedy, "SARS-CoV-2 infection induces long-lived bone marrow plasma cells in humans," *Nature*, vol. 595, pp. 421-425, 15 July 2021.
- [25] K. W. Cohen, S. L. Linderman, Z. Moodie, ..., M. S. Suthar, R. Ahmed and M. J. McElrath, "Longitudinal analysis shows durable and broad immune memory after SARS-CoV-2 infection with persisting antibody responses and memory B and T cells," *Cell Reports Medicine*, vol. 2, no. 7, pp. 1-14, 14 July 2021.
- [26] National Institutes of Health, "Lasting immunity found after recovery from COVID-19," 26 January 2021. [Online]. Available: <https://www.nih.gov/news-events/nih-research-matters/lasting-immunity-found-after-recovery-covid-19>.
- [27] S. Lumley, D. O'Donnell, N. E. Stoesser, P. C. Matthews, A. Howarth, S. B. Hatch, B. D. Marsden, S. Cox, T. James, F. Warren, L. J. Peck, T. G. Ritter, Z. de Toledo, L. Warren, D. Axten, R. J. Cornall, E. Y. Jones, D. I. Stuart, G. Screatton, D. Ebner, S. Hoosdally, M. Chand, D. W. Crook, A. M. O'Donnell, C. P. Conlon, K. B. Pouwels, A. S. Walker, T. E. A. Peto, S. Hopkins, T. M. Walker, K. Jeffery and D. W. Eyre, "Antibody Status and Incidence of SARS-CoV-2," *The New England Journal of Medicine*, vol. 384, no. 6, pp. 533-540, 11 February 2021.
- [28] S. Pilz, Ali Chakeri, J. P. Ioannidis, L. Richter, V. Theiler-Schwetz, C. Trummer, R. Krause and F. Allerberger, "SARS-CoV-2 re-infection risk in Austria," Graz, Austria, 11 February 2021.
- [29] Y. Goldberg, M. Mandel, Y. Woodbridge, R. Fluss, I. Novikov, R. Yaari, A. Ziv, L. Freedman and A. Huppert, "Protection of previous SARS-CoV-2 infection is similar to that of BNT162b2 vaccine protection: A three-month nationwide experience from Israel," Tel Aviv, Israel, 24 April 2021.
- [30] S. Gazit, R. Shlezinger, G. Perez, R. Lotan, A. Peretz, A. Ben-Tov, D. Cohen, K. Muhsen, G. Chodick and T. Patalon, "Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections," Tel Aviv, Israel, 25 August 2021.
- [31] R. K. Raw, C. Kelly, J. Rees, C. Wroe and D. R. Chadwick, "Previous COVID-19 infection but not Long-COVID is associated with increased adverse events following BNT162b2/Pfizer vaccination," United Kingdom, 22 April 2021.
- [32] National Institutes of Health, "NIH COVID-19 Treatment Guidelines - Anti-SARS-CoV-2 Monoclonal Antibodies," 24 09 2021. [Online]. Available: <https://www.covid19treatmentguidelines.nih.gov/therapies/anti-sars-cov-2-antibody-products/anti-sars-cov-2-monoclonal-antibodies/>. [Accessed 18 10 2021].
- [33] S. Ramakrishnan, D. V. Nicolau Jr., B. Langford, M. Mahdi, H. Jeffers, C. Mwasuku, K. Krassowska, R. Fox, I. Binnian, V. Glover, S. Bright, C. Butler, J. L. Cane, A. Halner, P. C. Matthews, L. E. Donnelly, J. L. Simpson, J. R. Baker, N. T. Fadai, S. Peterson, T. Bengtsson, P. J. Barnes, R. E. Russell and M. Bafadhel, "Inhaled budesonide in the treatment of early COVID-19 illness: a randomised controlled trial," United Kingdom, 08 February 2021.

- [34] A. Israel, A. Cicurel, I. Feldhamereldhamer, Y. Dror, S. M. Givon, D. Gillis, D. Strich and G. Lavie, "The link between vitamin D deficiency and COVID-19 in a large population," Israel, 07 September 2020.
- [35] C. Annweiler, B. Hanotte, C. G. de l'Éprevier, J.-M. Sabatier, L. Lafaie and T. Célarier, "Vitamin D and survival in COVID-19 patients: A quasi-experimental study," *Journal of Steroid Biochemistry and Molecular Biology*, vol. 204, 13 October 2020.
- [36] G. Sivakumar, A. Koziarz and F. Farrokhyar, "Vitamin D Supplementation in Military Personnel: A Systematic Review of Randomized Controlled Trials," *Sports Health*, vol. 11, no. 5, pp. 425-431, October 2019.
- [37] S. R. Maloney and P. Goolkasian, "Low Vitamin D States Observed in U.S. Marines and Navy Sailors with Early Multi-Symptom Illness," *Biomolecules*, vol. 10, no. 1032, pp. 1-12, 2020.
- [38] Joseph R. Biden Jr., US President, "Executive Order on Requiring Coronavirus Disease 2019 Vaccination for Federal Employees," 09 September 2021. [Online]. Available: <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/09/09/executive-order-on-requiring-coronavirus-disease-2019-vaccination-for-federal-employees/>. [Accessed 12 October 2021].
- [39] K. Devlin, M. Fagan and A. Connaughton, "People in Advanced Economies Say Their Society Is More Divided Than Before Pandemic," Pew Research Center, 23 June 2021.
- [40] K. Hochul, "Executive Order No. 4: Declaring a Statewide Disaster Emergency Due to Healthcare Staffing Shortages in the State of New York," 27 September 2021. [Online]. Available: <https://www.governor.ny.gov/news/no-4-declaring-statewide-disaster-emergency-due-healthcare-staffing-shortages-state-new-york>. [Accessed 11 October 2021].

ⁱ It is unclear whether hospitalizations were due to COVID-19 infection or for issues unrelated to COVID-19, but the individual tested positive for COVID-19 after admission.

ⁱⁱ Reference pages 19-20, Table 5: Attendance to emergency care and deaths of sequenced and genotyped Delta cases in England by vaccination status.

ⁱⁱⁱ Slide 8 of 50: For vaccine recipients aged 16-25 years of age, medical care in an emergency room or hospital is required for 0.1% following dose 1 and 0.2% following dose 2 of the Pfizer vaccine. Additional doses are not recommended for people with significant adverse reactions to the initial shot, so it is likely these groups are distinct. (0.1% + 0.2% = 0.3% = 3/1000 = 1/333)

^{iv} Slide 42 of 50: "Preliminary myocarditis/pericarditis crude reporting rates to VAERS following mRNA COVID 19 vaccination" states an incidence of 30.7 (all doses), 8.7 (after first dose), and 56.3 (after second dose) respectively per million vaccines for males aged 18-24 years.

^v Section 2.6: Exemptions, subsection a.1 states. "General examples of medical exemptions include the following... (b) Evidence of immunity based on serologic tests, documented infection, or similar circumstances."

^{vi} Given approximately 2.1 million military members, 248,865 cases / 1,900,000 people = 13.1%.