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March 31, 2022

Kasari Govender
Human Rights Commissioner
Office of the Human Rights Commissioner
536-999 Canada Place
Vancouver BC V6C 3E1

Dear Commissioner:

Thank you for your service during the pandemic. It has been a pleasure to work with you during these challenging times to ensure that the human rights of all British Columbians are upheld and respected.

Thank you, too, for your letter. I have reviewed your concerns in depth and have shared them with colleagues to be sure we have addressed both the public health and public health ethical considerations that underlie the decisions we made.

Your letter reflects some important and understandable concerns, ones that we know are held quite broadly in the public even as the pandemic situation has evolved over the past two years. We are very grateful for the opportunity to clarify three important issues:

- Who amongst us carries a higher risk of serious outcomes with COVID-19 at this stage of the pandemic, and what is the current risk to those most vulnerable to infection?
- What are the most effective means of protecting those vulnerable to COVID-19 at this stage of the pandemic?
- When does a legally enforceable Order, such as mandatory masking in public settings, meet the ethical and legal standards for imposition, and what principles guide the decision to impose or rescind such an order?

Due to the effectiveness of vaccination, the number of people at risk for serious outcomes from COVID-19 has dropped significantly.

Prior to the availability of vaccines, there was a significant proportion of the population at risk for serious outcomes, including many of the groups you referenced in your letter (older people, people with immune-compromising conditions, racialized and Indigenous people and people

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living in low-income communities). Now that BC has achieved an exceptionally high vaccination rate, the majority of those previously at risk for serious outcomes are protected through vaccination.

As you reference in your letter, and as we have heard as well, there are many people in the province who believe they remain at very high risk of serious COVID-19 outcomes due to their underlying medical conditions. We continue to follow the data very carefully on who is more severely affected, ends up needing hospital care or is dying from COVID-19. Thankfully the data tell us the risk is no longer elevated in most people, even in people with underlying medical conditions, who are fully vaccinated. The leading risk factor for serious outcomes continues to be older age (see Appendix 1), and some very specific severe immune compromising conditions that do not respond well to the vaccines (specifically people who have or have had haematologic malignancies, people being treated for melanoma, people who have had a solid organ transplant and people with chronic renal failure requiring hemodialysis). All other underlying medical conditions present significantly lower risk in people who have the protection that vaccines provide[1]. At this stage of the pandemic, even amongst the frailest elderly populations in long term care facilities, most vaccinated residents with COVID-19 experience mild symptoms.

Overall, the rates of COVID-19 hospitalization and death remain low and stable (Appendix 2). The exception is among unvaccinated individuals at any age where the rates remain disproportionately high (Appendix 3). These findings demonstrate the importance of vaccination as the most effective intervention to protect individuals from serious outcomes[2]. We will continue to carefully monitor the protection provided by each dose of vaccine and will provide additional doses as needed to protect those who remain at greatest risk as the pandemic continues to evolve.

The most effective means of protecting those most vulnerable to serious outcomes due to COVID-19 is vaccination. However, other important measures can contribute to mitigating risk.

While remaining up to date with vaccinations is by far the most important measure to protect against serious outcomes of COVID-19, other effective measures individuals can take have been instituted and should be continued at a population level, including:

- A culture of staying home when sick and practicing basic hygiene measures such as coughing into your sleeve and washing your hands regularly
- Employment policies and supports that enable employees to stay home when sick
- Paying attention to adequate ventilation in indoor spaces

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[1] Velásquez García HA, Wilton J, Smolina K, et al. Mental Health and Substance Use Associated with Hospitalization among People with COVID-19: A Population-Based Cohort Study. Viruses. 2021;13(11):2196. Published 2021 Oct 31. doi:10.3390/v13112196

[2] BCCDC Situation Report accessed March 29th, 2022 at: http://www.bccdc.ca/Health-Info-Site/Documents/COVID_sitrep/Week_10_2022_BC_COVID-19_Situation_Report.pdf

For people who are more vulnerable to serious outcomes from COVID-19 due to age, being unvaccinated, or having very specific immune compromising conditions (see Appendix 4.) the following measures may further mitigate risk, although to a lesser degree than vaccination:

- Seeking COVID-19 testing at the onset of symptoms, and notifying their healthcare practitioner if they have a positive test to determine whether they are eligible for treatment
- Asking family members and loved ones to stay away when they're feeling unwell until their symptoms have fully resolved
- Making the choice to wear a good quality mask in crowded indoor spaces where prolonged contact with others is anticipated.

Today, the vast majority of British Columbians are protected against serious illness through immunization, and those who cannot be immunized, mostly children under five, continue to be at very low risk of serious illness. The virus itself has also changed. As the SARS-CoV-2 virus has evolved to become more transmissible, we anticipate that virtually everyone will have the potential to be exposed. We also know that people are most commonly exposed in their homes or in social settings where masks are not generally worn. In this scenario, a legal requirement to wear a mask in public settings is likely to have little additional benefit.

Principles of best practice, public health policy and public health ethics guide decision-making for both imposing and repealing legally enforceable Public Health Orders, including the *Face Coverings Order*.

Throughout the pandemic our common goals have been to minimize, to the extent possible, pandemic related morbidity (sickness) and mortality (death), to protect those most vulnerable to infection, and to minimize the adverse societal impacts on populations and individuals resulting from the pandemic and our response to it. These shared goals require continual review and adjustment as we progress through the pandemic phases.

We aim to achieve these goals through good public health policy, which means implementing restrictions that are the least intrusive available, based on scientific evidence, neither arbitrary nor discriminatory in application, of limited duration, respectful of human dignity and subject to review. In making the decision to lift the *Face Coverings* Order in British Columbia we carefully and cautiously considered all these factors.

Once a respiratory virus has become established in the population, as is the case with COVID-19, the public health goal is to reduce the harms associated with exposure. Effective means of reducing harms include vaccination, treatment, and the use of infection control measures in settings where people most at risk of severe illness live or receive care.

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Any enforceable mandate at a population level is by definition, intrusive and that is why I take these measures considering carefully the balancing of risk and benefit. While mask requirements are certainly less burdensome than many other public health restrictions, they are still associated with some burdens and inequities, which means the order requiring their use still needs to be constantly reviewed for harms vs benefits. While harms are likely to be limited for short-term requirements, extending legally enforceable Orders to wear masks, with no clearly achievable threshold for removal, increases those burdens. While many people only needed to wear a mask for limited periods when in public spaces, school-aged children, post-secondary students and those working in service occupations have been required to wear them throughout their school or work day. It is important to note that these same groups experienced some of the greatest impact from other public health measures, such as loss of employment, educational disruption, and restriction of social interactions that are critical for healthy development during childhood and youth. These same individuals are also at lowest risk of serious outcomes from COVID-19. In addition, mandates come with enforcement, which brings consequences for non-compliance. Enforcing a mandate that is now of minimal population level benefit, even if it still benefits some individuals in some instances, can also result in social disruption, relationship fractures and stigmatization.

According to the *Public Health Act*, as well as public health ethical principles, an Order such as the requirement to wear a mask in indoor public places may be made *temporarily* when an Order is necessary to protect greater public health. Now we have entered a time when safe and effective vaccines have been developed and distributed and we have achieved very high population immunity. Treatments are available for those who remain at higher risk of serious illness. Safety plans that address risk and include, as appropriate, the use of barriers and ventilation remain in place in indoor public settings. Apart from variant specific vaccines, no further interventions are anticipated and there is no indication that temporizing measures, such as legally enforceable Orders to wear masks in public settings, will be of further benefit. Indefinite restrictions bring social, psychological, and economic harm, as well as competing health risks. It was in carefully considering all these factors that I made the decision that this was the appropriate time to repeal the *Face Coverings* Order. Knowing that this would increase concerns and anxieties for some, I gave notice of the timing in February and detailed the conditions that would allow for the Order to be repealed in early March.

However, I must be clear: just because the legally enforceable Order is being repealed, this does not mean that people cannot or should not wear masks in certain situations. From now on, people are encouraged to assess their own risk and decide what measures they feel they need to take to protect themselves or feel comfortable. Wearing a mask in those higher risk indoor public spaces is still encouraged depending on your own comfort level and risk, and I have been clear that others should respect peoples' decisions to wear or not wear masks now that the *Face Coverings* Order is no longer required by law. We are in a time of transition, and it is as important as ever to support and respect each other with kindness, just as people in British Columbia have been doing throughout this pandemic.

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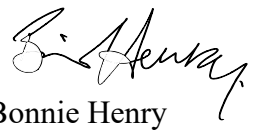
The balance of considerations for public health restrictions—that they be necessary, least intrusive, based on scientific evidence, neither arbitrary nor discriminatory in application, of limited duration, respectful of human dignity and subject to review—lead me to conclude that extension of a legally enforceable Order is not justified in British Columbia at this time. As we have always done, we will continue to monitor the pandemic around the globe and in BC and should conditions change, we will adapt our response and the measures in place as needed to protect public health.

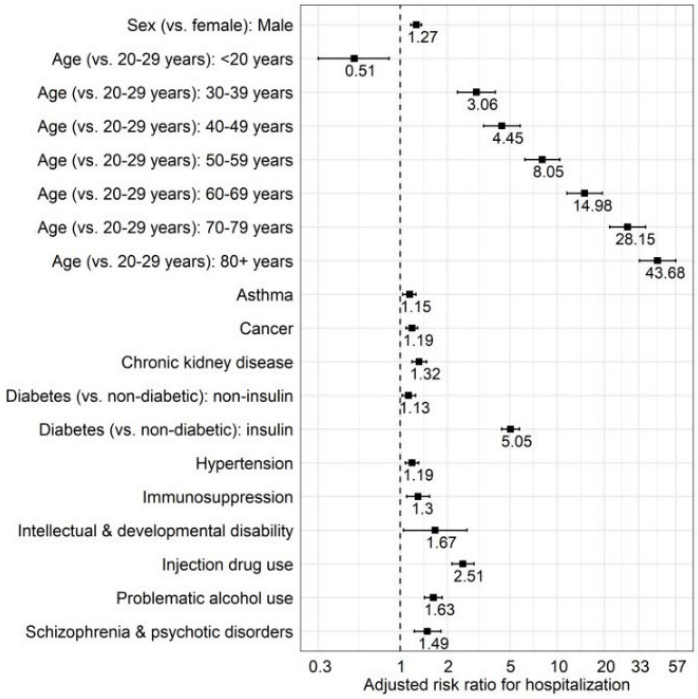
Sincerely,



Bonnie Henry
OBC, MD, MPH, FRCPC
Provincial Health Officer

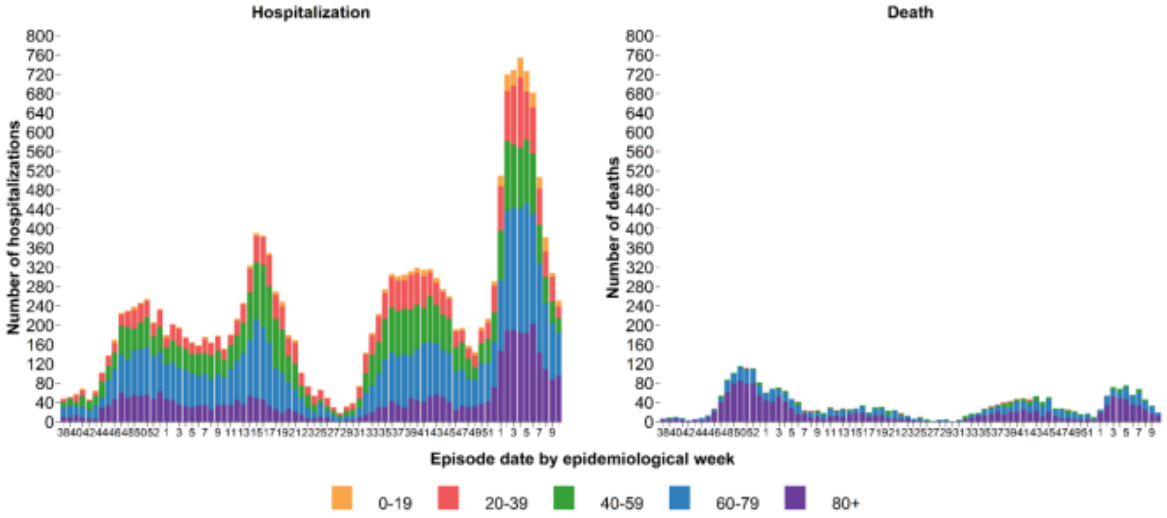
Appendix 1.

Figure 1. Multivariable model for factors associated with COVID-19 related hospitalization in British Columbia.



Appendix 2.

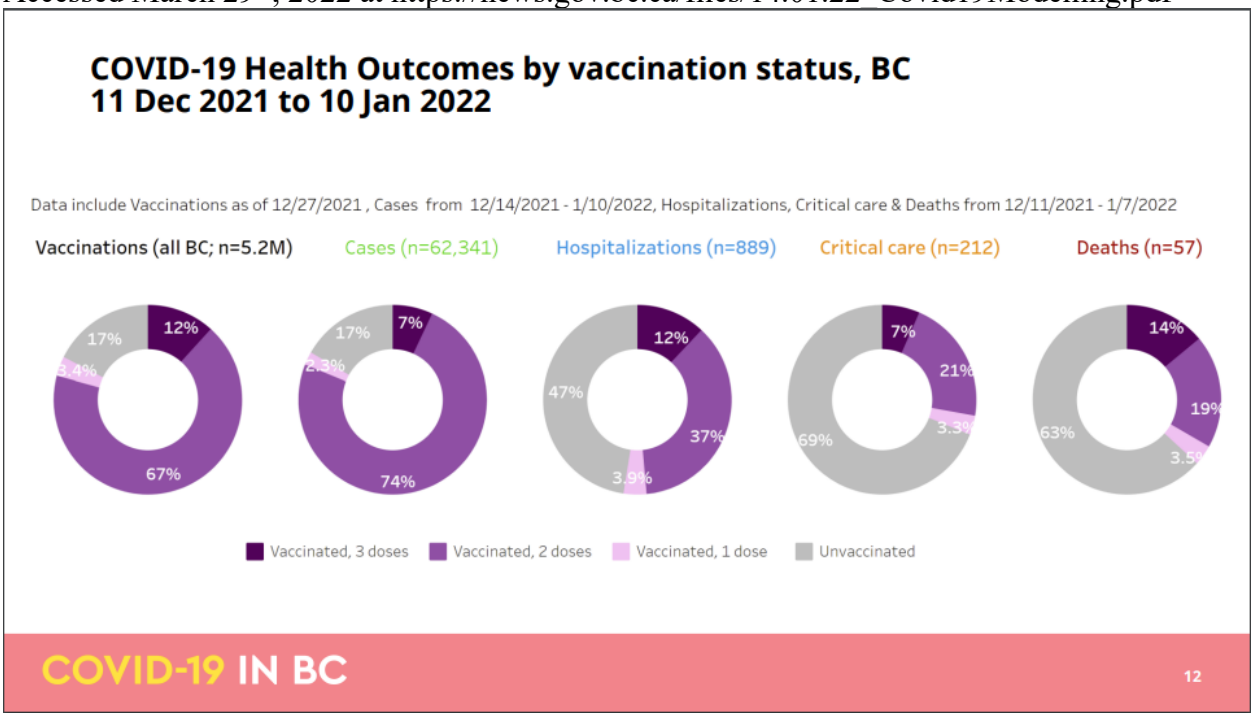
Figure 2. Weekly COVID-19 hospital admissions and deaths by age groups, BC, Sept 13, 2020 – Mar 1, 2022.



a. Among those with available age information only.

b. Data source: Health Authority case line lists only. Data may be incomplete and subject to change.

Appendix 3.
Accessed March 29th, 2022 at https://news.gov.bc.ca/files/14.01.22_Covid19Modelling.pdf



Appendix 4.
Conditions of moderate to severe immunocompromise
Accessed March 29th, 2022: https://www2.gov.bc.ca/gov/content/covid-19/vaccine/register

Have had a solid-organ transplant and are taking immunosuppressive therapy:

- Have had a solid organ transplant. May include a heart, lung, liver, kidney, pancreas or islet cells, bowel or combination organ transplant

Are on active treatment for solid tumour or hematologic malignancies (like myeloma or leukemia):

- Since January 2020 have received an anti-CD20 drug for a malignant condition
- Since March 2020, have received or are receiving systemic therapy (including chemotherapy, molecular therapy, immunotherapy, targeted therapies including CAR-T, monoclonal antibodies, hormonal therapy for cancer). This includes solid tumours as well as hematologic cancers within this time period
- Since October 2020, have received or are receiving radiation therapy for cancer

Have had a hematopoietic stem cell transplant:

- Since September 2019, have had bone marrow or stem cell transplant or are still taking immunosuppressant medications related to transplant

Have moderate to severe primary immunodeficiency:

- Have combined immune deficiencies affecting T-cells, immune dysregulation (particularly familial hemophagocytic lymphohistiocytosis) or those with type 1 interferon defects (caused by a genetic primary immunodeficiency disorder or secondary to anti-interferon autoantibodies)
- Have a moderate to severe primary immunodeficiency which has been diagnosed by an adult or pediatric immunologist and requires ongoing immunoglobulin replacement therapy (IVIG or SCIG) or the primary immunodeficiency has a confirmed genetic cause (e.g. DiGeorge syndrome, Wiskott-Aldrich syndrome)

Prior AIDS defining illness or prior CD4 count ≤ 200/mm3 or prior CD4 fraction ≤ 15% or any detectable plasma viral load since January 2021 or HIV infection and ≥ 65 years old or perinatally acquired HIV infection.

Are on active treatment with the following categories of immunosuppressive therapies:

- Since January 2020, been treated with anti-CD20 agents: rituximab, ocrelizumab, ofatumumab, obinutuzumab, ibritumomab, tositumomab
- Since January 2020, been treated with B-cell depleting agents: epratuzumab, MEDI-551, belimumab, BR3-Fc, AMG-623, atacicept, anti-BR3, alemtuzumab
- Since December 15, 2020 been treated with biologics: abatacept, adalimumab, anakinra, benralizumab, brodalumab, canakinumab, certolizumab, dupilumab, etanercept,

golimumab, guselkumab, infliximab, interferon products (alpha, beta, and pegylated forms), ixekizumab, mepolizumab, natalizumab, omalizumab, resilizumab, risankizumab, sarilumab, secukinumab, tildrakizumab, tocilizumab, ustekinumab, or vedolizumab

- Since December 15, 2020 been treated with oral immune-suppressing drugs: azathioprine, baricitinib, cyclophosphamide, cyclosporine, leflunomide, dimethyl fumerate, everolimus, fingolimod, mycophenolate, siponimod, sirolimus, tacrolimus, tofacitinib, upadacitinib, methotrexate, dexamethasone, hydrocortisone, prednisone, methylprednisolone, or teriflunomide
- Since December 15, 2020 been treated with steroids orally or by injection on an ongoing basis: dexamethasone, hydrocortisone, methylprednisolone, or prednisone
- Since December 15, 2020, been treated with immune-suppressing Infusions/injections: cladribine, cyclophosphamide, glatiramer, methotrexate

Are on dialysis and/or with severe kidney or renal disease:

- On dialysis (hemodialysis or peritoneal dialysis) or have stage 5 chronic kidney disease (eGFR <15ml/min or have glomerulonephritis and receiving steroid treatment