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* I have read and understand that my name, contact information and comments will be made publicly available in the Council Agenda.

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* Subject Bylaw 26M2020 upcoming review

* Comments - please refrain from providing personal information in this field (maximum 2500 characters)

I have conversed with member of council who has made it abundantly clear to me that the majority vote in favour of Bylaw 26M2020, was a vote made in absolute ignorance by the majority of council of scientific data which states clearly and directly that medical and non medical masks do NOT prevent the spread of Covid 19, and in fact can worsen the health of the wearer. Until there is UNBIASED scientific evidence that common place masks prevent or stop the spread of covid 19, without further harming the wearer, then there is ZERO justification to continue with bylaw 26M2020, and it needs to be repealed immediately, for the actual true health and safety of the citizens of Calgary.

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Masks Don't Work: A review of science relevant to COVID-19 social policy

Technical Report · April 2020

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Masks Don't Work

A review of science relevant to COVID-19 social policy

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Working report, published at Research Gate
(https://www.researchgate.net/profile/D_Rancourt)

April 2020

Summary / Abstract

Masks and respirators do not work.

There have been extensive randomized controlled trial (RCT) studies, and meta-analysis reviews of RCT studies, which all show that masks and respirators do not work to prevent respiratory influenza-like illnesses, or respiratory illnesses believed to be transmitted by droplets and aerosol particles.

Furthermore, the relevant known physics and biology, which I review, are such that masks and respirators should not work. It would be a paradox if masks and respirators worked, given what we know about viral respiratory diseases: The main transmission path is long-residence-time aerosol particles ($< 2.5 \mu\text{m}$), which are too fine to be blocked, and the minimum-infective-dose is smaller than one aerosol particle.

The present paper about masks illustrates the degree to which governments, the mainstream media, and institutional propagandists can decide to operate in a science vacuum, or select only incomplete science that serves their interests. Such recklessness is also certainly the case with the current global lockdown of over 1 billion people, an unprecedented experiment in medical and political history.

Review of the Medical Literature

Here are key anchor points to the extensive scientific literature that establishes that wearing surgical masks and respirators (e.g., “N95”) does not reduce the risk of contracting a verified illness:

Jacobs, J. L. 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.

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.

bin-Reza 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.”

Smith, J.D. 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

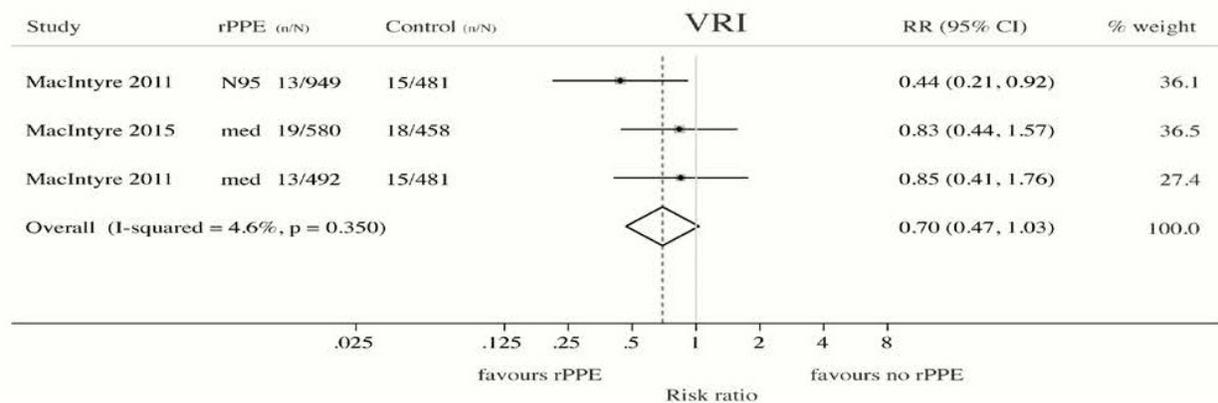
<https://www.cmaj.ca/content/188/8/567>

“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.”

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>

<https://academic.oup.com/cid/article/65/11/1934/4068747>

“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 Fig. 2c therein:



Radonovich, L.J. 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.”

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>

<https://onlinelibrary.wiley.com/doi/epdf/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 influenza-like illness using N95 respirators and surgical masks. Meta-analysis indicated a protective effect of N95 respirators against laboratory-confirmed bacterial colonization (RR = 0.58, 95% CI 0.43-0.78). The

use of N95 respirators compared with surgical masks is not associated with a lower risk of laboratory-confirmed influenza.”

Conclusion Regarding that Masks Do Not Work

No RCT study with verified outcome shows a benefit for HCW or community members in households to wearing a mask or respirator. There is no such study. There are no exceptions.

Likewise, no study exists that shows a benefit from a broad policy to wear masks in public (more on this below).

Furthermore, if there were any benefit to wearing a mask, because of the blocking power against droplets and aerosol particles, then there should be more benefit from wearing a respirator (N95) compared to a surgical mask, yet several large meta-analyses, and all the RCT, prove that there is no such relative benefit.

Masks and respirators do not work.

Precautionary Principle Turned on Its Head with Masks

In light of the medical research, therefore, it is difficult to understand why public-health authorities are not consistently adamant about this established scientific result, since the distributed psychological, economic and environmental harm from a broad recommendation to wear masks is significant, not to mention the unknown potential harm from concentration and distribution of pathogens on and from used masks. In this case, public authorities would be turning the precautionary principle on its head (see below).

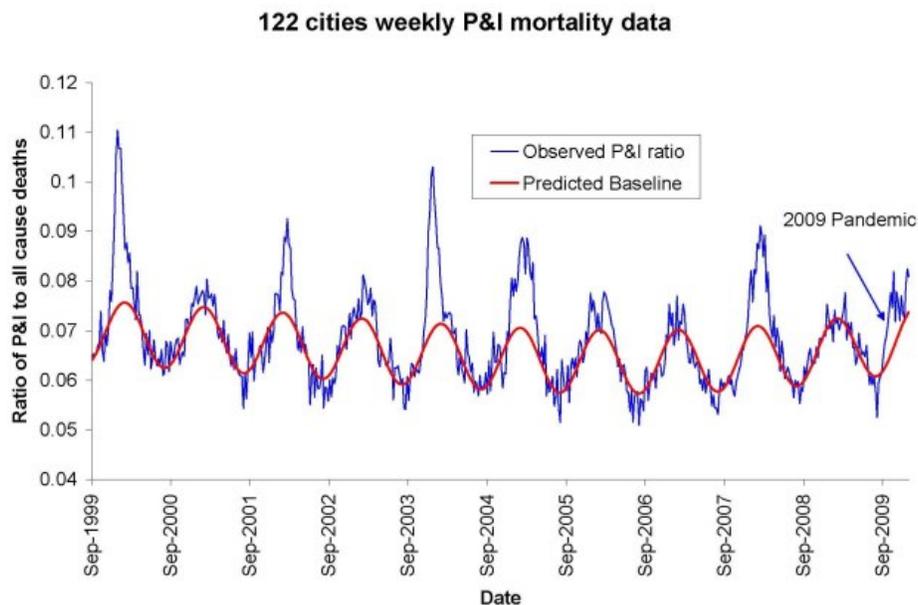
Physics and Biology of Viral Respiratory Disease and of Why Masks Do Not Work

In order to understand why masks cannot possibly work, we must review established knowledge about viral respiratory diseases, the mechanism of seasonal variation of excess deaths from pneumonia and influenza, the aerosol mechanism of infectious disease transmission, the physics and chemistry of aerosols, and the mechanism of the so-called minimum-infective-dose.

In addition to pandemics that can occur anytime, in the temperate latitudes there is an extra burden of respiratory-disease mortality that is seasonal, and that is caused by viruses. For

example, see the review of influenza by Paules and Subbarao (2017). This has been known for a long time, and the seasonal pattern is exceedingly regular.

For example, see Figure 1 of Viboud (2010), which has “Weekly time series of the ratio of deaths from pneumonia and influenza to all deaths, based on the 122 cities surveillance in the US (blue line). The red line represents the expected baseline ratio in the absence of influenza activity,” here:



The seasonality of the phenomenon was largely not understood until a decade ago. Until recently, it was debated whether the pattern arose primarily because of seasonal change in virulence of the pathogens, or because of seasonal change in susceptibility of the host (such as from dry air causing tissue irritation, or diminished daylight causing vitamin deficiency or hormonal stress). For example, see Dowell (2001).

In a landmark study, Shaman et al. (2010) showed that the seasonal pattern of extra respiratory-disease mortality can be explained quantitatively on the sole basis of absolute humidity, and its direct controlling impact on transmission of airborne pathogens.

Lowen et al. (2007) demonstrated the phenomenon of humidity-dependent airborne-virus virulence in actual disease transmission between guinea pigs, and discussed potential underlying mechanisms for the measured controlling effect of humidity.

The underlying mechanism is that the pathogen-laden aerosol particles or droplets are neutralized within a half-life that monotonically and significantly decreases with increasing ambient humidity. This is based on the seminal work of Harper (1961). Harper experimentally showed that viral-pathogen-carrying droplets were inactivated within shorter and shorter times, as ambient humidity was increased.

Harper argued that the viruses themselves were made inoperative by the humidity (“viable decay”), however, he admitted that the effect could be from humidity-enhanced physical removal or sedimentation of the droplets (“physical loss”): “Aerosol viabilities reported in this paper are based on the ratio of virus titre to radioactive count in suspension and cloud samples, and can be criticized on the ground that test and tracer materials were not physically identical.”

The latter (“physical loss”) seems more plausible to me, since humidity would have a universal physical effect of causing particle / droplet growth and sedimentation, and all tested viral pathogens have essentially the same humidity-driven “decay”. Furthermore, it is difficult to understand how a virion (of all virus types) in a droplet would be molecularly or structurally attacked or damaged by an increase in ambient humidity. A “virion” is the complete, infective form of a virus outside a host cell, with a core of RNA or DNA and a capsid. The actual mechanism of such humidity-driven intra-droplet “viable decay” of a virion has not been explained or studied.

In any case, the explanation and model of Shaman et al. (2010) is not dependant on the particular mechanism of the humidity-driven decay of virions in aerosol / droplets. Shaman’s quantitatively demonstrated model of seasonal regional viral epidemiology is valid for either mechanism (or combination of mechanisms), whether “viable decay” or “physical loss”.

The breakthrough achieved by Shaman et al. is not merely some academic point. Rather, it has profound health-policy implications, which have been entirely ignored or overlooked in the current coronavirus pandemic.

In particular, Shaman’s work necessarily implies that, rather than being a fixed number (dependent solely on the spatial-temporal structure of social interactions in a completely susceptible population, and on the viral strain), the epidemic’s **basic reproduction number** (R_0) is highly or predominantly dependent on ambient absolute humidity.

For a definition of R_0 , see HealthKnowledge-UK (2020): R_0 is “the average number of secondary infections produced by a typical case of an infection in a population where everyone is susceptible.” The average R_0 for influenza is said to be 1.28 (1.19–1.37); see the comprehensive review by Biggerstaff et al. (2014).

In fact, Shaman et al. showed that R_0 must be understood to seasonally vary between humid-summer values of just larger than “1” and dry-winter values typically as large as “4” (for example, see their Table 2). In other words, the seasonal infectious viral respiratory diseases that plague temperate latitudes every year go from being intrinsically mildly contagious to

virulently contagious, due simply to the bio-physical mode of transmission controlled by atmospheric humidity, irrespective of any other consideration.

Therefore, all the epidemiological mathematical modelling of the benefits of mediating policies (such as social distancing), which assumes humidity-independent R_0 values, has a large likelihood of being of little value, on this basis alone. For studies about modelling and regarding mediation effects on the effective reproduction number, see Coburn (2009) and Tracht (2010).

To put it simply, the “second wave” of an epidemic is not a consequence of human sin regarding mask wearing and hand shaking. Rather, the “second wave” is an inescapable consequence of an air-dryness-driven many-fold increase in disease contagiousness, in a population that has not yet attained immunity.

If my view of the mechanism is correct (i.e., “physical loss”), then Shaman’s work further necessarily implies that the dryness-driven high transmissibility (large R_0) arises from small aerosol particles fluidly suspended in the air; as opposed to large droplets that are quickly gravitationally removed from the air.

Such small aerosol particles fluidly suspended in air, of biological origin, are of every variety and are everywhere, including down to virion-sizes (Despres, 2012). It is not entirely unlikely that viruses can thereby be physically transported over inter-continental distances (e.g., Hammond, 1989).

More to the point, indoor airborne virus concentrations have been shown to exist (in day-care facilities, health centres, and onboard airplanes) primarily as aerosol particles of diameters smaller than $2.5 \mu\text{m}$, such as in the work of Yang et al. (2011):

“Half of the 16 samples were positive, and their total virus concentrations ranged from 5800 to 37 000 genome copies m^{-3} . On average, 64 per cent of the viral genome copies were associated with fine particles smaller than $2.5 \mu\text{m}$, which can remain suspended for hours. Modelling of virus concentrations indoors suggested a source strength of $1.6 \pm 1.2 \times 10^5$ genome copies $\text{m}^{-3} \text{air h}^{-1}$ and a deposition flux onto surfaces of 13 ± 7 genome copies $\text{m}^{-2} \text{h}^{-1}$ by Brownian motion. Over 1 hour, the inhalation dose was estimated to be 30 ± 18 median tissue culture infectious dose (TCID_{50}), adequate to induce infection. These results provide quantitative support for the idea that the aerosol route could be an important mode of influenza transmission.”

Such small particles ($< 2.5 \mu\text{m}$) are part of air fluidity, are not subject to gravitational sedimentation, and would not be stopped by long-range inertial impact. This means that the slightest (even momentary) facial misfit of a mask or respirator renders the design filtration norm of the mask or respirator entirely irrelevant. In any case, the filtration material itself of

N95 (average pore size $\sim 0.3\text{--}0.5\ \mu\text{m}$) does not block virion penetration, not to mention surgical masks. For example, see Balazy et al. (2006).

Mask stoppage efficiency and host inhalation are only half of the equation, however, because the minimal infective dose (MID) must also be considered. For example, if a large number of pathogen-laden particles must be delivered to the lung within a certain time for the illness to take hold, then partial blocking by any mask or cloth can be enough to make a significant difference.

On the other hand, if the MID is amply surpassed by the virions carried in a single aerosol particle able to evade mask-capture, then the mask is of no practical utility, which is the case.

Yezli and Otter (2011), in their review of the MID, point out relevant features:

- most respiratory viruses are as infective in humans as in tissue culture having optimal laboratory susceptibility
- it is believed that a single virion can be enough to induce illness in the host
- the 50%-probability MID (“TCID₅₀”) has variably been found to be in the range 100–1000 virions
- there are typically $10^3\text{--}10^7$ virions per aerolized influenza droplet with diameter $1\ \mu\text{m}$ – $10\ \mu\text{m}$
- the 50%-probability MID easily fits into a single (one) aerolized droplet

For further background:

- A classic description of dose-response assessment is provided by Haas (1993).
- Zwart et al. (2009) provided the first laboratory proof, in a virus-insect system, that the action of a single virion can be sufficient to cause disease.
- Baccam et al. (2006) calculated from empirical data that, with influenza A in humans, “we estimate that after a delay of ~ 6 h, infected cells begin producing influenza virus and continue to do so for ~ 5 h. The average lifetime of infected cells is ~ 11 h, and the half-life of free infectious virus is ~ 3 h. We calculated the [in-body] basic reproductive number, R_0 , which indicated that a single infected cell could produce ~ 22 new productive infections.”
- Brooke et al. (2013) showed that, contrary to prior modeling assumptions, although not all influenza-A-infected cells in the human body produce infectious progeny (virions), nonetheless, 90% of infected cell are significantly impacted, rather than simply surviving unharmed.

All of this to say that: if anything gets through (and it always does, irrespective of the mask), then you are going to be infected. Masks cannot possibly work. It is not surprising, therefore, that no bias-free study has ever found a benefit from wearing a mask or respirator in this application.

Therefore, the studies that show partial stopping power of masks, or that show that masks can capture many large droplets produced by a sneezing or coughing mask-wearer, in light of the above-described features of the problem, are irrelevant. For example, such studies as these: Leung (2020), Davies (2013), Lai (2012), and Sande (2008).

Why There Can Never Be an Empirical Test of a Nation-Wide Mask-Wearing Policy

As mentioned above, no study exists that shows a benefit from a broad policy to wear masks in public. There is good reason for this. It would be impossible to obtain unambiguous and bias-free results:

- Any benefit from mask-wearing would have to be a small effect, since undetected in controlled experiments, which would be swamped by the larger effects, notably the large effect from changing atmospheric humidity.
- Mask compliance and mask adjustment habits would be unknown.
- Mask-wearing is associated (correlated) with several other health behaviours; see Wada (2012).
- The results would not be transferable, because of differing cultural habits.
- Compliance is achieved by fear, and individuals can habituate to fear-based propaganda, and can have disparate basic responses.
- Monitoring and compliance measurement are near-impossible, and subject to large errors.
- Self-reporting (such as in surveys) is notoriously biased, because individuals have the self-interested belief that their efforts are useful.
- Progression of the epidemic is not verified with reliable tests on large population samples, and generally relies on non-representative hospital visits or admissions.
- Several different pathogens (viruses and strains of viruses) causing respiratory illness generally act together, in the same population and/or in individuals, and are not resolved, while having different epidemiological characteristics.

Unknown Aspects of Mask Wearing

Many potential harms may arise from broad public policies to wear masks, and the following unanswered questions arise:

- Do used and loaded masks become sources of enhanced transmission, for the wearer and others?

- Do masks become collectors and retainers of pathogens that the mask wearer would otherwise avoid when breathing without a mask?
- Are large droplets captured by a mask atomized or aerolized into breathable components? Can virions escape an evaporating droplet stuck to a mask fiber?
- What are the dangers of bacterial growth on a used and loaded mask?
- How do pathogen-laden droplets interact with environmental dust and aerosols captured on the mask?
- What are long-term health effects on HCW, such as headaches, arising from impeded breathing?
- Are there negative social consequences to a masked society?
- Are there negative psychological consequences to wearing a mask, as a fear-based behavioural modification?
- What are the environmental consequences of mask manufacturing and disposal?
- Do the masks shed fibres or substances that are harmful when inhaled?

Conclusion

By making mask-wearing recommendations and policies for the general public, or by expressly condoning the practice, governments have both ignored the scientific evidence and done the opposite of following the precautionary principle.

In an absence of knowledge, governments should not make policies that have a hypothetical potential to cause harm. The government has an onus barrier before it instigates a broad social-engineering intervention, or allows corporations to exploit fear-based sentiments.

Furthermore, individuals should know that there is no known benefit arising from wearing a mask in a viral respiratory illness epidemic, and that scientific studies have shown that any benefit must be residually small, compared to other and determinative factors.

Otherwise, what is the point of publicly funded science?

The present paper about masks illustrates the degree to which governments, the mainstream media, and institutional propagandists can decide to operate in a science vacuum, or select only incomplete science that serves their interests. Such recklessness is also certainly the case with the current global lockdown of over 1 billion people, an unprecedented experiment in medical and political history.

Endnotes:

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Phone	(403) 585-2601
* Subject	Mandatory Mask By-Law and Desire to Speak at Council Meeting on Sept 14, 2020

* Comments - please refrain from providing personal information in this field (maximum 2500 characters)

I am a constituent of Jeff Davison and would like an opportunity to speak at the City Council meeting to be held on September 14th to discuss the Mandatory Mask Bylaw. I am opposed to the Mandatory Mask By-Law as it is a contravention of our rights under the Canadian Charter of Human Rights and Freedoms. There is sufficient scientific evidence that mandating masks for the general public is both unsafe and ineffective. Additionally, it is a discriminatory by-law for a very long list of reasons, just a few of these include: Those who are hearing impaired and use lip reading to get by, those who have medical conditions who cannot wear a mask, those who suffer from mental illnesses and cannot wear a mask (e.g. PTSD). Regardless of these points, it has been established that masks commonly worn by the general public provide little to no value in terms of containing the spread of any virus. Finally, the City of Calgary's public consultation on this matter is sorely lacking. These measures are dividing the City, causing undue harm and discrimination and eroding the fabric of our society for no good reason. I would like an opportunity to speak to the City Council on these matters during their meeting on September 14th, 2020, or at some other near-term opportunity.

https://vaccinechoicecanada.com/in-the-news/vcc-invites-elected-to-consider-the-evidence/?fbclid=IwAR2E3vCFPoBd1MmOQzOC90izFX5WL5IsHjO9QOAWsFZY1_UfDqYfL_nXuec

September 1, 2020

Dear Elected Representative

I am writing on behalf of Canadians who are deeply concerned that government measures imposed in response to CV-19 are **out of proportion to the actual risk** and **contrary to medical and scientific evidence**. It is our contention that many of the imposed measures are a gross over-reaction due to irrational fear, avoidance of liability, and/or excess caution rather than evidence-based interventions that are justifiably necessary and finite.

Over the last six months, Canadians have experienced the following grievous violations of our charter rights and freedoms with no projected end in sight:

- severe curtailment of civil liberties with the mass and indiscriminate containment of citizens
- the imposition of non-medical masks, physical distancing, contact tracing, and limits on socialization
- the shutdown of economic activity with widespread permanent business closures and job losses
- the effective closure of our parliaments and courts of justice denying citizens a ready recourse

The impact of these measures on our physical, emotional, psychological, social, and economic well-being is profoundly destructive and clearly not sustainable.

My purpose in writing is to share information to assist you in your leadership and decision-making. It is incumbent that all elected representatives become fully informed on the evidence, or lack of evidence as the case may be, for measures being considered and imposed. It does not serve Canada to blindly rely on the dictates of foreign and financially conflicted agencies and corporations.

My request is that you consider this information so that you are equipped to make sound, fact-based decisions.

I also request that you use your position to ensure that the **required actions** listed at the end of this document are implemented without delay.

I look forward to your earliest response after you have considered the information below.

Sincerely,

Ted Kuntz, President
Vaccine CHOICE Canada

*“If the main pillar of the system is living a lie,
then it is not surprising that the fundamental threat to it is living in truth.”*

– Vaclav Havel

Are Government Imposed CV-19 Measures Necessary and Effective?

1. Masking Does Not Prevent Infection or Transmission

The scientific evidence is clear. The use of non-medical masks do not prevent viral infection or transmission. Even more disconcerting, masking increases the risk of respiratory infection.

- A July 2020 report by the **Centre for Evidence Based Medicine** concluded that *“masks alone have no significant effect in interrupting the spread of Influenza-like Illness or influenza in the general population.”*
- Denis Rancourt, Ph.D, a retired University of Ottawa Physics Professor and internationally recognized researcher, conducted an extensive review of the scientific literature on masking that used randomized clinical trials (RCT) with verified outcomes. Dr. Rancourt found no scientific evidence to support masking of the general population. He concluded that face masks have **“no detectable benefit”** for reducing the risk of person-to-person transmission of a viral respiratory disease.
- In April 2020, the **World Health Organization** issued ‘advice on the use of masks in the context of Covid-19’ and concluded – *“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 evidence.”* **The WHO confirmed that masks carry uncertainties and critical risk including increased risk of self-contamination.**
- According to a randomized controlled trial study, the use of cloth masks actually **increases** the risk of respiratory infection. Researchers found the risk of infection with influenza-like illness was **13 times higher** in hospital workers using cloth masks compared to medical/surgical masks, and over **three times higher** when compared to not wearing a mask at all.
- It is widely acknowledged that the masking of children disrupts their emotional and psychological development.

References:

<https://www.cebm.net/covid-19/masking-lack-of-evidence-with-politics>
<http://ocla.ca/ocla-letter-who/>

<https://www.marktaliano.net/masks-dont-work-a-review-of-science-relevant-to-covid-19-social-policy-by-denis-rancourt-phd-11-june-2020/>

2. Physical Distancing Measures are Arbitrary

The imposition of two metre physical distancing is arbitrary rather than evidence-based.

- The World Health Organization recommends only one metre distancing.
- There is no scientific evidence to support the effectiveness of two metre distancing to reduce SARS-CoV-2 transmission.
- Former Chief Medical Officer, Dr. Joel Kettner stated – *“We need approaches with a better balance of benefits and harms. Rather than generalized restrictions for all people in all settings, most people at low risk should be allowed now to go to work, school, and other settings. **They should not be required, as a general rule, to socially distance or wear a mask.**”*

Reference:

<https://www.cbc.ca/news/canada/manitoba/joel-kettner-opinion-covid-19-response-1.5654062>

3. PCR Testing is Scientifically Meaningless

The PCR test used to identify SARS-CoV-2 is not intended for use as a diagnostic tool.

- The PCR test used to identify the SARS-CoV-2 virus was never designed as a diagnostic tool and should not be used as such.
- The high rate of false positives and false negatives makes any test results unreliable.
- The SARS-CoV-2 virus purported to be the cause of CV-19 has never been isolated, purified, and scientifically proven to cause CV-19.
- The testing for SARS-CoV-2 is based upon assumptions and speculations rather than established scientific facts.
- There is no scientific evidence that current PCR testing is measuring the SARS-CoV-2 virus. This renders the use of PCR testing for SARS-CoV-2 meaningless.

Reference:

<https://off-guardian.org/2020/06/27/covid19-pcr-tests-are-scientifically-meaningless/>

4. Concern with Positive Test Results Unwarranted

Public health officials and the mainstream media are vigilant in reporting the number of individuals who test positive for SARS-CoV-2. The message implied is that the higher the number who test positive, the higher the risk. This is fear-mongering and irresponsible.

- The increase in individuals testing positive for SARS-CoV-2 is most often a reflection of the increase in the number of individuals tested and does not necessarily reflect an increase in the rate of community infection.
- An increase in those testing positive (assuming the testing is reflective of real infection) means a higher percentage of the population has developed immunity to the virus thereby increasing herd immunity.
- Herd immunity results in a lower risk of transmission.
- An increase in those testing positive, without an increase in hospitalizations and deaths, is a positive development and should be reported as such.
- The reporting of those testing positive, without context, is meaningless and irresponsible.
- A better indicator of the risk of CV-19 is the rate of hospitalization and deaths purportedly due to CV-19.

5. The Risk of Dying from CV-19 is Extremely Low

The survival rate of CV-19 is more than 99.9%.

- The fact is that that the risk of dying from CV-19 for the vast majority of the population is extremely low.
- The number of Canadians who have purportedly died due to CV-19 is 9,117 (as of Aug. 30) in a population of 37,700,000. This is **less than 1/40th of one percent of Canada's population.**
- Of all deaths attributed to CV-19, less than 5% occurred in individuals under age 60, and most of these individuals had chronic disease.
- At least 82% of deaths attributed to CV-19 in Canada occurred in senior's care facilities. This means that less than 18% of deaths occurred outside of a senior's care facility.
- More than 95% of these seniors had multiple chronic health conditions.

References:

<https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html?stat=num&measure=deaths#a2>

<https://www.cbc.ca/news/health/coronavirus-canada-long-term-care-deaths-study-1.5626751>

6. Data Manipulation

The number of deaths attributed to CV-19 has been artificially inflated and is therefore unreliable as an indicator of the risk of CV-19.

- Public Health, under the direction of the World Health Organization, has directed physicians to not distinguish between those who died from CV-19 and those who died with CV-19. This is unprecedented in medicine.
- More than 95% of individuals whose deaths are attributed to CV-19 had one or more serious co-morbidities that are more likely the cause of death.
- Ontario Public Health admits to arbitrarily inflating the number of CV-19 deaths by **50%**.
- These measures artificially inflate the number of deaths attributed to CV-19 and makes this data unreliable as a measurement of risk.
- A more reliable way to measure the impact of CV-19 is to examine whether the total all-cause deaths in the first six months of 2020 is greater than all-cause deaths during the same period in the previous decade.
- **To date, no evidence has been provided to show that all-cause deaths in 2020 exceeds any previous year.**

Reference:

<https://www.publichealthontario.ca/-/media/documents/ncov/epi/2020/06/covid19-epi-case-identification-age-only-template.pdf?la=en>

7. CV-19 Comparable to Annual Influenza/Pneumonia

The number of deaths attributed to CV-19 is comparable to a moderate to severe influenza season.

- According to the **Infection Prevention Control Canada**, approximately 8,000 Canadians die annually from influenza and pneumonia.
- In 2018, the mortality of influenza and pneumonia was calculated at **230 per million** or 8,687 deaths.
- As of August 30, 2020, the mortality rate attributed to CV-19 is **241 per million**, a difference of 11 deaths per million. Given the deaths attributed to CV-19 are purposely inflated, there is no evidence to support the claim that CV-19 has a higher mortality than annual influenza/pneumonia.

References:

<https://ipac-canada.org/influenza-resources.php>

<https://www.statista.com/statistics/434445/death-rate-for-influenza-and-pneumonia-in-canada>

<https://www.worldometers.info/coronavirus/>

8. The Risk to Children Extremely Low

The risk of infection in children is extremely low.

- According to a public statement issued by the BC Ministry of Health:
 - SARS-CoV-2 has a very low infection rate in children and youth
 - In BC, less than 1% of children and youth have tested positive
 - There is no conclusive evidence that children pose a risk to other children or to adults
 - The closure of schools and childcare facilities has significant negative mental health and socioeconomic impacts on vulnerable children and their families.
- According to Dr. Mark Lysyshyn, MD, Deputy Chief Medical Health Officer with Vancouver Coastal Health: *“Although children are often at increased risk for viral respiratory illnesses, that is not the case with Covid-19. Compared to adults, children are less likely to become infected with CV-19, less likely to develop severe illness as a result of infection and less likely to transmit the infection to others. **Personal protective equipment such as medical masks and gloves are not recommended in the school environment.**”*
- There have been no deaths in children in Canada attributed to CV-19.

References:

<http://www.vch.ca/Documents/COVID-VCH-Schools-May-21-2020.pdf>

<https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/covid-19/covid-19-pho-guidance-k-12-schools.pdf>

9. Censorship of Alternative Perspectives and Treatments

Information that challenges the current CV-19 narrative is actively censored in the mainstream media and on social media platforms.

- Media appear to have been instructed to suppress any information that challenges the official narrative.
- This censorship prevents accountability and transparency, unnecessarily inflates fear and anxiety, and prevents the consideration of treatment strategies other than vaccination.
- Numerous researchers and public health experts globally have had their public statements and videos removed because they challenged the measures being implemented by governments.
- Preventative medications as Hydroxychloroquine, and natural treatments as zinc, high dose Vitamin C, Vitamin D, and others are being withheld from those affected by CV-19.
- People should have the right to full disclosure of all information pertinent to adverse impacts of mitigation measures, including information on legal and constitutional human rights issues, and the public should be guaranteed a voice in a transparent process as authorities establish public health policy.

References:

<https://doi.org/10.1017/dmp.2020.298>

<https://questioningcovid.com/>

<https://www.tabletmag.com/sections/science/articles/hydroxychloroquine-morality-tale>

10. Lack of Science to Support Measures

The measures being implemented in response to CV-19 are not science based.

- British Columbia's Chief Health Officer, Dr. Bonnie Henry, when asked about the inconsistency of CV-19 measures across Canada stated: *"None of this is based on science."*

Reference:

<https://www.youtube.com/watch?v=SY8fclCOG4c>

11. Negative Impact of Measures

The negative consequences of CV-19 measures is not fully considered.

- There is increasing awareness that the number of deaths due to the response of governments is substantially higher than the number of deaths purportedly caused by CV-19.
- The rates of domestic violence, suicide, drug and alcohol addiction, and deaths due to the inability to access medical treatment have increased significantly as a result of CV-19 measures.
- The financial consequences of CV-19 measures include massive job loss, bankruptcy, closure of businesses, homelessness, and insurmountable debt. Our economy is in "free fall".
- The social fabric of our communities has been severely impacted by government measures.
- Our democracy and rights and freedoms are in serious and immediate danger. One only need witness what is happening in Australia and New Zealand to appreciate how vulnerable we are to tyranny.

References:

<https://www.aier.org/article/madness-in-melbourne/>

12. Innate Immune System

We all possess immune systems that have adapted to challenges and allowed humanity to survive over millennia.

- Each time we are exposed to germs, viruses and bacteria, our immune system grows smarter and stronger.
- It is healthy and necessary for our very survival to be exposed to different germs.
- If we purposely prevent such exposure, we may gain in the short term, but we may negatively impact our natural immune system in the long term.
- Numerous public health experts have advocated for exposure amongst those populations under the age of 60 who are in good health and where the risk of serious consequences is low.
- This exposure allows for the development of herd immunity, a necessary condition for life to return to normal.

Reference:

https://www.americanthinker.com/blog/2020/06/immune_systems_matter.html

What Is Needed Now

What is needed during this critical time is leaders who fully inform themselves to enable them to make decisions based upon evidence rather than politics. We also need leaders who do not succumb to media pressure or the public's over reaction due to fear and anxiety. The public, including our elected officials, are being bombarded with misinformation from extremely biased and manipulative media outlets and public health officials. The result is that misinformed citizens as well as our elected representatives are acting emotionally rather than logically and rationally.

Required Actions

1. **Eliminate all masking mandates.**
2. **Eliminate all physical distancing measures.**
3. **Open all businesses immediately.**
4. **Open our schools without masking or physical distancing requirements.**
5. **Open our parliaments and courts so citizens can hold their governments accountable.**
6. **Allow open and honest debate about this medical condition and the measures needed to treat it.**
7. **Recognize that financial conflicts of interest are distorting our understanding of this condition and access to treatment options.**
8. **Insist on robust, peer reviewed science and evidence-based measures to guide our actions.**
9. **Defend our rights and freedoms and the sovereignty of the human body.**
10. **Tell the truth.**

It is the government's job to increase both freedom and security.