A FIRST-PRINCIPLES REVIEW OF PUBLIC HEALTH

BOOK 7

NPI-B: MASS TESTING, CONTACT TRACING, MASKS ETC.

Draft

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FRONTISPIECE

PART 1: MASS TESTING

1. Distinguishing between mass screening and mass testing

One of the points I'm trying to figure out is the difference between mass screening and mass testing.

1) Mass screening seems to me to be always voluntary - and typically offered by a government at a low cost as a way to inform the relevant citizen about any risks to his private health. E.g. screening for breast or prostate cancer. This is not intended to stop the disease for OTHERS, but for the person himself.

2) Mass testing, however, is coercive. It is also not advocated for the welfare of the individual who is being tested but for the WELFARE OF OTHERS. PCR tests for covid come under this category.

https://heinonline.org/HOL/LandingPage?handle=hein.journals/clqv47&div=22&id=&page=

There are few (if any) perfect medical tests. Almost all suffer from a range of shortcomings (illustrated in the screenshot below).

It seems that tests can be used, at best, to start a process of further evaluation of individual patients. They are not definitive for any disease.

Now, just imagine if the false negatives of covid were as high as those for glaucoma: That would mean that a VAST NUMBER of infectious patients would "slip through" any PCR barrier.

This would be particularly relevant for GBD – did its authors consider the proportion of false negatives from PCR tests? Any proportion >0 would create a HOLE in the "focused protection" system - with high risk of failure of protection as the system continues for more than a few days.

Of course, this PCR failure is OVER AND ABOVE the vast variety of failures inevitable from normal human factors. In other words, there is NO WAY that GBD can be successful for more than few days, at best.

SO HOW SHOULD TESTS BE USED? I'm a great fan of tests which serve a useful purpose for individuals by providing preliminary guidance. For instance, after increasing PSA numbers over a few years, I was sent for ultrasound and then MRI; only then was my cancer confirmed. So tests can serve a useful purpose - as part of individual diagnosis.

But for infectious disease prevention, we are talking of INSTANTANEOUS decisions about letting someone in, or keeping them out. PCR tests ARE SIMPLY NOT fit for such a determination. The idea of mass testing of people for IMMEDIATE DECISIONS on their movement is simply untenable.

https://heinonline.org/HOL/LandingPage?handle=hein.journals/clqv47&div=22&id=&page=

2. Mass testing

2.1 Australian mass testing in 1919-1920

Mass testing is not new. Thus, Tim Colbourn was not the first fool public health "expert" to propose mass-scale swabbing of the throat/ nose of people. It actually happened in Australia in 1919 & 1920.

> It was largely the concern with diphtheria control that wrote the carrier problem into the law. Between 1919 and 1921, most Australian States passed legislation which enabled government agents and medical officers to treat all known "carriers" as if they were actually ill, and therefore legally subject to quarantine or enforced hospitalization.
>
> In one typical report, Dr Legge of Swan Hill, Victoria, reported that 134 swabs were taken in school, and altogether 290 contacts swabbed; the State and Sunday schools were closed for three weeks, and before any patient was allowed back to school he or she was reswabbed. In Tallangatta, 530 swabs were taken of the whole population, resulting in the discovery and isolation of 10 carriers. In Bendigo, over 7,000 swabs resulted in the isolation of more than 500 carriers. These and other reports were published as exemplars of successful campaigns when the immediate statistics showed a drop of over 50 per cent in the incidence rate.[1]

2.2 Mass testing for TB

It turns out that mass testing was also used for TB. This had a problem of false positives.

> **Targeted testing and treatment of LTBI.** In the 1950s and 1960s, child-centered TB control activities were based on periodic testing of all children for LTBI (*344*). However, as the number of TB cases dropped, the disease became concentrated among persons at high risk in particular subpopulations. Consequently, the majority of U.S. children have negligible risk for acquiring LTBI. Among children at low risk, the majority of positive tuberculin skin test results are false positives caused by nonspecific reactivity or exposure to nontuberculous mycobacteria in the environment (*344*). False-positive results lead to unnecessary health-care expenditures and anxiety for the child, family, school, and HCWs (*345*). Thus, while the testing of children with an expected high prevalence of LTBI is desirable, mass testing of children with a low prevalence of LTBI is counterproductive and should not be undertaken.[2]

2.3 Mass testing during covid

https://x.com/sabhlok/status/1865976052193038825

[1] https://cambridge.org/core/services/aop-cambridge-core/content/view/1E362D08718726FD16869E917C8BBBCF/S0025727300068733a.pdf/diphtheria-and-australian-public-health-bacteriology-and-its-complex-applications-c-1890-1930.pdf

[2] https://cdc.gov/mmwr/preview/mmwrhtml/rr5412a1.htm

3. False negatives open a huge gate for spread of disease

3.1 Covid PCR tests have a false negative rate of 12%

A December 2021 study looked at 32 studies and found the "overall false-negative rate was 0.12"[3].

3.1.1 *The impossibility of focused protection*

Not all persons entering a nursing home will have caught covid, but of those who've caught it we are looking at 12% of them walking through with a negative PCR test.

This won't be active deception on the part of the visitor/ staff member, because during the first few days of covid (when most false negatives occur) no symptoms might have developed. Or they might have had it and are still carriers but without symptoms. Or they might have minor sniffles but the negative PCR test tells them that they probably have something else (hay fever, or one of other diseases like the flu or common cold that mimic the symptoms of covid).

And once it is in, the virus will spread via human failure - of which there are thousands of kinds. A nursing home protection model based on PCR tests will fail. 100%, like all other forms of quarantine. And it will cause great harm, guaranteed - of which we have extensive proofs.

The correct answer in ALL such cases is isolation of the sick, which itself is a huge challenge. Trying to quarantine the healthy is a bad idea.

[3] https://pubmed.ncbi.nlm.nih.gov/34741305/

PART 2: CONTACT TRACING

4. Contact tracing

xxx

PART 3: MASKS

5. Masks

https://x.com/kristinadawn7/status/1591168887336624129?s=46

5.1 The mandatory mask policy

Since late February 2020 I have been wearing a N95 mask, disposable gloves and a face shield in crowded settings. But I also know that masks are unnecessary outdoors. I asked the Chief Health Officer via Twitter for his evidence for requiring masks outdoors. He never responded. Later, he blocked my Twitter account.

Andrews does not like any questions, either. On 29 September 2020 it was reported that: 'Asked why he would require Victorians to wear masks when there is no health purpose, Mr Andrews dismissed the question. "That's an esoteric debate, isn't it? Maybe there will be a time when we have the luxury of having those debates"'.[4]

Victorians are required to wear masks even in extreme summer. School children aged over 12 must wear masks as well. This is dangerous.

5.1.1 *Dr Brett Sutton's own study contradicts the mandatory mask mandate*

Dr Brett Sutton, Victoria's current Chief Health Officer, published a meta-analysis in 2001 in which he found that there is little evidence to suggest that wearing surgical face masks by staff in the operating theatre decreases postoperative wound infections (Skinner & Sutton, 2001[5]). In fact, evidence indicates a significant reduction in postoperative wound infections when theatre staff were unmasked.

And yet, Dr Sutton is insisting on the mask mandate even though it directly contradicts his own research, and despite the lack of any rigorous research to justify his change of mind.

5.1.2 *Arbitrary, illogical, complex and self-defeating mask rules*

The masks mandate in Victoria is arbitrary without **any** scientific backing. Moreover, the rules are confusing as well.

Constantly changing rules

The rules keep changing.

- The first time Victoria "achieved" zero cases was without any mandatory masks policy. This time around, **even with zero cases** (as at 10 November 2020), masks are mandated.
- Perhaps the biggest give-away that the masks mandate in Victoria has nothing to do with the virus is that ***any type*** of mask can be used. At one time any face covering was considered OK. Then certain types were banned (such as face shields). But as Anesthetist Dr Babak Amin said on Sky News on 29 October 2020[6]:

  > [T]he Andrews governments' mask mandate is another **'dreamt up' draconian measure** because it **does not refer exclusively to surgical masks** but rather masks with no universal standard of manufacture. 'We're talking about cloth masks, **non-medical masks with no universal standards for their manufacture**,' Dr Amin told Sky News host Alan Jones. 'We're

[4] Creighton, Adam, Tweet, 29 September, 2020. Short URL: https://bit.ly/2G7suHg.

[5] Skinner, M. W., & Sutton, B. A. (2001), "Do anaesthetists need to wear surgical masks in the operating theatre? A literature review with evidence-based recommendations", *Anaesthesia and Intensive Care*, 29(4), 331-338.' https://www.researchgate.net/publication/11832106_Do_Anaesthetists_Need_to_Wear_Surgical_Masks_in_the_Operating_Theatre_A_Literature_Review_with_Evidence-Based_Recommendations

[6] https://www.skynews.com.au/details/_6205476904001

> talking about masks that – when you look through the medical literature – play no role in stopping the spread of respiratory illnesses. 'There is a significant body of evidence from years gone by, looking at the role of these cloth masks in community settings with previous pandemics.
>
> 'There is a raft of high-quality data, what we call meta-analyses, studies that compile multiple other studies together, and these studies have found that **non-medical masks in community settings play no role in protecting the wearer from infection.**'
>
> 'We are dealing with the administration who dreamt up… three draconian unforgivable measures with no basis in scientific evidence whatsoever,' Dr Amin said. 'And now they're trying to do it again with this mask mandate.'

In this context, Dr Babak Amin should be made aware that **there is no evidence that even surgical masks do any good in high-transmission settings**, with 3,500 healthcare workers having contracted the virus despite using surgical masks. On 11 November 2020 a news report stated:

> Austin Hospital radiographer Bruno Treglia is one of more than 3,500 Victorian healthcare workers who contracted coronavirus during the state's second wave. He believes he caught the virus because of the type of mask he was wearing at work. After initially being given a high-protection N95 respirator mask, Mr Treglia says he was later told to use a surgical mask instead. About half of Victoria's infected healthcare workers were in aged care, nearly 1,100 in hospitals, with the remainder in community healthcare.[7]

This last issue (about surgical vs N95 masks) is important for another reason. It shows the comprehensive failure of the "public health" policies of the Accused who have burnt hundreds of billions of dollars of taxpayer funds in first stopping the young from going to work and then paying them through vast borrowing, but failing to buy health workers N95 masks – which has then led to 3,500 of them getting infected by the virus and transmitting it to the elderly in hospitals and aged care centres.

Constant touching of masks is encouraged

The mask rules remain obscure and leave many questions unanswered.[8] The rules are also self-defeating. For instance, the government's guidance states that:

> You must carry a face mask with you when leaving home, even if you don't need to wear it while undertaking your current activity. For example, you can take your face mask off to eat or while you are running, but you must carry it with you and put it back on when you finish.

But carrying a mask and constantly putting it on and taking it off, putting it one's pocket, and so on, defeats the point of masks (assuming there is any) – with people constantly touching them.

Does anyone wash their mask or replace their disposable mask?

It is unclear whether anyone washes their masks made from washable material or disposes their disposable masks appropriately. I would hazard a guess that most Victorians have not bought more than a couple of masks each during 2020: after all, masks do not come free. We will only know about the actual use of masks once sales data come. That means most masks are absolutely filthy: a collection centre for all the world's pathogens.

5.1.3 *Masks do not work and can be harmful*

The following table is extracted from a meta-analysis published by the CDC in May 2020. The article studied the effect of masks on flu and found they don't work[9]. The coronavirus is broadly similar in size to the flu virus, so **masks can't work for coronavirus, either.**

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[7] https://www.abc.net.au/news/2020-11-11/why-did-so-many-healthcare-workers-in-victoria-catch-covid-19/12869008

[8] https://www.dhhs.vic.gov.au/face-masks-vic-covid-19

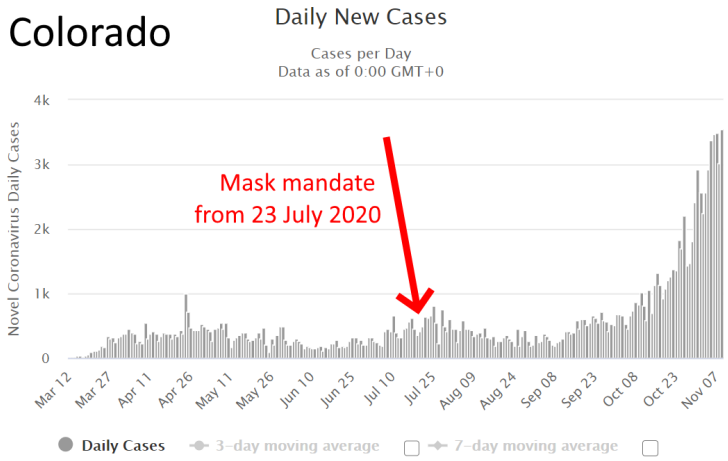
[9] https://wwwnc.cdc.gov/eid/article/26/5/19-0994_article

Table 1. Summary of literature searches for systematic review on personal and environmental nonpharmaceutical interventions for pandemic influenza*

Types of interventions	No. studies identified	Study designs included†	Main findings
Face masks	10	RCT	The evidence from RCTs suggested that the use of face masks either by infected persons or by uninfected persons does not have a substantial effect on influenza transmission.

Dr Jim Meehan's analysis shows that: "Masks worn properly are well documented to cause harm to their wearers. **Masks worn improperly, re-used, or contaminated are dangerous**"[10].

There is more data about effectiveness of masks available today and many new analyses will surely emerge. Being a data person I decided to look at the performance of masks in the State of Colorado in the USA. Colorado State's mask mandate started from 23 July 2020. The chart below suggest to me that masks have had no influence on the transmission of the virus in Colorado and possibly increased it (many factors come into play, so this is not conclusive, but masks definitely don't eliminate the virus).



5.1.4 *Masks are particularly harmful for children*

It is mandatory for children over 12 in Victoria to wear masks. It is hard to imagine a more ill-targeted and harmful recommendation for an age group that has not even been slightly impacted by the virus *anywhere in the world.*

Dr. Margarite Griesz-Brisson (a Consultant Neurologist and Neurophysiologist) has warned against significant harms from masks, particularly for children.[11] Likewise, Dr Sucharit Bhakdi has warned against masks use in children[12].

Masks cause oxygen deprivation which can lead to fainting and even seizures. There is evidence that breathing in one's own CO2 can exacerbate bacterial infections and respiratory disorders. All this is over and beyond the fact that wearing masks can cause significant stress and anxiety in the wearer, particularly if these are coercively imposed. For children of growing age, though, wearing a mask is **positively harmful**.

5.1.5 *The list of other harms from masks*

In the box below, I present some peer-reviewed evidence that I have been sent (see the acknowledgements section), that questions the use of masks and concludes that **face masks are insufficient at protecting the wearer and others from SARS-CoV-2 and are even harmful in many ways**.

[10] https://www.meehanmd.com/blog/2020-10-10-an-evidence-based-scientific-analysis-of-why-masks-are-ineffective-unnecessary-and-harmful/

[11] https://www.sott.net/article/442455-German-Neurologist-Warns-Against-Wearing-Facemasks-Oxygen-Deprivation-Causes-Permanent-Neurological-Damage

[12] https://www.bitchute.com/video/UkzVcsPlladv/

BOX: Summary of some peer-reviewed literature on masks

It was formerly presumed that the benefits of surgical face masks outweighed the harm. However, it has also been suggested that they do more harm than good (Lipp, 2003[13]).

Brett Sutton's 2001 study

- Sutton and Skinner summated Duguid, (1948) and stated; 'The numbers of airborne bacteria expelled from the nose and mouth are insignificant when compared with the substantial numbers shed from the skin'.
- Table 3 in Sutton and Skinner's (2001) study illustrates that the diameters of viral and bacterial particles are usually much smaller (0.1-0.8 microns), in relation to the filtration properties of high filtration surgical masks, (0.60 microns). This echoed Weber's (1993) work which concluded that surgical masks offer insufficient protection against potentially hazardous aerosols.
- Sutton and Skinner (2001) reported that Mitchell (1991) found there was no need for theatre staff, away from the immediate vicinity of the surgical site, to wear masks, as zero colony forming airborne microbial dispersal under laminar air flow conditions was detected.
- According to Sutton and Skinner's meta-analysis: 'The evidence for discontinuing the use of surgical face masks would appear to be stronger than the evidence available to support their continued use. In this climate of economic justification it would appear prudent to say that the use of surgical face masks by non-scrub operating theatre staff cannot be scientifically justified'.
- Further, 'There is little evidence to suggest that the wearing of surgical face masks by staff in the operating theatre decreases postoperative wound infections. Published evidence indicates that postoperative wound infection rates are not significantly different in unmasked versus masked theatre staff. However, there is evidence indicating a significant reduction in postoperative wound infection rates when theatre staff are unmasked. Currently there is no evidence that removing masks presents any additional hazard to the patient'.

Datta's study

- Datta (2010)[14] found that surgical face masks are associated with increased surgical site infections as a result of raising operating theatre germ concentration.

ISSUES WITH MASKS

Venting/tenting

- Surgical facemasks do not filter all particles from inhaled and exhaled air as much of the air exhaled escapes from where there is least resistance, usually around the sides of the facemask, permitting nonfiltered air from escaping and entering the face mask allowing the dispersion of microbes (Lipp, 2003 - *ibid*).
- Surgical face masks are loose fitting, especially when the strings are tied incorrectly or with insufficient tension (Nicolette, 2011[15]; Roberge, Kim & Coca, 2012[16]; Skinner & Sutton, 2001- *ibid*).

Wicking

- There is a problem of wicking: capillary action of liquid (i.e. sweat/moisture of expired air) from the inside to the outside of the surgical face mask.

Wiggling

- There is a problem of wiggling: Of the surgical facemask causes dead skin cells and bacteria from beards to shed and disseminate due to friction (Lipp, 2003 - *ibid*; Skinner & Sutton, 2001 - *ibid*). In fact, Skinner and Sutton (2001) stated that the numbers of airborne bacteria expelled from the nose and mouth are insignificant in comparison to the substantial numbers shed from the skin. Few, if any, nasal bacteria are

[13] Lipp, A. (2003), "The effectiveness of surgical face masks: What the literature shows", *Nursing Times*, 99(39), 22.

[14] Datta, R. (2010), "Use of surgical facemasks in the operation theatre: Effective or habit?", *Medical Journal*, Armed Forces India, 66(2), 163. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4920922/

[15] Nicolette, L.H. (2011), "Infection prevention and control in the perioperative setting", in J.C. Rothrock (Eds.), *Alexander's Care of the Patient in Surgery* (14th ed., pp. 48-110). Elsevier Mosby.

[16] Roberge, R. J., Kim, J. H., & Coca, A. (2012), "Protective facemask impact on human thermoregulation: An overview", *Annals of Occupational Hygiene*, 56(1), 102-112. https://pubmed.ncbi.nlm.nih.gov/21917820/

expelled into the air during quiet breathing despite a high number of colonisation (Skinner & Sutton, 2001).

- Even the most effective filter face mask can be useless if worn incorrectly and even dangerous if handled improperly (Nicolette, 2011 - *ibid*). Surgical face mask wear is recommended to last no longer than 4 hours as they become less effective over time (Datta, 2010 - *ibid*). A fresh surgical face mask almost completely prevented contamination of an agar plate 30 cm away from the mouth, but after 15 minutes there was a measurable increase in the level of contamination (Datta, 2010). This time is even further reduced when they are poorly fitted, placed below the nose or are wet (Datta, 2020).
- The filtration efficiency and protective ability of a wet face mask is compromised (Datta, 2010; Lipp, 2003 - *ibid*).
- Face masks should never be allowed to hang around the neck nor be folded and placed in a pocket for later use as this causes dry bacteria that has been filtered by the face mask airborne (Datta, 2010; Nicolette, 2010 - *ibid*). However, this is exactly what we are seeing the public do as people remove their face masks before they eat, drink and smoke. We are also seeing people handling their face masks by its faceplate, thereby contaminating the wearer's hands with droplet nuclei which he/she most likely is unaware of and consequently touches their face or surroundings (Datta, 2010).
- Contaminated disposable facemasks should be disposed of immediately into infectious waste bins however they are either ending up in landfill or in our oceans killing sea creatures and birds (Lipp, 2003; Nicolette, 2011 - *ibid*).
- The facial heat created by wearing a face mask causes skin reactions, increased temperature of breathing air, elevated core body temperature and psychophysiological effects (Roberge, Kim & Coca, 2012 - *ibid*). Roberge, Kim and Coca (2012) further demonstrate that mask-associated changes in body temperature are created by:

Respiratory heat exchange mechanisms

- Body heat is lost through the skin via radiation, convection and evaporation which can only occur optimally if the skin is exposed to the ambient environment. This ability is impeded by the barrier effect of face masks.

The impact of breathing through one's mouth versus their nose

- Most face mask wearers switch to mouth breathing which bypasses the nose's role in retaining heat and humidity, therefore air exhaled via the mouth is hotter and contains more moisture.

Ambient climate heat and humidity/moisture content

- At ambient temperatures of 18.9-25.5 degrees Celsius and 49-63% humidity, the skin temperature of the tip of the nose and chin rose by 4.7-7.3 and 2.6-3.6 degrees Celsius respectively, during sedentary activity while wearing a surgical face mask for only 15 minutes.

Microclimate (space between one's face and face mask which becomes the wearer's breathing environment) heat and humidity/moisture content

- In hot conditions, especially combined with physical activity, when temperatures approach or exceed body temperature, evaporative cooling through sweating becomes the main source of heat loss. The high heat and humidity of the expired air in the breathing environment can cause moisture to condense in the outside of the mask, impairing air permeability (creating breathing resistance), increasing venting and increasing exposure of the wearer to infectious microbes via wicking. The World Health Organisation (2020) also advises against wearing face masks while exercising as sweat can make breathing difficult and promotes the growth of microorganisms. Not to mention the discomfort of facial heat for the wearer.

Psychophysiological heat responses

- Anxiety disorders (e.g. panic attacks) send a false suffocation alarm to the person's central nervous system and high levels of carbon dioxide in the body can trigger a panic attack. The body's response during a panic attack involves releasing adrenaline which in turn increases metabolic rate and initiates the fight or flight response (increased blood pressure, heart rate and respiratory rate). The flushing of the skin and increase breathing effort in those with anxiety disorders are exacerbated by the effects of mask-wearing (i.e. perceptions of mask-related breathing resistance and increased sweating in the microenvironment). Together, these lead to an intolerable warm sensation in individuals with anxiety

disorder.

- Surgical face masks can limit emission of large droplet sprays and aerosol droplets larger than 5 μm (Milton, Fabian, Cowling, Grantham & McDevitt, 2013[17]). However, it is well known that they provide insufficient protection from potentially dangerous sub-micron sized particles including viruses (Lipp, 2003; Milton et al, 2013). Furthermore, the majority of virus in the exhaled aerosol appear to be too small to be contained by surgical face masks (Milton et al, 2013). A study conducted in Hong Kong in 2003 found that surgical face masks did not provide sufficient protection from SARS (Ho et al, as cited in Lipp, 2003). Surgical face masks also do not form a complete seal around the wearer's face (Lipp, 2003). It is for these reasons that they are not classified as personal protective equipment (Lipp, 2003).
- Studies on this matter during 2020 are not reliable since they have been done in a hurry without proper controls.
- In sum, there is good evidence that **face masks are insufficient at protecting the wearer and others from SARS-CoV-2 and are even harmful in many ways**.

5.1.6 *Reports on mask harms from Victorians*

As part of her research, a well-known Victorian doctor, Dr Suzanne Humphries asked a question[18] on Facebook:

> Has wearing a mask caused you an injury or illness? Please tell your story here. Use pictures of injuries if possible. One of my good friends' 14 year old son passed out today wearing a face mask. Cloth. He smashed his face and his knee. He's healthy at baseline.

She received many responses that document a range of harms. Some of these below:

> 1) My 18 year old niece has debilitating asthma. She works at a pizza restaurant with mask on all day. At the end of her shift she bought a pizza to take home and passed out in their parking lot. She ended up with 11 stitches in her forehead and ... she was told she was a customer so she can risk being fired to file an accident claim.
>
> 2) Early in COVID i went into a tachycardia (svt) from mask usage while at work. I am in the medical field so after doing a carotid massage. I had to revert to medication. I wear a cloth mask at work now not an N95. The headaches and recurrent aphthous stomatitis(canker sore) r ridiculous. I have had no less than 5 outbreaks since march.
>
> 3) After wearing my mask at work for several hours I have experienced extreme fatigue and crushing chest pain afterwards.

A person reported this on Twitter:

> Older people are tripping over steps because they cannot see them because of the mask bad rashes because of mask people cannot understand people speaking because of mask we do lip read half the time.[19]

In a Tweet, a person reported to me:

> Just had to call an ambulance for an old man in my local park who became dizzy and fainted because of wearing a mask.[20]

5.1.7 *Doctors harassed if they issue mask exemptions*

There have been reports that doctors in Victoria are being harassed by the Andrews government if they give exemptions to their patients from wearing masks[21]. But people are also reporting that the Police (and many shops like IGA and Bunnings) do not trust those who claim an exemption without presenting a

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[17] Milton, D. K., Fabian, M. P., Cowling, B. J., Grantham, M. L., & McDevitt, J. J. (2013), "Influenza virus aerosols in human exhaled breath: Particle size, culturability, and effect of surgical masks", *PLoS Pathog*, 9(3), e1003205.

[18] https://www.facebook.com/drsuzanne/posts/2673270776264280

[19] https://twitter.com/tyrelle123/status/1322057334948950016

[20] https://twitter.com/patambur/status/1322013617106026496

[21] https://twitter.com/sabhlok/status/1322308598165250048

medical certificate[22] - which they can't get. This situation is absolutely inhuman and will cause major health harms to thousands of Victorians, apart from destroying trust in the community.

5.1.8 *Huge inconsistency in mask requirements within Australia*

The *Australian Health Management Plan for Pandemic Influenza*[23], published in August 2019 said that "**Mask wearing [should only be] by symptomatic individuals in the community"** (page 115).

It was not a recommendation or mandate in that plan that an entire population wear a mask. This position was consistent with WHO's October 2029 guidelines.

However, on 6 November 2020 the Australian Government website[24] states:

> Where there is low community transmission of COVID-19, wearing a mask in the community when you are well is not generally recommended.
>
> However, where there is significant community transmission (as determined by jurisdictional public health authorities), you may choose, or be required to, wear a mask. If physical distancing is difficult to maintain, for example on public transport, covering your face with a mask can provide some extra protection.

While this says that "Where there is low community transmission of COVID-19, wearing a mask in the community when you are well is not generally recommended", there is a today **mandatory mask requirement in Victoria despite <u>zero community transmission</u>** as at 10 November 2020.

Moreover, the Australian Government has provided no evidence for why it changed its August 2019 position regarding masks. This seems political, not scientific. Science must never be done in a rush, particularly on a matter as complex as masks. It is entirely inappropriate to overturn well-established science in the middle of a pandemic.

Even within Australia there is no consistency about the use masks. Masks are only mandatory in Victoria. The fact that different jurisdictions within the same country are able to decide their own recommendations shows that this mandate is not based on **any** science. Science leads to clear and uniform recommendations across the world: it does not vary by state jurisdiction.

5.1.9 *Other documents and videos on masks*

I invite the ICC Prosecutor to consider the following documents and videos:

Documents

- Four potential consequences of wearing face masks we need to be wary of
- Masks Don't Work: A Review of Science Relevant to COVID-19 Social Policy

Videos

- https://thehighwire.com/videos/mask-whistleblowers-tell-all/
- https://brandnewtube.com/watch/2020-laboratory-testing-data-for-face-masks_fvpnVmscgjmu6Ge.html

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[22] https://twitter.com/sabhlok/status/1322326739456909312/photo/1

[23] https://www1.health.gov.au/internet/main/publishing.nsf/Content/519F9392797E2DDCCA257D47001B9948/$File/w-AHMPPI-2019.PDF

[24] https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/how-to-protect-yourself-and-others-from-coronavirus-covid-19/masks

5.2 Side effects

5.2.1 *As noted in a 2021 paper*

See https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2021.696818/full#h4

> Psychomotor Effects
>
> Mask-wearing could affect infants' and children's psychomotor development, as well as facial recognition (41). The still-face effect (42), for example, illustrates the human grasp of emotional expressions from very early in life, something obviously interrupted in a world filled with masked people.
>
> Moreover, one could speculate that because brain areas in the left fusiform cortex were recycled for reading expertise (43), while face recognition expertise is more lateralized in the homolateral fusiform cortex (44), some upcoming dyslexic syndromes could be expected as a consequence of the lack of face visual recognition skills' development due to bilateral ventral stream impairment.
>
> Masks also block vision of one's lower far peripheral visual field, which is crucial for visuomotor feedback when engaged in walking (45–48), something almost never consciously realized (49). Falls are a major public health concern because falls are the second leading cause of accidental or unintentional injury deaths worldwide—each year approximately 650,000 individuals die from falls (50).