



Ontario
Civil Liberties
Association

“The OCLA takes a vigorous and highly principled approach to defending free speech rights, which is an approach that is sorely needed in Canada today.”

—John Carpay,
President,
Justice Centre for
Constitutional Freedoms

“I am very pleased to learn of the Ontario Civil Liberties Association, and wish it the greatest success in its work, which could not be more timely and urgent as elementary civil rights, including freedom of speech, are under attack in much of the world, not excluding the more free and democratic societies.”

—Noam Chomsky,
Institute Professor, MIT

“Freedom of expression is our most fundamental and most precious freedom. It has been under attack in Canada for years. The Ontario Civil Liberties Association has taken a position on freedom of expression that is both courageous and principled. The OCLA now stands alone and its position should be supported by all Canadians who cherish democracy and freedom.”

—Robert Martin,
Professor of Law,
Emeritus,
Western University

June 21, 2020

By Email

Dr Tedros Adhanom Ghebreyesus

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RE: WHO advising the use of masks in the general population to prevent COVID-19 transmission

Director General:

The Ontario Civil Liberties Association (OCLA) requests that the WHO retract its recommendation to decision makers advising the use of face masks in the general population (“the WHO recommendation”).

The said WHO recommendation is detailed in the WHO’s “interim guidance” document entitled “Advice on the use of masks in the context of COVID-19”, which is dated 5 June 2020:

WHO Reference Number: WHO/2019-nCov/IPC_Masks/2020.4

The document is presently published on this page:

<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public/when-and-how-to-use-masks>

You have personally promoted the WHO recommendation on twitter:



We believe that the WHO recommendation is harmful to public health, and harmful to the very fabric of society. The recommendation is used by governments as a ready-made justification to impose mask use in the general population. The resulting legislative dictates and policies of coercion broadly violate civil, political and human rights. We ask that your ill-conceived recommendation be retracted immediately.

The context is one where: ¹

- Viral respiratory diseases, based on rapid mutations, have co-evolved with powerful, complex, and adaptive immune systems of breathing animals for some 300 million years and with human ancestors for some 5 million years, in the absence of vaccines.
- There was no statistically significant increase in winter-burden all-cause mortality in 2019-2020, compared to the last many decades of reliable data for Northern mid-latitude nations.
- A sharp peak in all-cause mortality by week occurred synchronously in several jurisdictions, across continents and oceans, immediately following the WHO declaration of the pandemic.
- The said peak can be attributed to government preparedness response to COVID-19, impacting immune-vulnerable institutionalized persons in those jurisdictions.

In your document, you state (at p. 6):

At the present time, the widespread use of masks by healthy people in the community setting is not yet supported by high quality or direct scientific

¹ Rancourt, DG (2020) "All-cause mortality during COVID-19: No plague and a likely signature of mass homicide by government response", *ResearchGate*, 2 June 2020, [DOI: 10.13140/RG.2.2.24350.77125](https://doi.org/10.13140/RG.2.2.24350.77125) ; Rancourt, DG (2020) "Mortalité toutes causes confondues pendant la COVID-19 : Pas de fléau et une signature probable d'homicide de masse par la réponse du gouvernement", *Le Saker Francophone*, 2 juin 2020, <https://lesakerfrancophone.fr/mortalite-toutes-causes-confondues-pendant-la-covid-19>

evidence and there are potential benefits and harms to consider (see below).

Even this introductory statement of yours has two problems.

First, it contains the palpable bias that “there must be benefits”.

Second, more importantly, you fail to mention that several randomized controlled trials with verified outcomes (infections) were specifically designed to detect a benefit, and did not find any measurable benefit, for any viral respiratory disease. This includes the many randomized controlled trials that find no difference between open-sided surgical masks and respirators. ²

² • Xiao, J et al. (2020) "Nonpharmaceutical Measures for Pandemic Influenza in Nonhealthcare Settings—Personal Protective and Environmental Measures", *Emerg Infect Dis.* 5 May 2020;26(5):967-975. <https://dx.doi.org/10.3201/eid2605.190994>

["Although mechanistic studies support the potential effect of hand hygiene or face masks, evidence from 14 randomized controlled trials of these measures did not support a substantial effect on transmission of laboratory-confirmed influenza. We similarly found limited evidence on the effectiveness of improved hygiene and environmental cleaning."]

• Rancourt, DG (2020) “Masks Don’t Work: a Review of Science Relevant to Covid-19 Social Policy”, *ResearchGate*, 11 April 2020, now at *viXra*: <https://vixra.org/abs/2006.0044>

• Long, Y et al. (2020) “Effectiveness of N95 respirators versus surgical masks against influenza: A systematic review and meta-analysis”, *J Evid Based Med.* 2020; 1- 9. <https://doi.org/10.1111/jebm.12381>
 ["A total of six RCTs involving 9 171 participants were included. There were no statistically significant differences in preventing laboratory-confirmed influenza, laboratory-confirmed respiratory viral infections, laboratory-confirmed respiratory infection and influenzalike illness using N95 respirators and surgical masks. Meta-analysis indicated a protective effect of N95 respirators against laboratory-confirmed bacterial colonization."]

• Bartoszko, JJ et al. (2020) "Medical masks vs N95 respirators for preventing COVID-19 in healthcare workers: A systematic review and meta-analysis of randomized trials", *Influenza Other Respir Viruses*, 2020;14(4):365-373, <https://doi.org/10.1111/irv.12745>

["Four RCTs were meta-analyzed adjusting for clustering. Compared with N95 respirators; the use of medical masks did not increase laboratory-confirmed viral (including coronaviruses) respiratory infection or clinical respiratory illness."]

• Radonovich, LJ et al. (2019) “N95 Respirators vs Medical Masks for Preventing Influenza Among Health Care Personnel: A Randomized Clinical Trial”, *JAMA.* 2019; 322(9): 824–833. doi:10.1001/jama.2019.11645, <https://jamanetwork.com/journals/jama/fullarticle/2749214>

["Among 2862 randomized participants, 2371 completed the study and accounted for 5180 HCW-seasons. ... Among outpatient health care personnel, N95 respirators vs medical masks as worn by participants in this trial resulted in no significant difference in the incidence of laboratory-confirmed influenza."]

• Offeddu, V et al. (2017) “Effectiveness of Masks and Respirators Against Respiratory Infections in Healthcare Workers: A Systematic Review and Meta-Analysis”, *Clinical Infectious Diseases*, Volume 65, Issue 11, 1 December 2017, Pages 1934–1942, <https://doi.org/10.1093/cid/cix681>

["Self-reported assessment of clinical outcomes was prone to bias. Evidence of a protective effect of masks or respirators against verified respiratory infection (VRI) was not statistically significant”; as per their Figure 2c]

• Smith, JD et al. (2016) “Effectiveness of N95 respirators versus surgical masks in protecting health care workers from acute respiratory infection: a systematic review and meta-analysis”, *CMAJ*, Mar 2016, cmaj.150835; DOI: 10.1503/cmaj.150835, <https://www.cmaj.ca/content/188/8/567>

You failed to mention that such results set a probabilistic upper limit on mask effectiveness, and you failed to calculate this upper limit. Instead, you repeat the misleading notion that reliable evidence has “not yet” been found to confirm your adopted bias.

In other words, if masks were even moderately effective at reducing the risk of infection, then a benefit would have been statistically detected in one or more of the many reliable trials that have already been made.

More fundamentally, a major problem with your document is that you wrongly rely on substandard scientific reports as constituting usable “evidence”. With public policy, especially health policy having draconian consequences, there must be a standards threshold below which a given report cannot be used as an indicator of reality. The reason that science requires randomized controlled trials with verified outcomes is precisely because other study designs are susceptible to bias.

The context of a new disease and of a publicized pandemic is one in which all reporting (media, political, and scientific) is susceptible to large bias. The mechanisms of the biases are well known and anticipated, such as: political posturing, partisan conflicts, career advancement, publication-record padding, “discovery” recognition, public-interest and public-support mining, institutional and personal reputational enhancement, funding opportunities, corporate interests, and so on.

Group bias is not an uncommon phenomenon. Large numbers of bias-susceptible studies that agree are of little value. Any study that does not apply the established scientific tools

[“We identified 6 clinical studies ... In the meta-analysis of the clinical studies, we found no significant difference between N95 respirators and surgical masks in associated risk of (a) laboratory-confirmed respiratory infection, (b) influenza-like illness, or (c) reported work-place absenteeism.”]

- bin-Reza, F et al. (2012) “The use of masks and respirators to prevent transmission of influenza: a systematic review of the scientific evidence”, *Influenza and Other Respiratory Viruses* 6(4), 257–267, <https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1750-2659.2011.00307.x>

[“There were 17 eligible studies. ... None of the studies established a conclusive relationship between mask/respirator use and protection against influenza infection.”]

- Cowling, B et al. (2010) “Face masks to prevent transmission of influenza virus: A systematic review”, *Epidemiology and Infection*, 138(4), 449-456. doi:10.1017/S0950268809991658,

<https://www.cambridge.org/core/journals/epidemiology-and-infection/article/face-masks-to-prevent-transmission-of-influenza-virus-a-systematic-review/64D368496EBDE0AFCC6639CCC9D8BC05>

[None of the studies reviewed showed a benefit from wearing a mask, in either HCW or community members in households (H). See summary Tables 1 and 2 therein.]

- Jacobs, JL et al. (2009) “Use of surgical face masks to reduce the incidence of the common cold among health care workers in Japan: A randomized controlled trial”, *American Journal of Infection Control*, Volume 37, Issue 5, 417 - 419, <https://www.ncbi.nlm.nih.gov/pubmed/19216002>

[N95-masked health-care workers (HCW) were significantly more likely to experience headaches. Face mask use in HCW was not demonstrated to provide benefit in terms of cold symptoms or getting colds.]

for avoiding observational bias should be presumed to be biased, in any draconian policy context.

That is why the WHO cannot collect and rely on potentially biased studies to make recommendations that can have devastating effects (see below) on the lives of literally billions. Rather, the WHO must apply a stringent standards threshold, and accept only randomized controlled trials with verified outcomes. In this application, the mere fact that several such quality studies have not ever confirmed the positive effects reported in bias-susceptible reports should be a red flag.

For example, two amply promoted recent studies that do not satisfy the standards threshold, and that, in our opinion, have a palpable risk of large bias are the following.

The study of Renyi Zhang et al.:

“Identifying airborne transmission as the dominant route for the spread of COVID-19” by Zhang, Renyi et al., *Proceedings of the National Academy of Sciences*, 11 June 2020, 202009637; [DOI: 10.1073/pnas.2009637117](https://doi.org/10.1073/pnas.2009637117),

which was not used in your document, presumably because it was published later.

The Zhang study applies concocted linear extrapolations of non-linear epidemiological curves to conclude that mask-imposition policies must have worked. The work appears to be squarely contradicted by Sajadi et al. who rigorously showed that the COVID-19 outbreaks of high-transmission centers were restricted to a narrow band of latitude, temperature and absolute humidity, irrespective of any considerations of social-distancing impositions, including masks, as would be expected for known viral respiratory diseases.³

And, the study of DK Chu et al.:

“Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: a systematic review and meta-analysis” by Chu, DK et al., *Lancet*, 1 June 2020, S0140673620311429, [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)31142-9/](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31142-9/),

which is your reference 42.

The Chu study was funded by the WHO. It contains no randomized controlled trials, but rather uses a hodgepodge of data about associations of ill-defined factors. DK Chu et al.’s own appraisal of “certainty” regarding their conclusion about masks is “LOW” meaning “our confidence in the effect estimate is limited; the true effect could be

³ Sajadi, MM et al. (2020) “Temperature, Humidity, and Latitude Analysis to Estimate Potential Spread and Seasonality of Coronavirus Disease 2019 (COVID-19)”, *JAMA, Netw Open*. 11 June 2020; 3(6): e2011834. [doi:10.1001/jamanetworkopen.2020.11834](https://doi.org/10.1001/jamanetworkopen.2020.11834)

substantially different from the estimate of the effect” (their Table 2), yet such a result is a basis for your recommendation to governments.

In your document, having made the recommendation for the use of masks in the general population (your Table 2), you go on to describe “benefits” and “harms” of such applications.

Under the “**Potential benefits/advantages**” section (p. 7), you incorrectly claim that “likely advantages” include “reduced potential exposure risk from infected persons before they develop symptoms”. How this can be a “likely” advantage, in a total absence of reliable data, is beyond comprehension.

Your other “likely advantages” include:

- reduced potential stigmatization of individuals wearing masks to prevent infecting others ...;
- making people feel they can play a role in contributing to stopping spread of the virus;
- reminding people to be compliant with other measures (e.g., hand hygiene, not touching nose and mouth) ...;
- potential social and economic benefits. Amidst the global shortage of surgical masks and PPE, encouraging the public to create their own fabric masks may promote individual enterprise and community integration. Moreover, the production of non-medical masks may offer a source of income for those able to manufacture masks within their communities. Fabric masks can also be a form of cultural expression, encouraging public acceptance of protection measures in general...

Your document next has the section entitled “**Potential harms/disadvantages**”, in which you state:

The likely disadvantages of the use of mask by healthy people in the general public include:

- potential increased risk of self-contamination due to the manipulation of a face mask and subsequently touching eyes with contaminated hands;
- potential self-contamination that can occur if non-medical masks are not changed when wet or soiled. This can create favourable conditions for microorganism to amplify;
- potential headache and/or breathing difficulties, depending on type of mask used;
- potential development of facial skin lesions, irritant dermatitis or worsening acne, when used frequently for long hours;
- difficulty with communicating clearly;
- ...

- waste management issues; improper mask disposal leading to increased litter in public places, risk of contamination to street cleaners and environment hazard; ...

On their face, the harms that you describe are more severe than the benefits. Therefore, we are all the more perplexed by your recommendation, which has no basis in reliable scientific results.

You are correct to point out that masks are collectors and concentrators of pathogen-laden substances and materials, in close proximity to the mouth, nose and eyes, such that one might expect contact transmission to occur by way of the said concentration.

A day of collecting pathogens on the mask by inhalation, accompanied by mask touching, and followed by mask removal and disposal or storage, indeed does not sound like a good idea. Can the general public realistically be expected to learn and follow medical protocols of mask safety? Most reliable trials have been made with professional health-care workers, and found no measurable benefit of masks. Would masks make things worse in a general population? We don't know, but virtually the entire public health establishment including the WHO used to think so.

Furthermore, you have omitted important foreseeable harms, which include the following.

1. On the medical side, directly attributable to masks, unanswered questions include: Are large droplets captured by a mask atomized or aerosolized into breathable components? Do virions escape an evaporating droplet stuck to a mask fiber? How do pathogen-laden droplets interact with environmental dust and aerosols captured on the mask, including in polluted environments? Do new, used and cleaned or recycled masks shed fibres or substances that are harmful? What are long-term health effects of constrained and modified breathing from prolonged mask use, both with health care workers and the general public?
2. Does imposed or socially coerced mask use induce or contribute to a psychological state of fear and stress, in part or most of the targeted population? Psychological stress is proven to be a factor that can measurably depress the immune system and induce diseases, including: immune response dysfunction, depression, cardiovascular disease and cancer.⁴
3. There is a body of reliable scientific work establishing that a dominant path of transmission of viral respiratory diseases is the smallest size fraction of aerosol particles, that these particles are suspended in the fluid air under conditions of low absolute humidity, that this is the reason for winter seasonality of these diseases, and that transmission occurs indoors (homes, hospitals, shopping centers, day-care centers, airplanes, ...) where high densities of the aerosol particles are

⁴ Cohen, S, Janicki-Deverts, D, Miller, GE (2007) "Psychological Stress and Disease", *JAMA*. 2007; 298(14):1685–1687. doi:10.1001/jama.298.14.1685

suspended in the air in the winters of mid-latitude regions. Therefore, policies of imposed (ineffective) mask wearing provide a cover for corporations and governments to evade their duty of care, which would be to effectively manage the indoor air environments such as not to constitute centres of transmission.

4. The WHO recommendation in-effect is “propaganda by policy” that promotes the undemonstrated view that global central planning can significantly and safely mitigate seasonal and pandemic viral respiratory diseases, which have been with us since breathing animals walked on earth, and which co-adapt with our complex immune system. This, in a context where science posturing is malleable, there are billions to be made every season from vaccine sales, vaccine harm liability has been socialized, and reparation for vaccine injury has been made increasingly difficult to access. And, what are the long-term effects of constant large-scale interference with the human immune response to viral respiratory diseases? One cannot fail to notice that your focus is on limiting transmission between healthy individuals and universal artificial immunity programs, rather than on integrated study of immune vulnerability and its determining factors, focusing on those actually at risk.
5. Are there detrimental effects on society itself, and the quality and depth of social connection and cohesion, in a society that is masked and distanced? Does the nuclear family or the lone individual become dangerously isolated from the social environment? Our primary schools have been made into nightmares. The promoted distancing is a social experiment of dystopia on a global scale, across cultures and peoples, planned to become routine.
6. When State power is applied in an absence of a valid scientific basis, and with little parliamentary debate, it constitutes arbitrarily applied power. Imposing masks is such a coercive power. What are the long-term societal consequences of habituation to arbitrarily applied State power? The recent scientific study of Hickey and Davidsen (2019) provides a theoretical foundation that such habituation is part of a progressive degradation towards a totalitarian state, depending on the degree of authoritarianism (whether individual contestation is effective) and the degree of violence (magnitude of the penalty for disobeying).⁵
7. Of great concern to the Ontario Civil Liberties Association are the direct and pernicious violations of civil rights and personal dignity, which forced masking embodies. These violations are multi-faceted.
 - i. In a free and democratic society, the individual has a presumed right to make their own evaluation of personal risk when acting in the world. Individuals evaluate risk, as a deeply personal matter that integrates experience, knowledge, personality, and culture, when they decide to walk outside, ride a

⁵ Hickey, J, Davidsen, J (2019) “Self-organization and time-stability of social hierarchies”, *PLoS ONE* 14(1): e0211403. <https://doi.org/10.1371/journal.pone.0211403>

car, train, bus or bicycle, take a particular route, eat a particular food, take a particular medication, accept a particular treatment, wear or not wear a particular garment, express or not express any image of themselves, have particular social interactions, adopt a work or pastime, and so on.

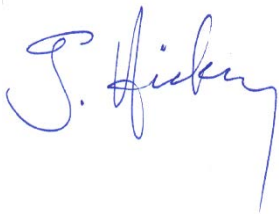
- ii. It is an unjustified authoritarian imposition, and a fundamental indignity, to have the State impose its evaluation of risk on the individual, one which has no basis in science, and which is smaller than a multitude of risks that are both common and often created or condoned by the State.
- iii. In a free and democratic society, corporations and institutions cannot impose individual behaviours that are irrelevant to the nature of the individual's dealings with the corporations or institutions, whether the individual is a consumer or a client of a service. These bodies cannot impose dress codes or visible symbols of compliance or membership on consumers, and thus discriminate or deny services.

Our association receives complaints and requests for help, such that we are acutely aware of the harm caused by the WHO's recommendations that are actuated by municipal, provincial and federal governments in Canada, despite our warnings.⁶

The WHO's pronouncements, unfortunately, have a disproportionate influence on our easily corralled governments.⁷

In view of the above, we conclude that your recent reversal on masks is, at best, reckless and irresponsible. Please retract the recommendation immediately. If not, we would appreciate your explanations that we can communicate to our members and the public.

Sincerely,



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⁶ Rancourt, DG (2020) "Criticism of Government Response to COVID-19 in Canada", 18 April 2020, Ontario Civil Rights Association, OCLA Report 2020-1, <http://ocla.ca/ocla-research-report-2020-1/>

⁷ "Mandatory mask laws are spreading in Canada: Mostly targeted at transportation so far, but calls are growing for more widespread application", by Emily Chung, *CBC News*, 17 June 2020.

<https://www.cbc.ca/news/health/mandatory-masks-1.5615728>