Canadian Covid Care Alliance
Alliance canadienne pour la prévention et prise-en-charge de la covid
CCCA

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Open Letter 2022 August 23

Re: Mandatory COVID-19 vaccinations at Canadian Universities and Colleges

To Whom It May Concern:

Many post-secondary institutions such as the University of British Columbia and the Toronto Metropolitan University (Ryerson) are not imposing vaccine mandates for the fall term of 2022. This is consistent with the best current evidence on COVID-19 transmission and severity as well as many international government policies. Unfortunately, some post-secondary institutions such as the University of Toronto have recently reinstated COVID-19 vaccines mandates for its students and staff living in residencies, claiming that these mandates are in the best interest of the well-being of its community. This is despite the lack of requirement for such actions by Public Health Ontario, and any of the other provincial health authorities.

The membership of the Canadian COVID Care Alliance (CCCA) includes over 600 doctors, researchers and health professionals, and is committed since its launch to carefully following the scientific literature related to COVID-19, including its prevention and treatment. We recently submitted a letter to the president of the University of Toronto, Dr. Meric Gertler, in which we explained why his mandate is a retrograde action with little scientific validation. We believe that it will be in the best interests of your students, faculty and staff if we also share with you our reasons for opposing the actions being taken by the University of Toronto in case similar COVID-19 restrictions are under consideration at your institution. This also comes in the face of sweeping new changes in the COVID-19 guidelines by the US Centers for Disease Control and Prevention (CDC) posted on their website (https://www.cdc.gov/mmwr/volumes/71/wr/mm7133e1.htm). In particular, these new CDC guidelines include:

- Masks need only be worn where community transmission is deemed to be high or if an individual is considered at high risk of serious disease;
- No need for quarantine if in close contact with an infected person;
- No need for social distancing;
- Infection provides the same level of immunity as does vaccination; and
- No justification for discriminating between vaccinated and non-vaccinated persons.

Any institution should be concerned for the well-being of the community that it serves. However, such a goal is meaningless unless it encompasses the social, economic, cultural and health dynamics of **all** members of that cohort irrespective of their beliefs or behaviour towards COVID-19 policies and procedures. To do otherwise is to stratify the welfare of that community on a discriminatory basis that fails to recognize the fundamental principles supporting the concept of well-being, including the ethical norms of medical privacy. One of those principles is that the welfare of those who choose not to undergo COVID-19 vaccination must be accorded the same value without undue coercion, segregation and stigma as those who cede to them, especially when high quality, evidential science raises issues with the rationale for calling for mandatory vaccination and masking.

Public health authorities are now claiming that the principal reasons for COVID-19 vaccinations is to avoid serious illness and hospitalizations from infection with SARS-CoV-2. Yet, these purported benefits of COVID-19 vaccines still remain uncertain as they were not demonstrated as primary outcomes in their truncated, randomized clinical trials. Health authorities recognize that these novel gene-based vaccines are not actually satisfying their original role, which was to prevent acquiring and transmitting this infectious disease, which was used to justify unprecedented workplace mandates across Canada under the guise of safety and occupational health.

Demanding which drugs students, faculty and other supporting staff must take to ward off unlikely serious illnesses is not within the remit of the administrators of institutions of higher learning. If it was, smoking, drinking and recreational drug use by students and faculty would be misconduct offences. Since this does not occur, universities have generally accepted that that individuals have the right to indulge within reasonable limits in behaviours that are known to result in serious illness and hospital admissions, and which might even adversely affect bystanders.

There is an absence of scientific evidence for the contention that individuals who are not 'up to date' with COVID-19 genetic vaccines pose any significantly greater risk to themselves or others than those who have one, two, three or however many doses universities wish to enforce, since these complex biologic products do not illicit sterilizing, durable and robust immunity. In fact, major outbreaks and growing infection rates among the 'up to date' provide ample evidence that enforcing vaccination mandates is not only potentially a violation of the Canadian Charter of Rights and Freedoms, but it is also reckless due to a greater risk for adverse effects from repeated injections of gene-based vaccine products that are dose-dependent.

Therefore, the corollary of that concept must be recognized, which is that an individual's welfare demands the right to refuse COVID-19 medications deemed to be personally harmful. This a fundamental precept of biomedical research, ethics, bodily autonomy and informed consent, clearly recognized by the Nuremberg Trials over 75 years ago.

Knowing the vaccination status of students and employees might allay concerns regarding the spread of SARS-CoV-2 throughout campus facilities. However, public health authorities have recently admitted what the CCCA and scientists throughout the world have expressed for over a year, *i.e.*, the level and rapidity of the protection varies between individuals and will be in a constant state of flux. Therefore, while vaccination documents might indicate when the COVID-19 genetic vaccines were administered, they offer no reliable assessment of the true immunologic status of students, supporting staff and faculty, and they ignore natural immunity from prior and subsequent viral exposures.

Sterilizing mucosal immunity to SARS-Cov-2 infection in the respiratory tract cannot be achieved via repeated intramuscular injection of the same genetic vaccine products encoding for a now extinct ancestral SARS-CoV-2 spike protein prone to mutations and immune escape. The concept of waning immunity is applicable to students and staff living in residencies. Any vaccine-induced immunity that those individuals might have gained from the vaccines could be lost well before the fall semester ends. In addition, since these individuals are presumably not being denied access to all other facilities and, considering the questionable efficacy of the vaccines, they are just as vulnerable to acquiring and transmitting SARS-CoV-2 as would be the rest of the campus community. In fact, demanding that those in residencies must have received a primary series of COVID-19 vaccinations and, at least, one booster,

not only has no scientific foundation, it is grossly discriminatory and unreasonable as it is based solely on a domiciliary location.

In this regard, a Public Health of Ontario report on vaccine outcomes shows that the risk of hospitalization between a booster dose and a completed primary series of vaccinations among Ontarians aged 18-29 years is equal, indicating that a booster offers no additional clinical benefit in preventing hospitalizations.

According to Health Canada's statistics, since the start of the COVID-19 pandemic, the chances of someone from 12 to 29 years of age being hospitalized if they have symptomatic COVID-19 is less than 1 in 100, is less than 1 in 1000 that they will require an ICU admission, and less than 1 in 5000 that they will die. The actual risks are at least a magnitude lower than these estimates, because the Health Canada numbers are based on less than 10% of Canadians recorded as having had COVID-19, whereas serological testing indicates 50 to 90% of the population has antibodies that support prior infection with SARS-CoV-2. Furthermore, about half of recorded hospitalizations, ICU admissions and deaths were with individuals that came to hospital initially for reasons distinct from COVID-19. On top of this, the current Omicron variants of SARS-CoV-2 induce less severe clinical disease and are accompanied by low rates of hospitalizations, ICU admissions and deaths from COVID-19 than seen with earlier variants.

Moreover, there are currently in the market an increasing number of early treatment drugs available to patients at risk of more severe illness, such as the elderly or those with multiple co-morbidities. Of note, students residing on campus are overwhelmingly young and healthy, so there is no rational medical basis for enforced protection with investigational gene-based therapeutics that are still undergoing phase 3 clinical trials.

Reinstating vaccine mandates also completely fails to acknowledge any degree of natural immunity that students and staff will have likely acquired from over two and a half years of exposure during the COVID-19 pandemic. There is mounting evidence that natural immunity is superior to genetic vaccine induced immunity in terms of breadth, persistence and appropriateness of antibody and T-cell responses to a respiratory viral infection that is initiated through entry into the upper airways. The evidence now indicates that after a period of a few months of enhanced protection from COVID-19 genetic vaccination, the risk of subsequent acquisition of SARS-CoV-2 infection actually increases following booster injections.

Of greatest concern is the risk of injury, disability and potential death that the COVID-19 genetic vaccines pose to the age demographic of university and college students. These include:

- A 1 in 5,000 risk of symptomatic myocarditis in males under 24 years of age following the second and subsequent injections of the mRNA gene based vaccines is now well accepted. However, a very recent study from Thailand indicates that symptomatic myocarditis, asymptomatic myocarditis or pericarditis may occur in as high as 1 in 29 males aged 13-18 years;
- A wide spectrum of documented thromboembolic events, neurological complications and autoimmune conditions following mRNA vaccinations;
- A 1 in 3,000 risk of Guillain-Barre syndrome with the COVID-19 adenovirus vaccines;
- Growing concern on the effects of repeated injections of non-sterilizing gene-based vaccine products that can elicit deleterious immune system dysfunction, including antibody-dependent enhancement, antigenic imprinting and immune tolerance; and

- Long term uncertainty related to repeated COVID-19 vaccinations on fertility as reflected by documented menstrual irregularities in nearly 1 in 2 women in multiple studies, and transient decreases in sperm count and motility in men.

Considering all of the above, the enforcement of mandatory vaccinations at this stage has the potential for more harmful than protective outcomes for vaccine recipients. The doctrine of informed consent demands that all students, faculty and staff are made aware of this realization.

Moreover, enough real-world studies already refute the idea that masks (of any kind) reduce the transmission of viral respiratory infections. This is not surprising since SARS-CoV-2 infection is mostly acquired by aerosolized droplets that rapidly shrink by evaporating into sizes that easily penetrate the pores of even N95 masks. The SARS-CoV-2 virus is similar in size to the influenza virus whose transmission is not stopped by masks. Encouraging or requiring mask use on campus falsely exaggerates their effectiveness, and may lead to a false sense of safety (*e.g.,* not staying home while feeling sick). Mask use should be a matter of personal choice based on the wearer performing a personal risk assessment.

Following two and a half years of disruptions to student learning and a positive university and college experience, it is high time to reinstate a full range of campus activities without unnecessary breaches to medical privacy and informed consent in light of the 75th anniversary of the Nuremberg code. Doing so requires respect, understanding and tolerance, and inclusivity – the much touted albeit little practiced principles of equity, diversity and inclusion (EDI), for a diverse range of decisions, comfort levels and health needs relating to COVID-19 policies and procedures. Such objectives can be readily accomplished by dispensing with all demands relating to vaccine mandates and mask use, while emphasizing the importance of one instruction. It is the simple but time-tested adage applicable to all: **stay home if you are feeling unwell due to cold, flu or COVID-19-like symptoms until they abate.**

Our Alliance is pleased to supply primary references to substantiate all of our claims and conclusions. We look forward to a response that - we trust - will not adversely affect the health and human rights of your campus community. We hope that your institution will follow the lead of other Canadian universities, such as the University of British Columbia, Simon Fraser University, the University of Alberta, the Toronto Metropolitan University, the University of Montreal, and McGill University, which have no stated plans to impose COVID-19-related restrictions and mandates this fall upon their campus communities at the time of writing this letter. Please inform us of any factual errors in this letter, which has been publicly posted to our website. We look forward to communicating your response to our over 30,000 supporters.

Respectfully submitted by,

The Science and Medical Advisory Committee,

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