Open Letter from the UK Medical Freedom Alliance to Headteachers and Teachers
Re: Face Masks for School Children

Dear Headteacher / Teacher 05 October 2021

The UK Medical Freedom Alliance (UKMFA) is an alliance of UK medical professionals, scientists and lawyers who are campaigning for Medical Freedom, Informed Consent and Bodily Autonomy to be preserved and protected.

We implore you to assimilate all the available scientific evidence when you consider your decision whether to mandate or even encourage face coverings for the children in your care.

We previously wrote an Open Letter[i] in February 2021 calling upon the UK's Governments and Health Ministers "to retract, with immediate effect, any guidance which relates to, and revoke any laws which mandate, the wearing of face coverings for all children under the age of 18 in all settings and under any circumstances."

We wrote a further Open Letter[ii] in August 2021 calling upon the UK's Chief Medical Officers and Health Ministers to publish a clear exit strategy from all Covid-19 mandates and restrictions. In this letter, we outline the poor scientific evidence base for government policies quoting their own documents and call for increased transparency regarding the justifications for their decisions, which should be available for independent and public scrutiny. We invite you to read this letter and its references.

Face masks are a medical intervention, with risks associated, so their indication should be subject to meticulous scrutiny, especially with regards to children's health. We are 18 months into the pandemic, however the evidence for mask effectiveness remains weak and sparse. Most concerningly, detailed impact and risk assessments have still not been carried out and published, neither for use by the general public nor for use by children in schools.

We would therefore urge you to carefully consider the following with regards to your school:

a. Face masks **potentially cause physical and psychological harms to the wearer**, especially when worn incorrectly or for prolonged periods, both common in schoolchildren.

b. Face masks provide **false reassurance**, as they do not actually prevent viral transmission.

c. Face masks are a medical intervention and mandates constitute an **unnecessary restriction on individual bodily autonomy and medical freedom**.

d. Face masks **promote societal fear and division, and impair healthy communication between people, which is of acute significance for children and their learning.**

We would like to specify some of the available evidence to support this letter as follows:

1. **Potential risks of face coverings to physical health**
2. **Potential risks of face coverings to mental health**
3. **Inconclusive evidence regarding benefits of face coverings**
4. **Specific concerns in relation to children**

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Potential risks of face coverings to physical health

1. The **WHO stipulates that decision-makers implementing mask policies for the public should "clearly communicate the purpose of wearing a mask" and "inform/train people on when and how to use masks"**. They also state that "the impact (positive, neutral or negative) of using masks in the general population (including behavioural and social sciences)" should be evaluated "through good quality research"[iii].

2. The **WHO acknowledges "potential disadvantages of mask use by healthy people in the general public"** including "headache and/or breathing difficulties", "facial skin lesions, irritant dermatitis or worsening acne" and "difficulty with communicating clearly"[iii]. This has been demonstrated particularly after prolonged use of masks[iv].

3. There has been little public education about the different types of masks, how to wear them, how long they may be worn, any additional precautions that may be necessary and how to dispose of them safely. Furthermore, there has been no clear advice on washing cloth masks to maintain good hygiene, particularly for masks worn daily for extended periods as typically by children in schools.

4. To our knowledge, **no impact or risk assessment relating to widespread mask wearing by the public has been considered, undertaken, or published to date in the UK.** The Cochrane Review on the use of physical interventions to reduce viral spread commented that **"Harms associated with physical interventions were under-investigated"**[v].

5. According to the available evidence, mask wearing (especially cloth masks) may not only **increase the risk to the wearer of contracting a respiratory illness but also increase the risk to others**, especially when worn and handled incorrectly[vi vii viii ix]. This was acknowledged by the Deputy Chief Medical Officer Jenny Harries as early as March 2020, who stated that **"people can adversely put themselves at more risk than less" by wearing a face mask**[x].

6. Rebreathing exhaled air may increase the risk of bacterial respiratory infections and consequently **increase the risk of bacterial pneumonia**[xi]. Surgical face masks were found to be a repository of bacterial contamination in a study on surgeons[xii]. Notably, this study recommended changing the mask after every operation, especially those taking more than 2 hours, and surgeons are trained not to touch their masks, unlike children.

7. Face coverings may also be associated with an **increased risk of bacterial skin infections around the mouth**[xiii xiv]. This may be particularly distressing for children and teenagers, affecting their confidence and self-image.

8. Several studies highlight **detrimental effects of face coverings on gas exchange**. The WHO states that "**several studies have demonstrated statistically significant deleterious effects on various cardiopulmonary physiologic parameters during exercise"** [xv]. Even in healthy people, masks caused breathing difficulties during a six-minute walk test. Ventilation and cardiopulmonary exercise capacity were reduced by surgical masks in young, healthy males[xvi]. Face masks have been shown to **lower oxygen saturations during exercise**[xvii], in pregnant women[xviii] and in patients during dialysis[xix]. This may lead to **increased adverse respiratory effects and thus to aggravation of established chronic disease**[xx xxi].

9. **Cloth face coverings (commonly used by children) increase exposure to chemical substances in the textiles**, which may be harmful. Many chemicals are used in the manufacture of textiles including dyes and "finishes" (e.g. crease-resistant, anti-microbial, hydrophilic, anti-static and fire-retardant finishes)[xxii]. Frequent washing of cloth masks will result in contamination from laundry detergent chemical residues including surfactants, alkalis, ion-exchangers, complexing agents, bleaching agents and other additives[xxiii]. Prolonged daily wearing of a cloth mask leads to inhalation of these chemical substances, which may be enhanced by the breathing action and the moist surface of the covering. It has also been suggested that the inhalation of small fibers shed by masks may cause harm. **We are unaware of any published risk assessments investigating any potential local respiratory and systemic adverse health effects.**

10. **No studies have examined the long-term safety or harmful effects of wearing a face covering for several hours a day over weeks or months**, as required of many UK schoolchildren.

Potential risks of face coverings to mental health and society

11. **Widespread and prolonged masking of a healthy population over months/years is highly experimental,** with no attempt to study the impact on mental health and social interactions. Healthy communication depends on facial expressions and non-verbal cues and is crucially important for the **emotional and social development of children.** The UK Parliament acknowledged that masks impede communication, making it harder to recognize who is speaking and to be heard[xxiv]. **The UK Government's own advice mentions the "negative impact" of face coverings on communication, especially in the context of education**[xxv].

12. The mental health charity MIND has raised concerns about the negative impact of face coverings on mental health[xxvi], highlighting the **risks of increased anxiety, worsening of mental health conditions and the harm caused by seeing other people in masks, which may feel threatening and induce a natural fear response.** This may apply specifically to survivors of rape[xxvii] and domestic abuse[xxviii], especially if the abuse included their faces or mouths being covered or being choked or smothered[xxix].

13. Effects on, and risks to, mental health are most important to be considered, especially amid **concerns regarding rising suicide rates and an explosion of mental health issues** being reported as a result of the impacts of the Covid-19 pandemic[xxx].

14. Face covering legislation recognises that **some people have physical or mental health conditions that are exacerbated by wearing masks** and have granted these people an exemption from the mandate. However, **this has not been communicated clearly to the public**. Despite governmental acknowledgment that clarity of communications around exemptions would help mitigate instances of disability discrimination, this has not happened to any meaningful degree[xxxi] and has led to **continued incidents of illegal and often hostile discrimination towards vulnerable members of the community**, by other members of the public and by law enforcement officers and even in schools, posing further risk to mental health.

15. **Despite the substantial body of evidence that raises serious concerns about the harmful effects of face coverings on physical and mental health, no impact or risk assessments have been carried out to demonstrate that these are outweighed by potential benefits.**

Inconclusive evidence regarding benefits of face coverings

16. At the beginning of the pandemic, several senior health officials stated **"The global evidence is masks in the general population don't work"**[xxxii]. WHO guidance from December 2020, entitled "Mask use in the context of COVID-19," stated **"there is only limited and inconsistent scientific evidence to support the effectiveness of masking of healthy people in the community"**[xxxiii].

17. Nevertheless, policies changed dramatically, gradually mandating face coverings in every indoor setting, including schools. **The proposal and implementation of these policies is unsupported by any compelling or high-quality scientific evidence**[xxxiv]. It has remained unclear whether the purpose of face mask guidance for the public is for source control or personal protection.

18. **Currently available scientific evidence does not support the hypothesis that face coverings are an effective protective measure to prevent viral transmission**, as highlighted by several scientific bodies, detailed below. In addition, results from studies done in healthcare settings may not be applicable to public settings, and **no published studies have included children**.

19. A Cochrane review, dated November 2020, concluded that there is **"uncertainty about the effect of face masks"**[xxxv]. Detailed analyses by the Oxford Centre for Evidence-Based Medicine highlight the **paucity of reliable data** on the subject, which do not allow the conclusion that face coverings should be widely recommended[xxxvi] [xxxvii]. Twelve randomised controlled trials (RCTs) with 13,259 subjects showed **no significant effect in interrupting viral spread**.

20. The US Centres for Disease Control and Prevention (CDC) published a policy review in May 2020 stating that **evidence from 14 RCTs did not support a substantial effect of face masks on reducing transmission of laboratory-confirmed influenza**[xxxviii].

21. Only one trial assessed the effects of cloth masks, which are currently worn by most schoolchildren. This trial showed the **wearing of cloth masks to increase the risks of influenza-like illness (ILI) 13 times compared to medical masks**, and **3 times compared to no masks**[xxxix].

22. The **risk of potential self-contamination**, especially with prolonged mask wearing, has also been raised, questioning the value of face masks as a means of source control[xl]. Studies show masks worn by pre-symptomatic or mildly infected people may **increase the risk of spreading disease, due to virus accumulation on the outer mask surface combined with touching the mask**. There was **no good evidence for the protection of the public through the wearing of face coverings**[xli].

23. Most available studies have evaluated the effects of masks on transmission of influenza-like illness. One published systematic review and meta-analysis relating to Covid-19, supporting the use of face coverings, included only observational and comparative studies[xlii]. The type of masks evaluated was not specified. Recently published studies claiming that masks (including cloth masks) reduce SARS-CoV-2 transmission were not clinical or population-based studies but used computer modelling or laboratory simulation to reach their conclusions[xliii] [xliv].

24. **The Danish mask study, DANMASK-19**[xlv] was a large RCT, with 6,000 participants, designed specifically to investigate the effectiveness of face coverings in preventing transmission of SARS-CoV-2. **It did not show a statistically significant reduction in SARS-CoV-2 infection rate in participants wearing masks in addition to other precautions** including social distancing and hand hygiene (1.8% masks v 2.1% no masks). This large trial did not show face coverings to have a protective effect on the wearer.

25. Source control of asymptomatic individuals would only be required if they transmit the virus to others. There is **currently no evidence to support the hypothesis of asymptomatic transmission of SARS-CoV-2**. On the contrary, data from a recent large Chinese population study suggests there is virtually no risk of viral transmission from PCR positive, asymptomatic people to others[xlvi]. A further detailed analysis of the available published literature highlights the lack of persuasive evidence that asymptomatic transmission is of any clinical significance[xlvii].

26. A comprehensive literature review by Swiss Policy Research, recently updated in August 2021[xlviii], concluded that "Face masks in the general population might be effective, at least in some circumstances, but there is currently little to no evidence supporting this proposition. If the coronavirus is indeed transmitted via indoor aerosols, face masks are unlikely to be protective. **Health authorities should therefore not assume or suggest that face masks will reduce the rate or risk of infection**."

27. Data from countries (such as Sweden) and states in the US, who have implemented vastly different policies, show clearly that **mask mandates and other restrictive measures have had no impact on the rates of Covid-19 cases**[xlvii xlix]. Comparing numbers of Covid-19 deaths per million people between the UK and Sweden, where mask mandates and other lockdown measures were never implemented, indicates that **governmental restrictions are not effective in reducing Covid-19 deaths**. Data from the US states of Florida, where restrictions were lifted before October 2020, and California, where strict mandates remain in place, suggest the same.

28. **The presented evidence does not support face coverings to be effective for the purposes of either source control or personal protection, in the general population or in schools.**

Specific concerns in relation to children

29. Children have a negligible risk of serious morbidity or mortality from Covid-19[l]. They play a minimal role in transmission[li], supported by the data showing that teaching is a low-risk occupation[lii]. **In children, potential benefits of face coverings are expected to be minimal. It is therefore vital to ensure there are no harmful effects.**

30. There are no published studies investigating the effectiveness of face coverings in children in reducing transmission, morbidity, or mortality. **Children are likely to wear masks incorrectly and touch their faces, which will increase the risks to their respiratory health.** The increased risk of facial dermatitis and acne is specifically relevant for teenagers, as it may negatively affect their body image and consequently their mental health.

31. Inhaling sufficient oxygen is vital for optimal health, particularly for children whose brain development and function (allowing optimal learning) relies on adequate oxygen supply. **The long-term effects of face coverings on brain development, educational attainment, or any other aspects of children's physical and mental health, have never been studied.**

32. The Education Act 1996 (Part 1, Chapter 2)[liii] asserts that **schools have a statutory duty of care towards pupils, in relation to their mental and physical well-being, and a duty to promote and provide for education and development of children**. Yet, this recently published Government document acknowledges that face coverings "can have a negative impact on learning and teaching"[liv]. A group of 70 Flemish doctors stated that **"mandatory face masks in schools are a major threat" to children's development** and reported an increasing number of children presenting with anxiety, sleep problems and behavioural disorders[lv].

33. The only published **impact assessment on mask wearing in children** is a German registry, reporting results from parents, who entered data on a total of 25,930 children. Average wearing time of the mask was 270 minutes per day. **Impairments to children, caused by wearing face masks, were reported by 68% of the parents**. These included irritability (60%), headache (53%), difficulty concentrating (50%), less happiness (49%), reluctance to go to school / kindergarten (44%), malaise (42%) impaired learning (38%) and drowsiness or fatigue (37%)[lvi].

34. Experts have raised concerns, not only regarding **potential harms to children's physical and mental health, but also to their academic, social, and emotional development.**

Conclusions and Requests

35. We conclude citing this recent publication entitled "**Children are not Covid-19 super spreaders: time to go back to school**"[lvii].

36. Children have endured a disproportionate burden of the pandemic and all the imposed restrictions over the last 18 months. We advocate it is time to **scrutinize all the available evidence before subjecting them to a single further measure that has potential to harm them**.

37. We urge you to read this letter in detail with all the included references, prior to making any decisions regarding your school's policies on mask-wearing for children.

38. We also urge you to consider **potential liability for any measures you impose** in the absence of good quality scientific evidence and any published impact and risk assessments, should any of the children under your care come to harm, may this be as a direct result of wearing a face covering or due to emotional strains of discrimination or hindered education.

39. We point out to you that even the government's own documents suggesting measures of mandating face coverings, do not contain references to any scientifically valid justifications, as we have outlined in this and our previous letters. **The lack of evidence and risk assessments is most certainly pertinent with regards to face coverings for children within their learning environment.**

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We thank you for your time taken to consider our points.

UK Medical Freedom Alliance
www.ukmedfreedom.org

Cc: Rt Hon Boris Johnson – Prime Minister
Rt Hon Nicola Sturgeon – First Minister of Scotland
Rt Hon Mark Drakeford - First Minister of Wales
Rt Hon Arlene Foster - First Minister of Northern Ireland
Rt Hon Sajid Javid – Secretary of State for Health and Social Care
Jeane Freeman – Scottish Government Health Secretary
Vaughan Gething – Welsh Assembly Minister of Health and Social Services
Robin Swann - Northern Ireland Assembly Minister of Health

[i] https://uploads-ssl.webflow.com/5fa5866942937a4d73918723/602e6afd2d5e00dbe4cfd228_UKMFA_Open_Letter_Face_Mask_Mandates.pdf
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