

Commentary: CHAIR Responds to the Petition Opposing CSA Z94.4-25

The standard is clear, science-based, and long overdue.

By CHAIR (Coalition for Community and Healthcare Acquired Infection Reduction)

<https://chaircoalition.org>

The petition opposing CSA Z94.4-25 contains serious misrepresentations. As experts familiar with both the CSA process and respiratory protection science, we offer the following clarifications to help set the record straight.

The CSA Standard Is Evidence-Based and Clear

- The **CSA Z94.4-25 standard is thoroughly evidence-based**, with references included throughout.
- It reflects a **paradigm shift**: the new default is to **protect healthcare workers (HCWs)** unless safety without protection can be clearly demonstrated - not the outdated default of leaving HCWs unprotected.
- **Risk analysis now determines where respiratory protection can be waived, not where it must be justified.**
- **Modes of transmission are accurately classified**, with airborne transmission recognized as the predominant mode for many pathogens, including SARS-CoV-2.

What the Standard Does Not Say

Contrary to claims in the petition:

- It **does not claim that all antimicrobial resistant organisms are airborne.**
- It **does not require respirators for non-pathogenic organisms.** In fact, it explicitly defines protection levels:
 - **RG1 (non-pathogenic)**: No respiratory protection required
 - **RG2 & RG3**: N95 or equivalent
 - **RG4**: PAPR with APF 1000
- There is **no confusion** in the document - the protection logic is clear, practical, and science-based.

□ The CSA Process Is Transparent and Balanced

- The CSA standard committee follows a **transparent and inclusive process**. Committees are composed of a **balanced matrix of stakeholder interests**, and all author affiliations are disclosed.
- There were **dozens of healthcare representatives** engaged over two years. Some chose not to participate, but those who did were overwhelmingly supportive.
- Contrary to suggestions of bias, **there is no commercial conflict of interest**:
 - “Producer Interest” (e.g. manufacturers) is a required category, but in this case **was underrepresented** with only **one manufacturer (3M)** present on the committee.
- Disclosure - Barry Hunt, Co-Founder and Executive Director of CHAIR, is a CSA Z94.4 Committee member, former respirator producer, and provides unpaid voluntary guidance to the Canadian Association of PPE Manufacturers (CAPPEM).

💰 Respirator Use ≠ Commercial Windfall

- There is **no commercial “pot of gold”** from adopting this standard.
- Major manufacturers like 3M and Medicom already have **long-term contracts** (up to 10 years) in place with provincial and federal governments.
- Healthcare systems in Canada are **overstocked with respirators**. If not used, they will be **landfilled or recycled** when they expire.
- Implementing this standard would **prevent waste**, not create it.

🤝 A Moment to Build Trust, Not Undermine It

- Adopting CSA Z94.4-25 would **increase trust in healthcare**, not erode it.
- The standard provides **clarity, consistency, and science-aligned policy** to protect workers and patients alike.

➔ Final Thought

Opposition to increased respiratory protection in healthcare when one-third of respiratory disease in hospital (Flu, RSV, and CoVID) is caused by the hospital itself is the antithesis of **precautionary, protective, or scientific** in nature.

The CSA committee has done commendable work. At this point, it's **imperative they receive support** to see this standard through. We have an opportunity in Canada to move beyond outdated paradigms to align healthcare worker and patient protection with the care, concern, science and ethics people deserve and the sustainability our healthcare system needs.