

**Yashraj Roy**  
**Advocate**  
**HIGH COURT, CALCUTTA**

C/o. A. Chakraborty  
Advocate  
GD-10, Sector – III, Salt Lake  
Police Station – Bidhannagar South  
Kolkata - 700106  
Mobile No. 7439271212

Dated: 10.02.2022

To

1. The Learned Government Pleader,  
High Court, Calcutta.
2. The Chief Secretary,  
Government of West Bengal,  
Nabanna, 325, Sarat Chatterjee Road,  
Shibpur, Howrah - 711102.
3. The Principal Secretary (Health)  
Government of West Bengal,  
Swasthya Bhavan, GN-29, Sector - V,  
Salt Lake, Kolkata - 700091.
4. The Learned Additional Government Advocate,  
Ministry of Law and Justice,  
Department of Legal Affairs,  
Service through the Secretary, The Ministry of Health and Family Welfare,  
Government of India.  
11, Strand Road,  
Kolkata - 700001.
5. The Learned Additional Government Advocate,  
Ministry of Law and Justice,  
Service through the Secretary,  
The Ministry of Home Affairs,  
Government of India  
11, Strand Road, Kolkata - 700001.

Re: W.P.A. (P) No. 65 of 2022  
Sri Jagadish Chanda  
-Versus-  
The State of West Bengal & Ors.

...Petitioner

...Respondents

Dear Sir(s),

Please find enclosed herewith a copy of Writ petition alongwith all annexures was  
DM filed before Their Lordships the Hon'ble Chief Justice, <sup>Prakash Srinivasa</sup> and the Hon'ble Justice Rajarshi  
Bharadwaj at the High Court at Calcutta and the same will be appeared before His Lordship  
List on 21.02.2022 or any other subsequent date as per Court's business.

Kindly attend at the time of hearing.

Thanking you,

Encl: As above;

Yours faithfully

*Yashraj Roy*  
Advocate.

### SYNOPSIS

That the present petition filed against the mandate of the executive namely Home Secretary, Govt. of India and Chief Secretary, Govt. of West Bengal regarding use of face mask in public.

That there is no scientific /medical evidence came out as a result of research indicating that the face mask prevents spreading of Covid and also protect a healthy citizen from the Covid.

That as per report of W.H.O. the use of face mask cause serious damage to the health of the healthy citizens.

That the Department of Health and Family Welfare, Govt. of India categorically stated that there was no order which stated that the wearing mask is mandatory. The said department further stated that no research and study has been made to prove conclusively that wearing face mask prevents Covid;

That the Home Secretary, Govt. of India and the Chief Secretary, Government of West Bengal are arbitrarily forcing the citizen to wear face mask in public and also slapped criminal case arbitrarily and imposing fine and arresting the people without following the due process of law and such act is not backed by any legislation;

That even after vaccination people suffering from COVID-19 and the Government of India recently in a case filed by NGO, Evara Foundation categorically stated that Union Health Ministry do not envisage forceable vaccination without consent of individual.

That the direction/ SOP by the State Government which makes it mandatory to carry vaccination certificate for any purpose such as entry into public parks, availing gym facilities and saloon facilities and for certain IT sectors employees

That the said act of arresting the people is violative of Article 14 and Article 21 of the Constitution of India.

That even in the pandemic, the Constitution cannot be put away and forgotten. And the public health emergencies does not give the executives carte- blanche to disregard the constitution for as long as the medical problem persist.

## LIST OF DATES

- 12.04.2020, 24.04.2021,  
28.08.2021, 15.01.2022: The Chief Secretary, Govt. of West Bengal and Home Secretary, Govt. of India by orders dated 12.04.2020, 24.04.2021, 28.08.2021 and 15.01.2022 respectively made wearing mask mandatory and in West Bengal the police arrested people who does not wear mask invoking Section 53 Pandemic Act and Section 188 of I.P.C. which are not applicable.
- 01.12.2020  
There is no compelling evidence that use of face mask can significantly prevent transmission of COVID- 19, as documented in the report of WHO dated 01.12.2020 under the hearing "Mask use in the context of COVID- 19"
- 27.05.2021  
The Ministry of Health & Family Welfare, Government of India in reply to RTI query dated 27.05.2021, replied that use of mask/ face cover has been advised to all various SOPs and Guidelines issues by the Ministry of Health & Family Welfare, Government of India. However, as per these Guidelines/ SOPs its use had not been explicitly made mandatory. That in the said reply the Government of India candidly admitted that no research has been made in support of asking using mask.
- 15.05.2020, 19.05.2021: The petitioner obtained the said guidelines from the above website guidelines referred to by the Ministry of Health, Government of India in its reply dated 15.05.2020, and 19.05.2021;
- 27.05.2021  
The Ministry of Health & Family Welfare, Government of India in reply to RTI query to Sourav Bysack dated 27.05.2021.
- 13.01.2022  
Union of India filed an affidavit dated 13.01.2022 wherein the Govt. of India in clear terms avert that without consent of the person, the Ministry of Health and Family Welfare do not envisage any forceable vaccination.
- , 2022  
Hence this P.I.L. filed;

DISTRICT : NORTH 24 PARGANAS  
IN THE HIGH COURT AT CALCUTTA  
CONSTITUTIONAL WRIT JURISDICTION  
(APPELLATE SIDE)

W.P.A. (P) NO. 65 OF 2022

In the matter of:

An application under Article 226 of the  
Constitution of India;

Subject matter relating to :

Group- (X), Head - <sup>N/L</sup>(h) of the Classification  
List;

Under

Cause Title :

SRI JAGADISH CHANDA

... Petitioner

-Versus-

THE STATE OF WEST BENGAL & ORS.

... Respondents

Advocate-on-record

*Yashraj Roy*  
YASHRAJ ROY

Advocate

GD-10, Sector-III, Salt Lake

P.S. Bidhannagar South

Kolkata- 700106

(M) 7439271212

DISTRICT : NORTH 24 PARGANAS

IN THE HIGH COURT AT CALCUTTA  
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DISTRICT : NORTH 24 PARGANAS

IN THE HIGH COURT AT CALCUTTA  
CONSTITUTIONAL WRIT JURISDICTION

(APPELLATE SIDE)

W.P.A. (P) NO. 65 OF 2022

In the matter of:

SRI JAGADISH CHANDA

... Petitioner

-Versus-

THE STATE OF WEST BENGAL & ORS.

... Respondents

LIST OF DATES

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28.08.2021, 15.01.2022: The Chief Secretary, Govt. of West Bengal and Home Secretary, Govt. of India by orders dated 12.04.2020, 24.04.2021, 28.08.2021 and 15.01.2022 respectively made wearing mask mandatory and in West Bengal the police arrested people who does not wear mask invoking Section 53 Pandemic Act and Section 188 of I.P.C. which are not applicable.

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There is no compelling evidence that use of face mask can significantly prevent transmission of COVID- 19, as documented in

the report of WHO dated 01.12.2020 under the hearing "Mask use in the context of COVID-19"

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The Ministry of Health & Family Welfare, Government of India in reply to RTI query dated 27.05.2021, replied that use of mask/face cover has been advised to all various SOPs and Guidelines issues by the Ministry of Health & Family Welfare, Government of India. However, as per these Guidelines/SOPs its use had not been explicitly made mandatory. That in the said reply the Government of India candidly admitted that no research has been made in support of asking using mask.

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Hence this P.I.L. filed;

DISTRICT: NORTH 24 PARGANAS

IN THE HIGH COURT AT CALCUTTA  
CONSTITUTIONAL WRIT JURISDICTION

(APPELLATE SIDE)

W.P.A. (P) NO. 65 OF 2022

In the matter of:

SRI JAGADISH CHANDA

... Petitioner

-Versus-

THE STATE OF WEST BENGAL & ORS.

... Respondents

SUBSTANTIAL POINTS OF LAW

- I. WHETHER the mandate of the Home Secretary, Govt. of India and the Chief Secretary of the State of West Bengal regarding wearing face mask in public is illegal, arbitrary and violative of Article 21, and Article 91 of the Constitution of India;
- II. WHETHER the direction regarding to wear mask in public places is arbitrary, subject to judicial review on account of manifest arbitrariness;
- III. WHETHER when the Ministry of Health, Govt. of India admitted that use of mask never made mandatory in their guidelines. The direction by the Home Secretary, Govt. of

India and Chief Secretary, Govt. of West Bengal is arbitrary and liable to be set aside;

- IV. WHETHER it is well settled that even in a pandemic situation the Constitution cannot be put away and forgotten and public health emergency does not give executive carte- blanche to disregard the constitution as long as medical problem persists.
- V. WHETHER the arrest of healthy people by the police for not wearing mask it is not only illegal but also unconstitutional as right to free movement is a fundamental right and one cannot be prosecuted without due process of law and without any offence committed;
- VI. WHETHER there is no penal provision either in the Indian Penal Code or Disaster Management Act, 2005 for not wearing mask.
- VII. WHETHER the arrest made by the police under Section 188 of I.P.C. for not wearing mask by the healthy person is illegal, arbitrary;
- VIII. WHETHER there is no compelling scientific evidence which proved that wearing mask prevents the spreading Covid.

- IX. WHETHER the Ministry of Health, Govt. of India admitted that no study and or research has been made which indicates that wearing mask prevents spreading of Covid;
- X. WHETHER the W.H.O. in his different reports stated that there is no evidence to show that mask prevents Covid on the contrary the report states that the mask causes serious health hazard to the people;
- XI. WHETHER submits that Section 60 of Disaster Management Act categorically mandated that no court shall take cognizance of any offence under this Act except on complaint by the authorities mentioned in the section

Harimayla,  
Taraknagar, Ran,  
Chandannagar.

DISTRICT: NORTH 24 PARGANAS

IN THE HIGH COURT AT CALCUTTA  
CONSTITUTIONAL WRIT JURISDICTION  
(APPELLATE SIDE)

W.P.A. (P) NO. 65 OF 2022

In the matter of:

An application under Article 226 of the  
Constitution of India;

AND

In the matter of:

SRI JAGADISH CHANDA, s/o Late  
Dinendra Kumar Chanda, AJ-70, 1st  
Floor, Sector-II, Salt Lake, P.S.  
Bidhannagar North, Kolkata-700091,  
North 24 Parganas, West Bengal;  
... Petitioner

-Versus-

1. THE STATE OF WEST BENGAL,  
by through the Principal Secretary, (Home  
Government of West Bengal, Nabanna,  
325 Sarat Chatterjee Road, Shibpur,  
Howrah-711102, West Bengal;
2. THE CHIEF SECRETARY,  
Government of West Bengal, Nabanna,  
325, Sarat Chatterjee Road, Shibpur,  
Howrah, PIN-711102, West Bengal;
3. THE PRINCIPAL SECRETARY  
(HEALTH), Government of West Bengal,

Swasthya Bhavan, GN-29, Sector-V, Salt Lake, Kolkata-700091;

4. THE SECRETARY, The Ministry of Health and Family Welfare, Government of India, Room No. 348, A-Wing, Nirman Bhawan, New Delhi-110011;

5. THE SECRETARY, The Ministry of Home Affairs, Government of India, Jai Singh Marg, Hanuman Road Area, Connaught Place, New Delhi- 110001;

... Respondents

To

The Hon'ble Prakash Shrivastava, Chief Justice and His companion Justices of the said Hon'ble Court.

The humble petition on behalf of the petitioner above named;

Most respectfully sheweth :

1. The petitioner is a social activist and citizen of India. He is a member of civil society.

2. Your petitioner states that the Chief Secretary, Govt. of West Bengal and Home Secretary, Govt. of India by orders dated 12.04.2020, 24.04.2021, 28.08.2021 and 15.01.2022 respectively made wearing mask mandatory and in West Bengal the police arrested people who does not wear mask invoking Section 53 Pandemic Act and Section 188 of I.P.C. which are not applicable.

Photo copy of the orders dated 12.04.2020, 24.04.2021, 28.08.2021 and 15.01.2022 are annexed herewith and marked as Annexure P-1 (collectively)

3. Your petitioner states that the said Orders / Notifications are not backed by any scientific research by eminent expert on this subject pertaining to wearing mask.
4. Your petitioner states that the Chief Secretary is not a doctor or expert in this field and issued the notification in absence of expert advice.
5. Your petitioner states that the Supreme Court of U.S. speaking in the wake of Covid-19 pandemic in various instances, has overruled policies by observing, inter alia, that the members of the court are not public health experts, and we should respect the judgment of those with special expertise and responsibility in this area. But even in the pandemic, the constitution cannot be put away and forgotten, and a public health emergency does not give governors and other public officials carte blanche to disregard the constitution as long as the medical problem persists.
6. Your petitioner states that although public health is subject under Entry-6 of List-2 (State List) of the 7<sup>th</sup> Schedule of the Constitution, Entry-81 of List-1 (Union List) deals with inter-state migration and inter-state quarantine and Entry-29 of List-3 (Concurrent List) deals with the prevention of extension from one state to another of infectious or contagious diseases. That the management of the pandemic control of the spread of Covid-19, Vaccination policy

and pricing are the responsibility of the Central Government, which must work in tandem with the state and Union Territory.

7. Your petitioner states that the direction by the State of West Bengal pertaining to wear mask and RTPCR test and forceful vaccination for any citizen to avail public facilities i. e. entering public parks, salons, gyms and for some employees in I.T. Sector is arbitrary and contrary to the guidelines of the Ministry of Health & Family Welfare, Government of India.

8. Your petitioner states that wearing a mask only gives a false sense of security and wearing a mask makes exhaled air go into the eyes. Face mask makes breathing more difficult, moreover a fraction of Carbon-di-Oxide (CO<sub>2</sub>) exhaled or inhaled is at each respiratory cycle. Those phenomena increase breathing frequency and deepness and they may worsen the burden of Covid-19 if infected people wearing mask spread more contaminated air. These may also worsen the clinical condition of infected people if the enhanced breathing pushes the viral load, down into their lungs.

9. Your petitioner states that there is no compelling evidence that use of face mask can significantly prevent transmission of COVID- 19, as documented in the report of WHO dated 01.12.2020 under the heading "Mask use in the context of COVID-19". In the said report of the W.H.O. it is stated in Column-1, para-1 as under-

"At present there is only limited and inconsistent scientific evidence to support the effectiveness of masking of healthy people in the community to prevent infection with respiratory viruses including SARS-COV-2. A large randomized community-based trial in



which 4,862 healthy participants were divided into a group wearing medical/ surgical mask and a control group found no difference in infection with SARS-COV-2. A recent systematic review found 9 trials (of which 8 were cluster- randomized controlled trials in which clusters of people, versus individuals, were randomized) comparing medical/ surgical masks versus no mask to prevent the spread of viral respiratory illness. Two trials were with health care workers and seven in the community. The review concluded that wearing a mask may make little or no difference to the prevention of influenza like illness (ILI) or laboratory confirmed illness (LCI). The certainty of the evidence was low for ILI, Moderate for LCI.

Photo copy of the report of W.H.O dated 01.12.2020 is annexed herewith and marked as Annexure P-2

10. Your petitioner states that potential disadvantages of mask use by the healthy people in general public as reported in para-2, Column-1 of the W.H.O. report dated 01.12.2020 include -

- a) Headache or breathing difficulties (depending upon the type of mask used).
- b) Development of facial skin lesions, irritant dermatitis or worsening acne, when used frequently for long hours,
- c) Difficulty while communicating clearly especially for persons who are deaf or a poor hearing or use lip reading,
- d) Discomfort,
- e) A false sense of security leading to potentially lower adherence to other critical preventive measures.

11. Your petitioner states that WHO in its report dated 05.06.2020 titled as "ADVICE ON THE USE OF MASKS IN THE

CONTEXT OF COVID-19" under sub-heading "Guidance on the use of mask for general public", states that-

"Studies of influenza, influenza-like illness and human Corona Viruses (not including COVID-19) that the use of medical mask can prevent the spread of infectious droplets from a symptomatic infected person to someone else and potential contamination of the environment by this droplet. There is limited evidence that wearing a medical mask by healthy individuals in households in particular those who shares a house with a sick person or among attendees of mass gatherings may be beneficial as a measure preventing transmission ... ..

Result from cluster randomized control trials on the use of mask among young adults living in university residences in U.S.A. indicate that face mask may reduce the rate of influenza-like illness but showed no impact on risk of laboratory confirmed influenza. At present there is no direct evidence (from studies on COVID-19 and in healthy people in the community) on the effectiveness of universal masking of healthy people in the community to prevent infection with respiratory viruses including COVID-19."

Photo copy of the report of W.H.O. dated 05.06.2020 is annexed herewith and marked as Annexure P-3

12. Your petitioner states that the WHO in the same report dated 05.06.2020 on page No.8 para-3 Column-1 further in clear terms under the Heading "Potential harm/ disadvantages" stated therein under that-

The likely disadvantages of the use of mask by healthy people in the general public include-

- a) Potentially increased risk of self-contamination due to the manipulation of a face mask and subsequently touching eyes with contaminated hands,
- b) Potential self-contamination that can occur if non-medical masks are not changed when wet or soiled, this can create favorable conditions for micro-organisms to amplify,
- c) Potential headache and/or breathing difficulties, depending upon type of mask used,
- d) Potential development of facial skin lesions or irritants dermatitis for worsening acne when used frequently for long hours;
- e) Difficulty while communicating clearly especially for persons who are deaf or a poor hearing or use leap reading;
- f) Disadvantage for/ or difficulty in wearing them especially for children, mentally challenged persons with cognitive impairments, those with asthma and chronic respiratory or breathing problem, those who have facial trauma or recent oral maxillofacial surgery and those who are living in hot and humid environment.

13. Your petitioner states that the WHO in its report dated 05.06.2020 further recommended that if the masks are recommended for the general public, the decision maker should-

- a) Clearly communicate the purpose of wearing a mask, where, when, how and what type of mask should be worn,
- b) Explain what wearing a mask may achieve and what it will not achieve and communicate clearly that this is one part of a package of measures along with and hygiene, physical distancing and other measures and all reinforce each other

- c) Consider the feasibility, supply, access issues, social and psychological acceptance (of both wearing and not wearing different types of masks in different context)
- d) Continue gathering scientific data and evidence on effectiveness of mask use (including different types and makes as well as other face covers such as scurf, in non-health care settings.
- e) Evaluating the impact (positive, neutral or negative) of using mask in general population (including behavioral and social sciences)

14. Your petitioner states that the Ministry of Health & Family Welfare, Government of India in reply to RTI query to Sourav Bysack dated 27.05.2021, replied that use of mask/ face cover has been advised to all various SOPs and Guidelines issued by the Ministry of Health & Family Welfare (MoHFW) Government of India. However, as per these Guidelines/ SOPs its use has not been explicitly made mandatory. That in the said reply the Government of India candidly admitted that no research has been made in support of asking for using mask.

Photo copy of the RTI Reply dated 27.05.2021 is annexed herewith and marked as Annexure P-4

15. Your petitioner states that without any aid of scientific research that the face mask prevent spread of Covid and without any result of the said research that wearing the face mask does not cause any health hazard. the MoHFW, Government of India advised people to use mask.

16. Your petitioner submits that another wing of the Government of India, i.e. Ministry of Home Affairs without having any jurisdiction issued Guidelines for making use of mask mandatory. It is strange that the concerned Health Department candidly admitted that use of mask is not mandatory and another department which deals with the security of the nation directed the people to wear mask without any relevant advice from experts and disregarding the harmful consequences of using mask.

17. Your petitioner states that the Ministry of Health & Family Welfare, Government of India through the website link <https://www.mohfw.gov.in/pdf/Useofmaskbypublic.pdf> informed the public that persons having no symptoms are not to use mask.

Photo copy of the guidelines is annexed herewith and marked as Annexure P-5

18. Your petitioner states that he downloaded from the said link the said guidelines for use of mask by public pertaining to Novel Coronal Virus diseases (COVID-19). The Ministry of Health & Family welfare candidly admitted that medical mask should not be used by healthy person who are not having any symptoms because it creates a false sense of security that can lead to neglecting other essential measures such as washing of hands.

The guidelines further stated that there is no scientific evidence to show health benefit for using mask for non-sick person in the community. In fact erroneous use of mask and continuous use of disposable mask for longer than six hours or repeated use of same mask may actually increase the risk of getting an infection. It also causes unnecessary cost.

19. Your petitioner states that the petitioner obtained the said guidelines from the above website guidelines referred to by the Ministry of Health, Government of India in its reply dated 15.05.2020, in reply to an RTI dated 18.04.2020. The same website link had also been referred to in R.T.I. reply to Amit Chouhan dated 19.05.2021;

Photo copy of the RTI reply dated 19.05.2021 and ~~15.05.2020~~ 15.05.2020 is annexed herewith and marked as Annexure P-~~7~~ (colly.)

20. Your petitioner states that many countries in the world namely United Kingdom, some of the states in U.S.A, Sweden, Hungary, Italy, Denmark, Norway, Spain etc. became a mask free country. The most interesting thing to note that China, the country from the pandemic began is now a mask free nation. China was one of the worst affected countries in initial days.

21. Your petitioner states that the Union of India filed an affidavit dated 13.01.2021 wherein the Govt. of India in clear terms avert that without consent of the person, the Ministry of Health and Family Welfare do not envisage any forceable vaccination. The Union of India further stated that the Govt. of India had not issued any SOP which makes carrying of vaccination certificate mandatory for any purpose.

Photo copy of the affidavit filed by the Union of India dated 13.01.2022 is annexed and marked as Annexure P-~~7~~

22. Your petitioner states that National Institution of Health quantitative evaluation and found relevant adverse effects of masks

leading to significant psychological and physical deterioration; Link: <https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC8072811>;

Your Petitioner craves leave to refer the report before this Hon'ble Court at the time of hearing.

23. Your petitioner submits that historically the judiciary has also recognized that constitutional scrutiny is transformed during such public health emergencies, where the executive functions in rapid consultation with scientists and other experts.

24. Your petitioner submits that the State Executive Authority cannot force the citizen to wear mask without having any scientific basis which conclusively proves that wearing mask prevents spreading of COVID-19 infection.

25. Your petitioner submits that the police in West Bengal forced the people to wear mask and arbitrarily arrested under Disaster Management Act and under section 188 of Indian Penal Code.

26. Your petitioner submits that no F.I.R. can be lodged/registered under Section 188 I.P.C.

27. Your petitioner submits that the police have no authority to impose or take any action under section 188 of I.P.C and also section 269 of I.P.C is not applicable for not wearing mask by a healthy person, specially when it is not medically established that wearing mask prevents spread of COVID-19.

28. Your petitioner submits that there is no Provision in Disaster Management Act that wearing mask is mandatory for healthy person and who have no symptoms of COVID-19.

29. Your petitioner further submits that Section 60 of Disaster Management Act categorically mandated that no court shall take cognizance of an offence under this Act except on a complaint made by-

a) The National Authority, the State Authority, the Central Government, the State Government, the district authority, or any other authority or other officers authorized in this behalf by that authority or government as the case may be;

b) Any person who has been given notice of not less than 30 days in the manner prescribed of the alleged offence and his intention to make a complaint to the national authority, the state authority, central and state government, the district authority or any other authority or officer authorized as aforesaid.

30. Your petitioner submits that such illegal arrest and imposing fine by the police is arbitrary and violation of fundamental rights enshrined in Article 19 and 21 of the Constitution of India.

31. Your petitioner submits that the obstruction of a citizen in his free movement is also not only an offence under the I.P.C. but also it violates the fundamental right of the citizen in their free movement.

32. Being aggrieved and dissatisfied with the several notifications dated 12.04.2020, 24.04.2021, 28.08.2021 and



15.01.2022 and the D.O. No. 4-3/20-D.M.-1(a) dated 29.06.2021 issued by the Chief Secretary, and Home Secretary for forcing healthy people to wear the mask, Your Petitioner, begs to prefer this instant application on the following amongst others.

#### GROUND

- I. FOR THAT the mandate of the Home Secretary, Govt. of India and the Chief Secretary of the State of West Bengal regarding wearing face mask in public is illegal, arbitrary and violative of Article 21, and Article 91 of the Constitution of India;
- II. FOR THAT the direction regarding to wear mask in public places is arbitrary, subject to judicial review on account of manifest arbitrariness;
- III. FOR THAT when the Ministry of Health and Family Welfare, Govt. of India admitted that use of mask never made mandatory in their guidelines. The direction by the Home Secretary, Govt. of India and Chief Secretary, Govt. of West Bengal is arbitrary and liable to be set aside;
- IV. FOR THAT it is well settled that even in a pandemic situation the Constitution cannot be put away and forgotten and public health emergency does not give executive carte- blanche to disregard the constitution as long as medical problem persists.
- V. FOR THAT the arrest of healthy people by the police for not wearing mask is not only illegal but also

unconstitutional as right to free movement is a fundamental right and one cannot be prosecuted without due process of law and without any offence committed;

- VI. FOR THAT there is no penal provision either in the Indian Penal Code or Disaster Management Act, 2005 for not wearing mask.
- VII. FOR THAT the arrest made by the police under Section 188 of I.P.C. for not wearing mask by the healthy person is illegal, arbitrary;
- VIII. FOR THAT there is no compelling scientific evidence which proved that wearing mask prevents the spreading Covid.
- IX. FOR THAT the Ministry of Health and Family Welfare, Govt. of India admitted that no study and or research has been made which indicates that wearing mask prevents spreading of Covid;
- X. FOR THAT the W.H.O. in his different reports stated that there is no evidence to show that mask prevents Covid-19. On the contrary the report states that the mask causes serious health hazard to the people;
- XI. FOR THAT submits that Section 60 of Disaster Management Act categorically mandated that no court shall take cognizance of any offence under this Act except on complaint by the authorities mentioned in the section

33. There is no other alternative and efficacious remedy available to your petitioner than to file this application and reliefs prayed for herein, if granted will be in the benefit of the public.

34. On the selfsame fact and cause of action no other application has been filed by your petitioner in this Hon'ble Court or any other court.

35. The cause of action has arisen within the jurisdiction of this Hon'ble Court.

36. That this application is Bonafede and in the interest of justice.

In view of the above mentioned facts and circumstances, it is therefore, most humbly prayed that Your Lordships would graciously be pleased to pass the following orders:-

a) This Hon'ble Court be pleased to issue a writ of mandamus or a writ in the nature of mandamus or any other writ or order under Article 226 of the Constitution of India for setting aside the guidelines issued by the Home Secretary Government of India and Chief Secretary West Bengal dated 12.04.2020, 15.01.2022, 24.04.2020, 29.06.2021, regarding wearing face mask in public on the ground till date as admitted by the

Ministry of Health and Family Welfare, Govt. of India that no study conducted by the concerned department or by any research institute to establish the effectiveness of face mask in preventing infection.

b) This Hon'ble Court be pleased to issue a writ of mandamus or a writ in the nature of mandamus or any other writ or order under Article 226 of the Constitution of India for setting aside the order regarding wearing face mask in public on the ground that W.H.O. in his different reports stated that there is no evidence to show that face mask prevents Covid, on the contrary the report states that the mask causes serious health hazard to the people having no symptoms.

c) This Hon'ble Court be pleased to issue a writ of mandamus or a writ in the nature of mandamus or any other writ or order under Article 226 of the Constitution of India for setting aside the orders regarding wearing face mask in public on the ground of Potential headache and/or breathing difficulties etc.

d) This Hon'ble Court be pleased to issue a writ of mandamus or a writ in the nature of mandamus or any other writ or order

under Article 226 of the Constitution of India for setting aside the orders regarding wearing face mask in public on the ground police indiscriminately arresting people wrongly invoking provision of Disaster management Act and Indian penal Code/

e) This Hon'ble Court be pleased to issue a writ of mandamus or a writ in the nature of mandamus or any other writ or order under Article 226 of the Constitution of India for setting aside the orders regarding wearing face mask in public on the ground every citizen has right to free movement under Article 19 of the Constitution and no person shall be deprived of his life or personal liberty except according to procedure established by law.

f) This Hon'ble Court be pleased to issue a writ of mandamus or a writ in the nature of mandamus or any other writ or order under Article 226 of the Constitution of India for setting aside the orders regarding wearing face mask in public on the ground judicial review is permissible on account of manifest arbitrariness as executive authorities are operating without medical and scientific opinion

g) This Hon'ble Court be pleased to issue a writ of mandamus or a writ in the nature

of mandamus or any other writ or order under Article 226 of the Constitution of India for setting aside the orders regarding wearing face mask in public on the ground that a public health emergency does not give executive authorities carte blanche to disregard the constitution for as long as the medical problem persists.

h) A declaration that the order of compulsory vaccination for entering into park, restaurant, gym, salon etc. is unconstitutional;

i) A declaration that the order one should get vaccinated for entering into park, restaurant, gym salon etc. is unsustainable;

j) A declaration that the order dated 12.04.2020, 24.04.2020, 15.01.2022, 28.08.2021 is bad in law and unconstitutional as the said orders are not backed by any medical evidence arising out of serious research work by the experts in the field;

k) To issue a writ in the nature of certiorari calling upon the concerned respondents to certify and transmit the records of the case before this Hon'ble Court so that conscienceless justice by passing the appropriate order;

- l) Rule NISI in the terms of prayers a), b),  
c) d), e), f), g), h), i);
- m) To pass ad-interim order of injunction  
restraining the respondents and their men  
and agents to carry out the orders till the  
disposal of the present case;
- n) To pass interim injunction in terms of  
prayer k);
- o) Make Rule absolute if no cause or  
insufficient cause is shown;
- p) To issue any other suitable  
writ/writs/order/Orders/ direction/  
directions which this Hon'ble Court may  
deem fit and proper;
- q) Cost and incidentals to the petitioner;

And for this act of kindness, your petitioner, as in duty bound, shall  
ever pray.

*Jagdish Chander*

## AFFIDAVIT

I, Sri Jagadish Chanda, son of late Dinendra Kumar Chanda, by occupation-business, aged about 52 years, of AJ-70, 1st Floor, Sector-II, Salt Lake, P.S. Bidhannagar North, Dist.: North 24 Parganas, West Bengal, PIN-700091, do solemnly affirm and say as follows:

1. That I am the petitioner and well-acquainted with the facts and circumstances of the case. I am also competent to affirm this affidavit.

2. That the statements made in paragraphs 1 to 32 are matter of records and paragraphs 33 to 36 are my statements and the rests are my submission before this Hon'ble Court.

3. That the statements made herein above are all true to my knowledge.

Prepared by me

Tashraj Roy.  
Advocate

Jagadish Chanda  
Deponent is known to me

S/D  
Clerk to

Advocate.

Solemnly affirm before me

On this 10<sup>th</sup> day of Feb, 2022

I certify that all annexure(s) are legible.

Tashraj Roy.  
Advocate

COMMISSIONER



Annexure P1 (collectively)  
Government of West Bengal

- 21 -

Order No 79-CS/2020

Dated 12/04/2020

**ORDER**

Whereas it is critical to adopt all possible measures for saving people from exposure to Corona virus,

Whereas covering mouth and nose at all times helps prevention of transmission of this virus.

Whereas, mouth and nose should be covered by facial masks or any other available piece of cloth which may even include a properly folded or rolled dupatta, gamcha, handkerchief or any such material that acts as a protective cover.

Therefore, it is hereby directed that it shall be mandatory to use this cover always, especially when in public places.

  
Chief Secretary

- 22 -

Government of West Bengal  
'Nabanna', 325, Sarat Chatterjee Road  
Howrah - 711 102.

Memo No. 486-CS/2021

Dated: 24<sup>th</sup> April, 2021

**ORDER**

Whereas, vide Order No. 79-CS/2020 dated 12.04.2020 of the Government of West Bengal, wearing of facial mask has been made mandatory in public places in the current pandemic disaster situation;

Whereas since the COVID-19 pandemic crisis is grave, all persons are to strictly comply with COVID-19 safety norms of wearing facial mask and maintaining social distance whenever they go out in public place;

Whereas the Home and Hill Affairs Department of the Government of West Bengal, vide notification number 347-I.S.S./2M -24/2020 dated 3<sup>rd</sup> June, 2020 has under Section 2 of the Epidemic Diseases Act, 1897 directed that any police officer not below the rank of Sub Inspector of Police or equivalent within the State of West Bengal, including Kolkata Police, is authorised to ensure and enforce mandatory use of face mask/facial covers in public places and to initiate appropriate legal action against any person not wearing facial mask in public place;

Whereas, vide advisory issued vide no. 715-Home (Cons)/RIM (Cons) -92/2021 dated 17.04.21, Government of West Bengal has stressed that any violation of mask and social distance norms should be strictly dealt with;

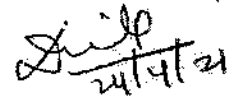
Now therefore, District and Police authorities are further directed to enforce above mentioned orders and take necessary legal actions against the violators of social distancing and mask norms under Section 51 of the Disaster Management Act, 2005 to ensure strict compliance with COVID-19 safety norms. Cases shall be started and prosecutions should be initiated strictly.

Sd/-  
Chief Secretary &  
Chairman, State Executive Committee WBSDMA

Memo No. 486/1(27) -CS/2021

Dated: 24<sup>th</sup> April, 2021

- 1) ACS, Home & Hill Affairs Department, Govt. of West Bengal.
- 2) Director General of Police, West Bengal.
- 3) Commissioner of Police, Kolkata.
- 4) DG, Enforcement Branch.
- 5) ADG, Law & Order
- 6) All DMs.



Principal Secretary  
Disaster Management &  
Civil Defence Department

अजय भल्ला, भा.प्र.से.  
AJAY BHALLA, IAS



-24-

गृह सचिव  
Home Secretary  
भारत सरकार  
Government of India  
नॉर्थ ब्लॉक/North Block  
नई दिल्ली/New Delhi

D.O. No. 40-3/2020-DM-1 (A)

28<sup>th</sup> August, 2021

Dear Chief Secretary,

Kindly refer to the MHA Order of even number issued today, vide which MHA Order dated 29.06.2021 issued for the implementation of targeted and prompt actions for COVID-19 management has been extended upto 30<sup>th</sup> September, 2021.

2. The overall pandemic situation at the national level now appears to be largely stable, except for the localised spread of virus in few States. Moreover, the total number of active cases and high case positivity in some districts continues to remain a matter of concern.
3. The State Governments/UT Administrations concerned, having high positivity in their districts, should take pro-active containment measures so as to effectively arrest the spike in cases and to contain the spread of transmission. It is important to identify warning signs of potential surges early on and to take appropriate measures to curb the spread. This would require a localized approach, as has been mentioned in Ministry of Health and Family Welfare (MoHFW) advisories dated 25.04.2021 and 28.06.2021.
4. State Governments/UT Administrations are further advised to take suitable measures to avoid large gatherings during the coming festive season and if required, impose local restrictions with a view to curb such large gatherings. In all crowded places, COVID Appropriate Behaviour should be strictly enforced. We need to continue focus on the five-fold strategy i.e. Test-Track-Treat-Vaccination and adherence to COVID Appropriate Behaviour, for effective management of COVID-19.
5. Enforcement of COVID-19 appropriate behavior is essential for tackling the pandemic on a sustained basis. Weekly Enforcement Data, received from States/UTs regarding wearing facemask in public, maintaining social distancing norms, imposition of fines etc., indicates a downward trend in enforcement. States and UTs are requested to augment their enforcement efforts for effectively checking transmission of the disease.

..Contd..p/2..

6. The country has made significant progress in vaccination. The State Governments/UT Administrations should continue with their vaccination programme so as to inoculate maximum number of eligible persons.

7. Further, it must be ensured that areas having no virus or low virus transmission are adequately protected by progressively ramping up testing and other measures like ILI/SARI surveillance, market surveillance, etc. with strict enforcement of COVID Appropriate Behaviour.

8. I would, therefore, urge you to issue strict directions to the district and all other local authorities concerned, to take necessary measures for management of COVID-19. The officers concerned should be made personally responsible for any laxity in strict enforcement of COVID Appropriate Behaviour. I would also advise that Orders issued by the respective State Governments/UT Administrations/district authorities in this regard, should be widely disseminated to the public and to the field functionaries, for their proper implementation.

With regards,

Yours sincerely,

  
(Ajay Bhalla) 28/08/21

Chief Secretaries of all States

Government of West Bengal  
NABANNA  
325, Sarat Chatterjee Road, Howrah -711102

-26-

ORDER

No-753/XX-ISS/2M-22/2020

Dated: 15/01/2022

Whereas, in order to contain spread of COVID-19 pandemic, state government vide order No 753/XVII-ISS/2M-22/2020 dated 02/01/2022 read with subsequent orders notified certain restriction and relaxation measures and advisory in terms of the provisions under Disaster Management Act 2005 read with West Bengal Epidemic Disease, Covid-19 Regulations 2020, which are in force till 15/01/2022.

Whereas, after a review of the current situation of COVID-19 pandemic and the concerns due to new COVID-19 variant "*Omicron*", State Executive Committee of West Bengal State Disaster Management Authority recommended to continue with the current restrictions in force and allow graded relaxations as necessary.

Accordingly, in terms of the provisions under Disaster Management Act 2005 read with West Bengal Epidemic Disease, Covid-19 Regulations 2020, restriction and relaxation measures and advisory as already in force vide aforesaid orders stand extended up to 31/01/2022.

Further, following additional relaxations are hereby notified with effect from 16/01/2022:

- i) Marriage related functions shall be allowed with a maximum of 200 people at a time or 50% seating capacity of the hall / venue, whichever is lower.
- ii) Mela / fair may be allowed in open air venue in a very restricted manner, following COVID appropriate discipline and protocols.

Wearing of masks, maintenance of physical distancing and health & hygiene protocol must be followed at all times.

District administration, police commissionerates and local authorities shall ensure strict compliance of the stated directives. Any violation of the restriction measures will be liable to be proceeded against as per the provisions of Disaster Management Act, 2005 and under Indian Penal Code.



Chief Secretary

# Mask use in the context of COVID-19

-27-

Interim guidance

1 December 2020



This document, which is an update of the guidance published on 5 June 2020, includes new scientific evidence relevant to the use of masks for reducing the spread of SARS-CoV-2, the virus that causes COVID-19, and practical considerations. It contains updated evidence and guidance on the following:

- mask management;
- SARS-CoV-2 transmission;
- masking in health facilities in areas with community, cluster and sporadic transmission;
- mask use by the public in areas with community and cluster transmission;
- alternatives to non-medical masks for the public;
- exhalation valves on respirators and non-medical masks;
- mask use during vigorous intensity physical activity;
- essential parameters to be considered when manufacturing non-medical masks (Annex).

## Key points

- The World Health Organization (WHO) advises the use of masks as part of a comprehensive package of prevention and control measures to limit the spread of SARS-CoV-2, the virus that causes COVID-19. A mask alone, even when it is used correctly, is insufficient to provide adequate protection or source control. Other infection prevention and control (IPC) measures include hand hygiene, physical distancing of at least 1 metre, avoidance of touching one's face, respiratory etiquette, adequate ventilation in indoor settings, testing, contact tracing, quarantine and isolation. Together these measures are critical to prevent human-to-human transmission of SARS-CoV-2.
- Depending on the type, masks can be used either for protection of healthy persons or to prevent onward transmission (source control).
- WHO continues to advise that anyone suspected or confirmed of having COVID-19 or awaiting viral laboratory test results should wear a medical mask when in the presence of others (this does not apply to those awaiting a test prior to travel).
- For any mask type, appropriate use, storage and cleaning or disposal are essential to ensure that they are as effective as possible and to avoid an increased transmission risk.

## Mask use in health care settings

- WHO continues to recommend that health workers (1) providing care to suspected or confirmed COVID-19

patients wear the following types of mask/respirator in addition to other personal protective equipment that are part of standard, droplet and contact precautions:

- medical mask in the absence of aerosol generating procedures (AGPs)
- respirator, N95 or FFP2 or FFP3 standards, or equivalent in care settings for COVID-19 patients where AGPs are performed; these may be used by health workers when providing care to COVID-19 patients in other settings if they are widely available and if costs is not an issue.
- In areas of known or suspected community or cluster SARS-CoV-2 transmission WHO advises the following:
  - universal masking for all persons (staff, patients, visitors, service providers and others) within the health facility (including primary, secondary and tertiary care levels; outpatient care; and long-term care facilities)
  - wearing of masks by inpatients when physical distancing of at least 1 metre cannot be maintained or when patients are outside of their care areas.
- In areas of known or suspected sporadic SARS-CoV-2 transmission, health workers working in clinical areas where patients are present should continuously wear a medical mask. This is known as targeted continuous medical masking for health workers in clinical areas;
- Exhalation valves on respirators are discouraged as they bypass the filtration function for exhaled air by the wearer.

## Mask use in community settings

- Decision makers should apply a risk-based approach when considering the use of masks for the general public.
- In areas of known or suspected community or cluster SARS-CoV-2 transmission:
  - WHO advises that the general public should wear a non-medical mask in indoor (e.g. shops, shared workplaces, schools - see Table 2 for details) or outdoor settings where physical distancing of at least 1 metre cannot be maintained.
  - If indoors, unless ventilation has been assessed to be adequate<sup>1</sup>, WHO advises that the general public should wear a non-medical mask, regardless of whether physical distancing of at least 1 metre can be maintained.

<sup>1</sup> For adequate ventilation refer to regional or national institutions or heating, refrigerating and air-conditioning societies enacting ventilation requirements. If not available or applicable, a

recommended ventilation rate of 10 l/s/person should be met (except healthcare facilities which have specific requirements). For more information consult "Coronavirus (COVID-19) response

- Individuals/people with higher risk of severe complications from COVID-19 (individuals  $\geq$  60 years old and those with underlying conditions such as cardiovascular disease or diabetes mellitus, chronic lung disease, cancer, cerebrovascular disease or immunosuppression) should wear medical masks when physical distancing of at least 1 metre cannot be maintained.
- In any transmission scenarios:
  - Caregivers or those sharing living space with people with suspected or confirmed COVID-19, regardless of symptoms, should wear a medical mask when in the same room.

#### Mask use in children (2)

- Children aged up to five years should not wear masks for source control.
- For children between six and 11 years of age, a risk-based approach should be applied to the decision to use a mask; factors to be considered in the risk-based approach include intensity of SARS-CoV-2 transmission, child's capacity to comply with the appropriate use of masks and availability of appropriate adult supervision, local social and cultural environment, and specific settings such as households with elderly relatives, or schools.
- Mask use in children and adolescents 12 years or older should follow the same principles as for adults.
- Special considerations are required for immunocompromised children or for paediatric patients with cystic fibrosis or certain other diseases (e.g., cancer), as well as for children of any age with developmental disorders, disabilities or other specific health conditions that might interfere with mask wearing.

#### Manufacturing of non-medical (fabric) masks (Annex)

- Homemade fabric masks of three-layer structure (based on the fabric used) are advised, with each layer providing a function: 1) an innermost layer of a hydrophilic material 2) an outermost layer made of hydrophobic material 3) a middle hydrophobic layer which has been shown to enhance filtration or retain droplets.
- Factory-made fabric masks should meet the minimum thresholds related to three essential parameters: filtration, breathability and fit.
- Exhalation valves are discouraged because they bypass the filtration function of the fabric mask rendering it unserviceable for source control.

#### Methodology for developing the guidance

Guidance and recommendations included in this document are based on published WHO guidelines (in particular the WHO Guidelines on infection prevention and control of epidemic- and pandemic-prone acute respiratory infections in health care) (2) and ongoing evaluations of all available scientific evidence by the WHO ad hoc COVID-19 Infection Prevention and Control Guidance Development Group (COVID-19 IPC GDG) (see acknowledgement section for list of GDG members). During emergencies WHO publishes interim guidance, the development of which follows a

transparent and robust process of evaluation of the available evidence on benefits and harms. This evidence is evaluated through expedited systematic reviews and expert consensus-building through weekly GDG consultations, facilitated by a methodologist and, when necessary, followed up by surveys. This process also considers, as much as possible, potential resource implications, values and preferences, feasibility, equity, and ethics. Draft guidance documents are reviewed by an external review panel of experts prior to publication.

#### Purpose of the guidance

This document provides guidance for decision makers, public health and IPC professionals, health care managers and health workers in health care settings (including long-term care and residential), for the public and for manufacturers of non-medical masks (Annex). It will be revised as new evidence emerges.

WHO has also developed comprehensive guidance on IPC strategies for health care settings (3), long-term care facilities (LTCF) (4), and home care (5).

#### Background

The use of masks is part of a comprehensive package of prevention and control measures that can limit the spread of certain respiratory viral diseases, including COVID-19. Masks can be used for protection of healthy persons (worn to protect oneself when in contact with an infected individual) or for source control (worn by an infected individual to prevent onward transmission) or both.

However, the use of a mask alone, even when correctly used (see below), is insufficient to provide an adequate level of protection for an uninfected individual or prevent onward transmission from an infected individual (source control). Hand hygiene, physical distancing of at least 1 metre, respiratory etiquette, adequate ventilation in indoor settings, testing, contact tracing, quarantine, isolation and other infection prevention and control (IPC) measures are critical to prevent human-to-human transmission of SARS-CoV-2, whether or not masks are used (6).

#### Mask management

For any type of mask, appropriate use, storage and cleaning, or disposal are essential to ensure that they are as effective as possible and to avoid any increased risk of transmission. Adherence to correct mask management practices varies, reinforcing the need for appropriate messaging (7).

WHO provides the following guidance on the correct use of masks:

- Perform hand hygiene before putting on the mask.
- Inspect the mask for tears or holes, and do not use a damaged mask.
- Place the mask carefully, ensuring it covers the mouth and nose, adjust to the nose bridge and tie it securely to minimize any gaps between the face and the mask. If using ear loops, ensure these do not cross over as this widens the gap between the face and the mask.



- Avoid touching the mask while wearing it. If the mask is accidentally touched, perform hand hygiene.
- Remove the mask using the appropriate technique. Do not touch the front of the mask, but rather untie it from behind.
- Replace the mask as soon as it becomes damp with a new clean, dry mask.
- Either discard the mask or place it in a clean plastic resealable bag where it is kept until it can be washed and cleaned. Do not store the mask around the arm or wrist or pull it down to rest around the chin or neck.
- Perform hand hygiene immediately afterward discarding a mask.
- Do not re-use single-use mask.
- Discard single-use masks after each use and properly dispose of them immediately upon removal.
- Do not remove the mask to speak.
- Do not share your mask with others.
- Wash fabric masks in soap or detergent and preferably hot water (at least 60° Centigrade/140° Fahrenheit) at least once a day. If it is not possible to wash the masks in hot water, then wash the mask in soap/detergent and room temperature water, followed by boiling the mask for 1 minute.

### Scientific evidence

#### Transmission of the SARS-CoV-2 virus

Knowledge about transmission of the SARS-CoV-2 virus is evolving continuously as new evidence accumulates. COVID-19 is primarily a respiratory disease, and the clinical spectrum can range from no symptoms to severe acute respiratory illness, sepsis with organ dysfunction and death.

According to available evidence, SARS-CoV-2 mainly spreads between people when an infected person is in close contact with another person. Transmissibility of the virus depends on the amount of viable virus being shed and expelled by a person, the type of contact they have with others, the setting and what IPC measures are in place. The virus can spread from an infected person's mouth or nose in small liquid particles when the person coughs, sneezes, sings, breathes heavily or talks. These liquid particles are different sizes, ranging from larger 'respiratory droplets' to smaller 'aerosols.' Close-range contact (typically within 1 metre) can result in inhalation of, or inoculation with, the virus through the mouth, nose or eyes (8-13).

There is limited evidence of transmission through fomites (objects or materials that may be contaminated with viable virus, such as utensils and furniture or in health care settings a stethoscope or thermometer) in the immediate environment around the infected person (14-17). Nonetheless, fomite transmission is considered a possible mode of transmission for SARS-CoV-2, given consistent finding of environmental contamination in the vicinity of people infected with SARS-CoV-2 and the fact that other coronaviruses and respiratory viruses can be transmitted this way (12).

Aerosol transmission can occur in specific situations in which procedures that generate aerosols are performed. The scientific community has been actively researching whether the SARS-CoV-2 virus might also spread through aerosol transmission in the absence of aerosol generating procedures (AGPs) (18, 19). Some studies that performed air sampling in

clinical settings where AGPs were not performed found virus RNA, but others did not. The presence of viral RNA is not the same as replication- and infection-competent (viable) virus that could be transmissible and capable of sufficient inoculum to initiate invasive infection. A limited number of studies have isolated viable SARS-CoV-2 from air samples in the vicinity of COVID-19 patients (20, 21).

Outside of medical facilities, in addition to droplet and fomite transmission, aerosol transmission can occur in specific settings and circumstances, particularly in indoor, crowded and inadequately ventilated spaces, where infected persons spend long periods of time with others. Studies have suggested these can include restaurants, choir practices, fitness classes, nightclubs, offices and places of worship (12).

High quality research is required to address the knowledge gaps related to modes of transmission, infectious dose and settings in which transmission can be amplified. Currently, studies are underway to better understand the conditions in which aerosol transmission or superspreading events may occur.

Current evidence suggests that people infected with SARS-CoV-2 can transmit the virus whether they have symptoms or not. However, data from viral shedding studies suggest that infected individuals have highest viral loads just before or around the time they develop symptoms and during the first 5-7 days of illness (12). Among symptomatic patients, the duration of infectious virus shedding has been estimated at 8 days from the onset of symptoms (22-24) for patients with mild disease, and longer for severely ill patients (12). The period of infectiousness is shorter than the duration of detectable RNA shedding, which can last many weeks (17).

The incubation period for COVID-19, which is the time between exposure to the virus and symptom onset, is on average 5-6 days, but can be as long as 14 days (25, 26).

Pre-symptomatic transmission – from people who are infected and shedding virus but have not yet developed symptoms – can occur. Available data suggest that some people who have been exposed to the virus can test positive for SARS-CoV-2 via polymerase chain reaction (PCR) testing 1-3 days before they develop symptoms (27). People who develop symptoms appear to have high viral loads on or just prior to the day of symptom onset, relative to later on in their infection (28).

Asymptomatic transmission – transmission from people infected with SARS-CoV-2 who never develop symptoms – can occur. One systematic review of 79 studies found that 20% (17-25%) of people remained asymptomatic throughout the course of infection. (28). Another systematic review, which included 13 studies considered to be at low risk of bias, estimated that 17% of cases remain asymptomatic (14%-20%) (30). Viable virus has been isolated from specimens of pre-symptomatic and asymptomatic individuals, suggesting that people who do not have symptoms may be able to transmit the virus to others. (25, 29-37)

Studies suggest that asymptotically infected individuals are less likely to transmit the virus than those who develop symptoms (29). A systematic review concluded that individuals who are asymptomatic are responsible for transmitting fewer infections than symptomatic and pre-symptomatic cases (38). One meta-analysis estimated that there is a 42% lower relative risk of asymptomatic transmission compared to symptomatic transmission (30).

## Guidance on mask use in health care settings

### Masks for use in health care settings

*Medical masks* are defined as surgical or procedure masks that are flat or pleated. They are affixed to the head with straps that go around the ears or head or both. Their performance characteristics are tested according to a set of standardized test methods (ASTM F2100, EN 14683, or equivalent) that aim to balance high filtration, adequate breathability and optionally, fluid penetration resistance (39, 40).

*Filtering facepiece respirators (FFR)*, or respirators, offer a balance of filtration and breathability. However, whereas medical masks filter 3 micrometre droplets, respirators must filter more challenging 0.075 micrometre solid particles. European FFRs, according to standard EN 149, at FFP2 performance there is filtration of at least 94% solid NaCl particles and oil droplets. US N95 FFRs, according to NIOSH 42 CFR Part 84, filter at least 95% NaCl particles. Certified FFRs must also ensure unhindered breathing with maximum resistance during inhalation and exhalation. Another important difference between FFRs and other masks is the way filtration is tested. Medical mask filtration tests are performed on a cross-section of the masks, whereas FFRs are tested for filtration across the entire surface. Therefore, the layers of the filtration material and the FFR shape, which ensure the outer edges of the FFR seal around wearer's face, result in guaranteed filtration as claimed. Medical masks, by contrast, have an open shape and potentially leaking structure. Other FFR performance requirements include being within specified parameters for maximum CO<sub>2</sub> build up, total inward leakage and tensile strength of straps (41, 42).

### A. Guidance on the use of medical masks and respirators to provide care to suspected or confirmed COVID-19 cases

#### Evidence on the use of mask in health care settings

Systematic reviews have reported that the use of N95/P2 respirators compared with the use of medical masks (see mask definitions, above) is not associated with statistically significant differences for the outcomes of health workers acquiring clinical respiratory illness, influenza-like illness (risk ratio 0.83, 95%CI 0.63-1.08) or laboratory-confirmed influenza (risk ratio 1.02, 95%CI 0.73-1.43); harms were poorly reported and limited to discomfort associated with lower compliance (43, 44). In many settings, preserving the supply of N95 respirators for high-risk, aerosol-generating procedures is an important consideration (45).

A systematic review of observational studies on the betacoronaviruses that cause severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS) and COVID-19 found that the use of face protection (including respirators and medical masks) is associated with reduced risk of infection among health workers. These studies suggested that N95 or similar respirators might be associated with greater reduction in risk than medical or 12-16-layer cotton masks. However, these studies had important

limitations (recall bias, limited information about the situations when respirators were used and limited ability to measure exposures), and very few studies included in the review evaluated the transmission risk of COVID-19 (46). Most of the studies were conducted in settings in which AGPs were performed or other high-risk settings (e.g., intensive care units or where there was exposure to infected patients and health workers were not wearing adequate PPE).

WHO continues to evaluate the evidence on the effectiveness of the use of different masks and their potential harms, risks and disadvantages, as well as their combination with hand hygiene, physical distancing of at least 1 metre and other IPC measures.

### Guidance

WHO's guidance on the type of respiratory protection to be worn by health workers providing care to COVID-19 patients is based on 1) WHO recommendations on IPC for epidemic- and pandemic-prone acute respiratory infections in health care (47); 2) updated systematic reviews of randomized controlled trials on the effectiveness of medical masks compared to that of respirators for reducing the risk of clinical respiratory illness, influenza-like illness (ILI) and laboratory-confirmed influenza or viral infections. WHO guidance in this area is aligned with guidelines of other professional organizations, including the European Society of Intensive Care Medicine and the Society of Critical Care Medicine, and the Infectious Diseases Society of America (48, 49).

The WHO COVID-19 IPC GDG considered all available evidence on the modes of transmission of SARS-CoV-2 and on the effectiveness of medical mask versus respirator use to protect health workers from infection and the potential for harms such as skin conditions or breathing difficulties.

Other considerations included availability of medical masks versus respirators, cost and procurement implications and equity of access by health workers across different settings.

The majority (71%) of the GDG members confirmed their support for previous recommendations issued by WHO on 5 June 2020:

1. In the absence of aerosol generating procedures (AGPs)<sup>2</sup>, WHO recommends that health workers providing care to patients with suspected or confirmed COVID-19 should wear a medical mask (in addition to other PPE that are part of droplet and contact precautions).
2. In care settings for COVID-19 patients where AGPs are performed, WHO recommends that health workers should wear a respirator (N95 or FFP2 or FFP3 standard, or equivalent) in addition to other PPE that are part of airborne and contact precautions.

In general, health workers have strong preferences about having the highest perceived protection possible to prevent COVID-19 infection and therefore may place high value on the potential benefits of respirators in settings without AGPs. WHO recommends respirators primarily for settings where AGPs are performed; however, if health workers prefer them and they are sufficiently available and cost is not an issue, they could also be used during care for COVID-19 patients in other settings. For additional guidance on PPE, including PPE

<sup>2</sup> The WHO list of AGPs includes tracheal intubation, non-invasive ventilation, tracheotomy, cardiopulmonary resuscitation, manual

ventilation before intubation, bronchoscopy, sputum induction using nebulized hypertonic saline, and dentistry and autopsy procedures.

beyond mask use by health workers, see WHO IPC guidance during health care when COVID-19 infection is suspected (3) and also WHO guidance on the rational use of PPE (45).

Exhalation valves on respirators are discouraged as they bypass the filtration function for exhaled air.

#### B. Guidance on the use of mask by health workers, caregivers and others based on transmission scenario

##### Definitions

*Universal masking* in health facilities is defined as the requirement for all persons (staff, patients, visitors, service providers and others) to wear a mask at all times except for when eating or drinking.

*Targeted continuous medical mask use* is defined as the practice of wearing a medical mask by all health workers and caregivers working in clinical areas during all routine activities throughout the entire shift.

*Health workers* are all people primarily engaged in actions with the primary intent of enhancing health. Examples are: nursing and midwifery professionals, doctors, cleaners, other staff who work in health facilities, social workers, and community health workers.

##### Evidence on universal masking in health care settings

In areas where there is community transmission or large-scale outbreaks of COVID-19, universal masking has been adopted in many hospitals to reduce the potential of transmission by health workers to patients, to other staff and anyone else entering the facility (50).

Two studies found that implementation of a universal masking policy in hospital systems was associated with decreased risk of healthcare-acquired SARS-CoV-2 infection. However, these studies had serious limitations: both were before-after studies describing a single example of a phenomenon before and after an event of interest, with no concurrent control group, and other infection control measures were not controlled for (51, 52). In addition, observed decreases in health worker infections occurred too quickly to be attributable to the universal masking policy.

##### Guidance

Although more research on universal masking in health settings is needed, it is the expert opinion of the majority (79%) of WHO COVID-19 IPC GDG members that universal masking is advisable in geographic settings where there is known or suspected community or cluster transmission of the SARS-CoV-2 virus.

1. In areas of known or suspected community or cluster SARS-CoV-2 transmission, universal masking should be advised in all health facilities (see Table 1).
- All health workers, including community health workers and caregivers, should wear a medical mask at all times, for any activity (care of COVID-19 or non-COVID-19 patients) and in any common area (e.g., cafeteria, staff rooms).

- Other staff, visitors, outpatients and service providers should also wear a mask (medical or non-medical) at all times
  - Inpatients are not required to wear a mask (medical or non-medical) unless physical distancing of at least 1 metre cannot be maintained (e.g., when being examined or visited at the bedside) or when outside of their care area (e.g., when being transported).
  - Masks should be changed when they become soiled, wet or damaged or if the health worker/caregiver removes the mask (e.g., for eating or drinking or caring for a patient who requires droplet/contact precautions for reasons other than COVID-19).
2. In the context of known or suspected sporadic SARS-CoV-2 virus transmission, WHO provides the following guidance:
    - Health workers, including community health workers and caregivers who work in clinical areas, should continuously wear a medical mask during routine activities throughout the entire shift, apart from when eating and drinking and changing their medical masks after caring for a patient who requires droplet/contact precautions for other reasons. In all cases, medical masks must be changed when wet, soiled, or damaged; used medical masks should be properly disposed of at the end of the shift; and new clean ones should be used for the next shift or when medical masks are changed.
    - It is particularly important to adopt the continuous use of masks in potentially high transmission risk settings including triage, family physician/general practitioner offices; outpatient departments; emergency rooms; COVID-19 designated units; haematology, oncology and transplant units; and long-term health and residential facilities.
    - Staff who do not work in clinical areas (e.g., administrative staff) do not need to wear a medical mask during routine activities if they have no exposure to patients.

Whether using masks for universal masking within health facilities or targeted continuous medical mask use throughout the entire shift, health workers should ensure the following:

- Medical mask use should be combined with other measures including frequent hand hygiene and physical distancing among health workers in shared and crowded places such as cafeterias, break rooms, and dressing rooms.
- The medical mask should be changed when wet, soiled, or damaged.
- The medical mask should not be touched to adjust it or if displaced from the face for any reason. If this happens, the mask should be safely removed and replaced, and hand hygiene performed.
- The medical mask (as well as other personal protective equipment) should be discarded and changed after caring for any patient who requires contact/droplet precautions for other pathogens, followed by hand hygiene.
- Under no circumstances should medical masks be shared between health workers or between others wearing them. Masks should be appropriately disposed of whenever removed and not reused.

- A particulate respirator at least as protective as a United States of America (US) National Institute for Occupational Safety and Health-certified N95, N99, US Food and Drug Administration surgical N95, European Union standard FFP2 or FFP3, or equivalent, should be worn in settings for COVID-19 patients where AGPs are performed (see WHO recommendations below). In these settings, this includes continuous use by health workers throughout the entire shift, when this policy is implemented.

**Note:** Decision makers may consider the transmission intensity in the catchment area of the health facility or community setting and the feasibility of implementing a universal masking policy compared to a policy based on assessed or presumed exposure risk. Decisions need to take into account procurement, sustainability and costs of the policy. When planning masks for all health workers, long-term availability of adequate medical masks (and when applicable, respirators) for all workers should be ensured, in particular for those providing care for patients with confirmed or suspected COVID-19. Proper use and adequate waste management should be ensured.

The potential harms and risks of mask and respirator use in the health facility setting include:

- contamination of the mask due to its manipulation by contaminated hands (53, 54);
- potential self-contamination that can occur if medical masks are not changed when wet, soiled or damaged; or by frequent touching/adjusting when worn for prolonged periods (55);
- possible development of facial skin lesions, irritant dermatitis or worsening acne, when used frequently for long hours (56-58);
- discomfort, facial temperature changes and headaches from mask wearing (44, 59, 60);
- false sense of security leading potentially to reduced adherence to well recognized preventive measures such as physical distancing and hand hygiene; and risk-taking behaviours (61-64);
- difficulty wearing a mask in hot and humid environments
- possible risk of stock depletion due to widespread use in the context of universal masking and targeted continuous mask use and consequent scarcity or unavailability for health workers caring for COVID-19 patients and during health care interactions with non-COVID-19 patients where medical masks or respirators might be required.

#### Alternatives to medical masks in health care settings

The WHO's disease commodity package (DCP) for COVID-19 recommends medical masks for health workers to be type II or higher (65). Type II medical masks provide a physical barrier to fluids and particulate materials and have bacterial filtration efficiency of  $\geq 98\%$  compared to Type I mask, which has bacterial filtration efficiency of  $\geq 95\%$  and lower fluid resistance (66). In case of stock outs of type II or higher medical masks, health workers should use a type I medical mask as an alternative. Other alternatives such as face shields or fabric masks should be carefully evaluated.

Face shields are designed to provide protection from splashes of biological fluid (particularly respiratory secretions), chemical agents and debris (67, 68) into the eyes. In the context of protection from SARS-CoV-2 transmission through respiratory droplets, face shields are used by health workers as personal protective equipment (PPE) for eye protection in combination with a medical mask or a respirator (69, 70). While a face shield may confer partial protection of the facial area against respiratory droplets, these and smaller droplets may come into contact with mucous membranes or with the eyes from the open gaps between the visor and the face (71, 67).

Fabric masks are not regulated as protective masks or part of the PPE directive. They vary in quality and are not subject to mandatory testing or common standards and as such are not considered an appropriate alternative to medical masks for protection of health workers. One study that evaluated the use of cloth masks in a health care facility found that health care workers using 2 ply cotton cloth masks (a type of fabric mask) were at increased risk of influenza-like illness compared with those who wore medical masks (72).

In the context of severe medical mask shortage, face shields alone or in combination with fabric mask may be considered as a last resort (73). Ensure proper design of face shields to cover the sides of the face and below the chin.

As for other PPE items, if production of fabric masks for use in health care settings is proposed locally in situations of shortage or stock out, a local authority should assess the product according to specific minimum performance standards and required technical specifications (see Annex).

#### Additional considerations for community care settings

Like other health workers, community health workers should apply standard precautions for all patients at all times, with particular emphasis regarding hand and respiratory hygiene, surface and environmental cleaning and disinfection and the appropriate use of PPE. When a patient is suspected or confirmed of having COVID-19, community health workers should always apply contact and droplet precautions. These include the use of a medical mask, gown, gloves and eye protection (74).

IPC measures that are needed will depend on the local COVID-19 transmission dynamics and the type of contact required by the health care activity (see Table 1). The community health workforce should ensure that patients and workforce members apply precautionary measures such as respiratory hygiene and physical distancing of at least 1 metre (3.3 feet). They also may support set-up and maintenance of hand hygiene stations and community education (74). In the context of known or suspected community or cluster transmission, community health workers should wear a medical mask when providing essential routine services (see Table 1).

**Table 1. Mask use in health care settings depending on transmission scenario, target population, setting, activity and type\***

| Transmission scenario  | Target population (who)   | Setting (where)  | Activity (what)   | Mask type (which one) *   |
|--|---|--|---|---|
| Known or suspected community or cluster transmission of SARS-CoV-2 | Health workers and caregivers                                     | Health facility (including primary, secondary, tertiary care levels, outpatient care, and long-term care facilities)   | For any activity in patient-care areas (COVID-19 or non-COVID-19 patients) or in any common areas (e.g., cafeteria, staff rooms)            | Medical mask (or respirator if aerosol generating procedures performed)   |
|  | Other staff, patients, visitors, service suppliers                |  | For any activity or in any common area  | Medical or fabric mask  |
|  | Inpatients  | In single or multiple-bed rooms  | When physical distance of at least 1 metre cannot be maintained   |   |
|  | Health workers and caregivers                                     | Home visit (for example, for antenatal or postnatal care, or for a chronic condition)  | When in direct contact with a patient or when a distance of at least 1 metre cannot be maintained.  | Medical mask  |
|  |   | Community  | Community outreach programmes/essential routine services  |   |
| Known or suspected sporadic transmission of SARS-CoV-2 cases       | Health workers and caregivers                                     | Health facility (including primary, secondary, tertiary care levels, outpatient care, and long-term care facilities)   | In patient care area- irrespective of whether patients have suspected/confirmed COVID-19  | Medical mask  |
|  | Other staff, patients, visitors, service suppliers and all others |  | No routine activities in patient areas  | Medical mask not required. Medical mask should be worn if in contact or within 1 metre of patients, or according to local risk assessment |
|  | Health workers and caregivers                                     | Home visit (for example, for antenatal or postnatal care, or for a chronic condition)  | When in direct contact or when a distance of at least 1metre cannot be maintained.  |   |
|  |   | Community  | Community outreach programs (e.g., bed net distribution)  | Medical mask  |
|  | Health workers and caregivers                                     | Health facility (including primary, secondary, tertiary care levels, outpatient care, and long-term care facilities)   | Providing any patient care  | Medical mask use according to standard and transmission-based precautions   |
|  |   | Community  | Community outreach programs   |   |
| No documented SARS-CoV-2 transmission                              | Health workers and caregivers                                     | Health facility (including primary, secondary, tertiary care levels, outpatient care, and long-term care facilities)   | Providing any patient care  | Medical mask use according to standard and transmission-based precautions   |
|  |   | Community  | Community outreach programs   |   |
| Any transmission scenario  | Health workers  | Health care facility (including primary, secondary, tertiary care levels, outpatient care, and long-term care facilities), in settings where aerosol generating procedures (AGP) are performed | Performing an AGP on a suspected or confirmed COVID-19 patient or providing care in a setting where AGPs are in place for COVID-19 patients | Respirator (N95 or N99 or FFP2 or FFP3)   |

*\*This table refers only to the use of medical masks and respirators. The use of medical masks and respirators may need to be combined with other personal protective equipment and other measures as appropriate, and always with hand hygiene.*

## Guidance on mask use in community settings

### Evidence on the protective effect of mask use in community settings

At present there is only limited and inconsistent scientific evidence to support the effectiveness of masking of healthy people in the community to prevent infection with respiratory viruses, including SARS-CoV-2 (75). A large randomized community-based trial in which 4862 healthy participants were divided into a group wearing medical/surgical masks and a control group found no difference in infection with SARS-CoV-2 (76). A recent systematic review found nine trials (of which eight were cluster-randomized controlled trials in which clusters of people, versus individuals, were randomized) comparing medical/surgical masks versus no masks to prevent the spread of viral respiratory illness. Two trials were with healthcare workers and seven in the community. The review concluded that wearing a mask may make little or no difference to the prevention of influenza-like illness (ILI) (RR 0.99, 95%CI 0.82 to 1.18) or laboratory confirmed illness (LCI) (RR 0.91, 95%CI 0.66-1.26) (44); the certainty of the evidence was low for ILI, moderate for LCI.

By contrast, a small retrospective cohort study from Beijing found that mask use by entire families before the first family member developed COVID-19 symptoms was 79% effective in reducing transmission (OR 0.21, 0.06-0.79) (77). A case-control study from Thailand found that wearing a medical or non-medical mask all the time during contact with a COVID-19 patient was associated with a 77% lower risk of infection (aOR 0.23; 95% CI 0.09-0.60) (78). Several small observational studies with epidemiological data have reported an association between mask use by an infected person and prevention of onward transmission of SARS-CoV-2 infection in public settings. (8, 79-81).

A number of studies, some peer reviewed (82-86) but most published as pre-prints (87-104), reported a decline in the COVID-19 cases associated with face mask usage by the public, using country- or region-level data. One study reported an association between community mask wearing policy adoption and increased movement (less time at home, increased visits to commercial locations) (105). These studies differed in setting, data sources and statistical methods and have important limitations to consider (106), notably the lack of information about actual exposure risk among individuals, adherence to mask wearing and the enforcement of other preventive measures (107, 108).

Studies of influenza, influenza-like illness and human coronaviruses (not including COVID-19) provide evidence that the use of a medical mask can prevent the spread of infectious droplets from a symptomatic infected person to someone else and potential contamination of the environment by these droplets (75). There is limited evidence that wearing a medical mask may be beneficial for preventing transmission between healthy individuals sharing households with a sick person or among attendees of mass gatherings (44, 109-114).

A meta-analysis of observational studies on infections due to betacoronaviruses, with the intrinsic biases of observational data, showed that the use of either disposable medical masks or reusable 12-16-layer cotton masks was associated with protection of healthy individuals within households and among contacts of cases (46). This could be considered to be indirect evidence for the use of masks (medical or other) by healthy individuals in the wider community; however, these studies suggest that such individuals would need to be in close proximity to an infected person in a household or at a mass gathering where physical distancing cannot be achieved to become infected with the virus. Results from cluster randomized controlled trials on the use of masks among young adults living in university residences in the United States of America indicate that face masks may reduce the rate of influenza-like illness but showed no impact on risk of laboratory-confirmed influenza (115, 116).

### Guidance

The WHO COVID-19 IPC GDG considered all available evidence on the use of masks by the general public including effectiveness, level of certainty and other potential benefits and harms, with respect to transmission scenarios, indoor versus outdoor settings, physical distancing and ventilation. Despite the limited evidence of protective efficacy of mask wearing in community settings, in addition to all other recommended preventive measures, the GDG advised mask wearing in the following settings:

1. In areas with known or suspected community or cluster transmission of SARS-CoV-2, WHO advises mask use by the public in the following situations (see Table 2):

#### Indoor settings:

- in public indoor settings where ventilation is known to be poor regardless of physical distancing: limited or no opening of windows and doors for natural ventilation; ventilation system is not properly functioning or maintained; or cannot be assessed;
- in public indoor settings that have adequate<sup>3</sup> ventilation if physical distancing of at least 1 metre cannot be maintained;
- in household indoor settings: when there is a visitor who is not a household member and ventilation is known to be poor, with limited opening of windows and doors for natural ventilation, or the ventilation system cannot be assessed or is not properly functioning, regardless of whether physical distancing of at least 1 metre can be maintained;
- in household indoor settings that have adequate ventilation if physical distancing of at least 1 metre cannot be maintained.

<sup>3</sup> For adequate ventilation refer to regional or national institutions or heating, refrigerating and air-conditioning societies enacting ventilation requirements. If not available or applicable, a recommended ventilation rate of 10 l/s/person should be met (except healthcare facilities which have specific requirements). For more information consult "Coronavirus (COVID-19) response

resources from ASHRAE and others"  
<https://www.ashrae.org/technical-resources/resources>

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Table 2. Mask use in community settings depending on transmission scenario, setting, target population, purpose and type\*

| Transmission scenario  | Situations/settings (where)  | Target Population (who)  | Purpose of mask use (why)                              | Mask type (which one)                                    |
|--|--|--|--|--|
| Known or suspected community or cluster transmission of SARS-CoV-2                 | Indoor settings, where ventilation is known to be poor or cannot be assessed or the ventilation system is not properly maintained, regardless of whether physical distancing of at least 1 meter can be maintained | General population in public* settings such as shops, shared workplaces, schools, churches, restaurants, gyms, etc. or in enclosed settings such as public transportation.   | Potential benefit for source control                   | Fabric mask  |
|  | Indoor settings that have adequate <sup>4</sup> ventilation if physical distancing of at least 1 metre cannot be maintained  | For households, in indoor settings, when there is a visitor who is not a member of the household   |  |  |
|  | Outdoor settings where physical distancing cannot be maintained  | General population in settings such as crowded open-air markets, lining up outside a building, during demonstrations, etc.   |  |  |
|  | Settings where physical distancing cannot be maintained, and the individual is at increased risk of infection and/or negative outcomes   | Individuals/people with higher risk of severe complications from COVID-19: <ul style="list-style-type: none"> <li>• People aged ≥60 years</li> <li>• People with underlying comorbidities, such as cardiovascular disease or diabetes mellitus, chronic lung disease, cancer, cerebrovascular disease, immunosuppression, obesity, asthma</li> </ul> | Protection   | Medical mask   |
| Known or suspected sporadic transmission, or no documented SARS-CoV-2 transmission | Risk-based approach  | General population   | Potential benefit for source control and/or protection | Depends on purpose (see details in the guidance content) |
| Any transmission scenario  | Any setting in the community   | Anyone suspected or confirmed of having COVID-19, regardless of whether they have symptoms or not, or anyone awaiting viral test results, when in the presence of others   | Source control   | Medical mask   |

\*Public indoor setting includes any indoor setting outside of the household

<sup>4</sup> For adequate ventilation refer to regional or national institutions or heating, refrigerating and air-conditioning societies enacting ventilation requirements. If not available or applicable, a recommended ventilation rate of 10 l/s/person should be met (except healthcare facilities which have specific requirements). For more information consult "Coronavirus (COVID-19) response resources from ASHRAE and others" <https://www.ashrae.org/technical-resources/resources>

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In outdoor settings:

- where physical distancing of at least 1 metre cannot be maintained;
- individuals/people with higher risk of severe complications from COVID-19 (individuals  $\geq 60$  years old and those with underlying conditions such as cardiovascular disease or diabetes mellitus, chronic lung disease, cancer, cerebrovascular disease or immunosuppression) should wear medical masks in any setting where physical distance cannot be maintained.

2. In areas with known or suspected sporadic transmission or no documented transmission, as in all transmission scenarios, WHO continues to advise that decision makers should apply a risk-based approach focusing on the following criteria when considering the use of masks for the public:

- **Purpose of mask use.** Is the intention source control (preventing an infected person from transmitting the virus to others) or protection (preventing a healthy wearer from the infection)?
- **Risk of exposure to SARS-CoV-2.** Based on the epidemiology and intensity of transmission in the population, is there transmission and limited or no capacity to implement other containment measures such as contact tracing, ability to carry out testing and isolate and care for suspected and confirmed cases? Is there risk to individuals working in close contact with the public (e.g., social workers, personal support workers, teachers, cashiers)?
- **Vulnerability of the mask wearer/population.** Is the mask wearer at risk of severe complications from COVID-19? Medical masks should be used by older people ( $\geq 60$  years old), immunocompromised patients and people with comorbidities, such as cardiovascular disease or diabetes mellitus, chronic lung disease, cancer and cerebrovascular disease (117).
- **Setting in which the population lives.** Is there high population density (such as in refugee camps, camp-like settings, and among people living in cramped conditions) and settings where individuals are unable to keep a physical distance of at least 1 metre (for example, on public transportation)?
- **Feasibility.** Are masks available at an affordable cost? Do people have access to clean water to wash fabric masks, and can the targeted population tolerate possible adverse effects of wearing a mask?
- **Type of mask.** Does the use of medical masks in the community divert this critical resource from the health workers and others who need them the most? In settings where medical masks are in short supply, stocks should be prioritized for health workers and at-risk individuals.

The decision of governments and local jurisdictions whether to recommend or make mandatory the use of masks should be based on the above assessment as well as the local context, culture, availability of masks and resources required.

3. In any transmission scenario:

- Persons with any symptoms suggestive of COVID-19 should wear a medical mask and (5) additionally:
  - self-isolate and seek medical advice as soon as they start to feel unwell with potential symptoms of COVID-19, even if symptoms are mild;

- follow instructions on how to put on, take off, and dispose of medical masks and perform hand hygiene (118);
- follow all additional measures, in particular respiratory hygiene, frequent hand hygiene and maintaining physical distance of at least 1 metre from other persons (46). If a medical mask is not available for individuals with suspected or confirmed COVID-19, a fabric mask meeting the specifications in the Annex of this document should be worn by patients as a source control measure, pending access to a medical mask. The use of a non-medical mask can minimize the projection of respiratory droplets from the user (119, 120).
- Asymptomatic persons who test positive for SARS-CoV-2, should wear a medical mask when with others for a period of 10 days after testing positive.

**Potential benefits/harms**

The potential advantages of mask use by healthy people in the general public include:

- reduced spread of respiratory droplets containing infectious viral particles, including from infected persons before they develop symptoms (121);
- reduced potential for stigmatization and greater acceptance of mask wearing, whether to prevent infecting others or by people caring for COVID-19 patients in non-clinical settings (122);
- making people feel they can play a role in contributing to stopping spread of the virus;
- encouraging concurrent transmission prevention behaviours such as hand hygiene and not touching the eyes, nose and mouth (123-125);
- preventing transmission of other respiratory illnesses like tuberculosis and influenza and reducing the burden of those diseases during the pandemic (126).

The potential disadvantages of mask use by healthy people in the general public include:

- headache and/or breathing difficulties, depending on type of mask used (55);
- development of facial skin lesions, irritant dermatitis or worsening acne, when used frequently for long hours (58, 59, 127);
- difficulty with communicating clearly, especially for persons who are deaf or have poor hearing or use lip reading (128, 129);
- discomfort (44, 55, 59)
- a false sense of security leading to potentially lower adherence to other critical preventive measures such as physical distancing and hand hygiene (105);
- poor compliance with mask wearing, in particular by young children (111, 130-132);
- waste management issues; improper mask disposal leading to increased litter in public places and environmental hazards (133);
- disadvantages for or difficulty wearing masks, especially for children, developmentally challenged persons, those with mental illness, persons with cognitive impairment, those with asthma or chronic respiratory or breathing problems, those who have had facial trauma or recent oral maxillofacial surgery and those living in hot and humid environments (55, 130).



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### Considerations for implementation

When implementing mask policies for the public, decision-makers should:

- clearly communicate the purpose of wearing a mask, including when, where, how and what type of mask should be worn; explain what wearing a mask may achieve and what it will not achieve; and communicate clearly that this is one part of a package of measures along with hand hygiene, physical distancing, respiratory etiquette, adequate ventilation in indoor settings and other measures that are all necessary and all reinforce each other;
- inform/train people on when and how to use masks appropriately and safely (see mask management and maintenance sections);
- consider the feasibility of use, supply/access issues (cleaning, storage), waste management, sustainability, social and psychological acceptance (of both wearing and not wearing different types of masks in different contexts);
- continue gathering scientific data and evidence on the effectiveness of mask use (including different types of masks) in non-health care settings;
- evaluate the impact (positive, neutral or negative) of using masks in the general population (including behavioural and social sciences) through good quality research.

### Mask use during physical activity

#### Evidence

There are limited studies on the benefits and harms of wearing medical masks, respirators and non-medical masks while exercising. Several studies have demonstrated statistically significant deleterious effects on various cardiopulmonary physiologic parameters during mild to moderate exercise in healthy subjects and in those with underlying respiratory diseases (134-140). The most significant impacts have been consistently associated with the use of respirators and in persons with underlying obstructive airway pulmonary diseases such as asthma and chronic obstructive pulmonary disease (COPD), especially when the condition is moderate to severe (136). Facial microclimate changes with increased temperature, humidity and perceptions of dyspnoea were also reported in some studies on the use of masks during exercise (134, 141). A recent review found negligible evidence of negative effects of mask use during exercise but noted concern for individuals with severe cardiopulmonary disease (142).

#### Guidance

WHO advises that people should not wear masks during vigorous intensity physical activity (143) because masks may reduce the ability to breathe comfortably. The most important preventive measure is to maintain physical distancing of at least 1 meter and ensure good ventilation when exercising.

If the activity takes place indoors, adequate ventilation should be ensured at all times through natural ventilation or a properly functioning or maintained ventilation system (144). Particular attention should be paid to cleaning and disinfection of the environment, especially high-touch surfaces. If all the above measures cannot be ensured, consider temporary closure of public indoor exercise facilities (e.g., gyms).

### Face shields for the general public

At present, face shields are considered to provide a level of eye protection only and should not be considered as an equivalent to masks with respect to respiratory droplet protection and/or source control. Current laboratory testing standards only assess face shields for their ability to provide eye protection from chemical splashes (145).

In the context of non-availability or difficulties wearing a non-medical mask (in persons with cognitive, respiratory or hearing impairments, for example), face shields may be considered as an alternative, noting that they are inferior to masks with respect to droplet transmission and prevention. If face shields are to be used, ensure proper design to cover the sides of the face and below the chin.

### Medical masks for the care of COVID-19 patients at home

WHO provides guidance on how to care for patients with confirmed and suspected COVID-19 at home when care in a health facility or other residential setting is not possible (5).

- Persons with suspected COVID-19 or mild COVID-19 symptoms should wear a medical mask as much as possible, especially when there is no alternative to being in the same room with other people. The mask should be changed at least once daily. Persons who cannot tolerate a medical mask should rigorously apply respiratory hygiene (i.e., cover mouth and nose with a disposable paper tissue when coughing or sneezing and dispose of it immediately after use or use a bent elbow procedure and then perform hand hygiene).
- Caregivers of or those sharing living space with people with suspected COVID-19 or with mild COVID-19 symptoms should wear a medical mask when in the same room as the affected person.

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WHO continues to monitor the situation closely for any changes that may affect this interim guidance. Should any factors change, WHO will issue a further update. Otherwise, this interim guidance document will expire 1 year after the date of publication.



## Annex: Updated guidance on non-medical (fabric) masks

### Background

A non-medical mask, also called fabric mask, community mask or face covering, is neither a medical device nor personal protective equipment. Non-medical masks are aimed at the general population, primarily for protecting others from exhaled virus-containing droplets emitted by the mask wearer. They are not regulated by local health authorities or occupational health associations, nor is it required for manufacturers to comply with guidelines established by standards organizations. Non-medical masks may be homemade or manufactured. The essential performance parameters include good breathability, filtration of droplets originating from the wearer, and a snug fit covering the nose and mouth. Exhalation valves on masks are discouraged as they bypass the filtration function of the mask.

Non-medical masks are made from a variety of woven and non-woven fabrics, such as woven cotton, cotton/synthetic blends, polyesters and breathable spunbond polypropylene, for example. They may be made of different combinations of fabrics, layering sequences and available in diverse shapes. Currently, more is known about common household fabrics and combinations to make non-medical masks with target filtration efficiency and breathability (119, 146-150). Few of these fabrics and combinations have been systematically evaluated and there is no single design, choice of material, layering or shape among available non-medical masks that are considered optimal. While studies have focussed on single fabrics and combinations, few have looked at the shape and universal fit to the wearer. The unlimited combination of available fabrics and materials results in variable filtration and breathability.

In the context of the global shortage of medical masks and PPE, encouraging the public to create their own fabric masks may promote individual enterprise and community integration. Moreover, the production of non-medical masks may offer a source of income for those able to manufacture masks within their communities. Fabric masks can also be a form of cultural expression, encouraging public acceptance of protection measures in general. The safe re-use of fabric masks will also reduce costs and waste and contribute to sustainability (151-156).

This Annex is destined intended for two types of readers: homemade mask makers and factory-made masks manufacturers. Decision makers and managers (national/sub-national level) advising on a type of non-medical mask are also the focus of this guidance and should take into consideration the following features of non-medical masks: breathability, filtration efficiency (FE), or filtration, number and combination of fabric layers material used, shape, coating and maintenance.

### Evidence on the effectiveness of non-medical (fabric) masks

A number of reviews have been identified on the effectiveness of non-medical masks (151-156). One systematic review (155) identified 12 studies and evaluated study quality. Ten were laboratory studies (157-166), and two reports were from a single randomized trial (72, 167). The majority of studies were conducted before COVID-19 emerged or used laboratory generated particles to assess filtration efficacy. Overall, the reviews concluded that

cloth face masks have limited efficacy in combating viral infection transmission.

### Homemade non-medical masks

Homemade non-medical masks made of household fabrics (e.g., cotton, cotton blends and polyesters) should ideally have a three-layer structure, with each layer providing a function (see Figure 1) (168). It should include:

1. an innermost layer (that will be in contact with the face) of a hydrophilic material (e.g., cotton or cotton blends of terry cloth towel, quilting cotton and flannel) that is non-irritating against the skin and can contain droplets (148)
2. a middle hydrophobic layer of synthetic breathable non-woven material (spunbond polypropylene, polyester and polyaramid), which may enhance filtration, prevent permeation of droplets or retain droplets (148, 150)
3. an outermost layer made of hydrophobic material (e.g. spunbond polypropylene, polyester or their blends), which may limit external contamination from penetrating through the layers to the wearer's nose and mouth and maintains and prevents water accumulation from blocking the pores of the fabric (148).

Although a minimum of three layers is recommended for non-medical masks for the most common fabric used, single, double or other layer combinations of advanced materials may be used if they meet performance requirements. It is important to note that with more tightly woven materials, breathability may be reduced as the number of layers increases. A quick check may be performed by attempting to breathe, through the mouth, through the multiple layers.

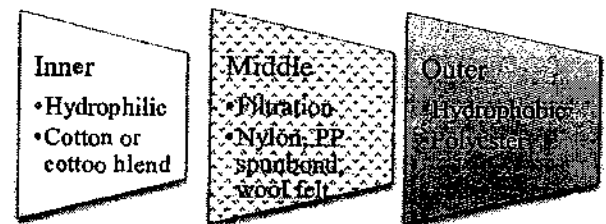


Figure 1. Non-medical mask construction using breathable fabrics such as cotton, cotton blends, polyesters, nylon and polypropylene spunbond that are breathable may impart adequate filtration performance when layered. Single- or double-layer combinations of advanced materials may be used if they meet performance requirements (72).

Assumptions regarding homemade masks are that individual makers only have access to common household fabrics and do not have access to test equipment to confirm target performance (filtration and breathability). Figure 1 illustrates a multi-layer mask construction with examples of fabric options. Very porous materials, such as gauze, even with multiple layers, may provide very low filtration efficiency (147). Higher thread count fabrics offer improved filtration performance (169). Coffee filters, vacuum bags and materials not meant for clothing should be avoided as they may contain injurious content when breathed in. Microporous films such as Gore-Tex are not recommended (170).

### Factory-made non-medical masks: general considerations for manufacturers

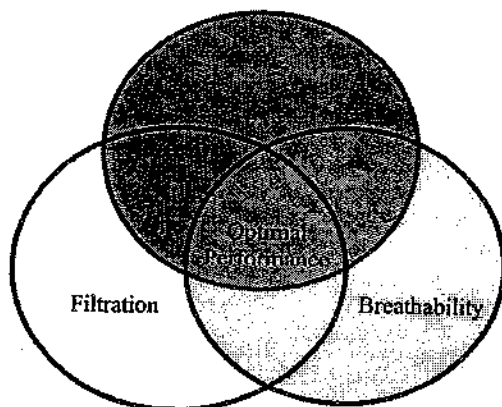
The non-medical mask, including all components and packaging, must be non-hazardous, non-toxic and child-friendly (no exposed sharp edges, protruding hardware or rough materials). Factory-made non-medical masks must be made using a process that is certified to a quality management system (e.g., ISO 9001). Social accountability standards (e.g., SAI SA8000) for multiple aspects of fair labour practices, health and safety of the work force and adherence to UNICEF's Children's Rights and Business Principles are strongly encouraged.

### Standards organizations' performance criteria

Manufacturers producing masks with consistent standardized performance can adhere to published, freely available guidance from several organizations including those from: the French Standardization Association (AFNOR Group), The European Committee for Standardization (CEN), Swiss National COVID-19 Task Force, the American Association of Textile Chemists and Colorists (AATCC), the South Korean Ministry of Food and Drug Safety (MFDS), the Italian Standardization Body (UNI) and the Government of Bangladesh.

### Essential parameters

The essential parameters presented in this section are the synthesis of the abovementioned regional and national guidance. They include filtration, breathability and fit. Good performance is achieved when the three essential parameters are optimized at the preferred threshold (Figure 2).



**Figure 2. Illustration of the three essential parameters of filtration, breathability and fit.**

The summary of the three essential parameters can be found in Table 1 and the additional performance considerations in Table 2. The minimum threshold is the minimum acceptable parameter, while the preferred threshold is the optimum.

### Filtration and breathability

Filtration depends on the filtration efficiency (in %), the type of challenge particle (nibs, solids, droplets containing bacteria) and the particle size (see Table 1). Depending on the fabrics used, filtration and breathability can complement or work against one another. The selection of material for droplet filtration (barrier) is as important as breathability. Filtration is dependent on the tightness of the weave, fibre or thread diameter. Non-woven materials used for disposable masks are manufactured using processes to create polymer fibres that are thinner than natural fibres such as cotton and that are held together by partial melting.

Breathability is the difference in pressure across the mask and is typically reported in millibars (mbar) or Pascals (Pa) or, normalized in the  $\text{cm}^2$  in  $\text{mbar}/\text{cm}^2$  or  $\text{Pa}/\text{cm}^2$ . Acceptable breathability of a medical mask should be below  $49 \text{ Pa}/\text{cm}^2$ . For non-medical masks, an acceptable pressure difference, over the whole mask, should be below  $60 \text{ Pa}/\text{cm}^2$ , with lower values indicating better breathability.

Non-medical fabric masks consisting of two layers of polypropylene spunbond and two layers of cotton have been shown to meet the minimum requirements for droplet filtration and breathability of the CEN CWA 17553 guidance. It is preferable not to select elastic material to make masks as the mask material may be stretched over the face, resulting in increased pore size and lower filtration through multiple usage. Additionally, elastic fabrics are sensitive to washing at high temperatures thus may degrade over time.

Coating the fabric with compounds like wax may increase the barrier and render the mask fluid resistant; however, such coatings may inadvertently completely block the pores and make the mask difficult to breathe through. In addition to decreased breathability unfiltered air may more likely escape the sides of the mask on exhalation. Coating is therefore not recommended.

Valves that let unfiltered air escape the mask are discouraged and are an inappropriate feature for masks used for the purpose of preventing transmission.

Table 1. Essential parameters (minimum and preferred thresholds) for manufactured non-medical mask

| Essential Parameters        | Minimum threshold  | Preferred threshold  |
|-----------------------------|--|--|
| <b>1. Filtration*</b>       |  |  |
| 1.1. filtration efficiency  | 70% @ 3 micron   | > 70%, without compromising breathability  |
| 1.2. Challenge particle     | Solid: sodium chloride (NaCl), Talcum powder, Holi powder, dolomite, Polystyrene Latex spheres<br>Liquid: DEHS Di-Ethyl-Hexyl-Sebacat, paraffin oil  | Based on availability  |
| 1.3. Particle size          | Choose either sizes:<br>3 µm, 1 µm, or smaller   | Range of particle sizes  |
| <b>2. Breathability</b>     |  |  |
| 2.1. Breathing resistance** | ≤60 Pa/cm <sup>2</sup>   | Adult: ≤ 40 Pa/cm <sup>2</sup><br>Paediatric: ≤ 20 Pa/cm <sup>2</sup>  |
| 2.2. Exhalation valves      | Not recommended  | N/A  |
| <b>3. Fit</b>               |  |  |
| 3.1. Coverage               | Full coverage of nose and mouth, consistent, snug perimeter fit at the nose bridge, cheeks, chin and lateral sides of the face; adequate surface area to minimize breathing resistance and minimize side leakage | Same as current requirements   |
| 3.2 Face seal               | Not currently required   | Seal as good as FFR (respirator):<br>Fit factor of 100 for N95<br>Maximum Total Inward Leakage of 25% (FFP1 requirement)                                   |
| 3.2. Sizing                 | Adult and child  | Should cover from the bridge of the nose to below the chin and cheeks on either side of the mouth<br>Sizing for adults and children (3-5, 6-9, 10-12, >12) |
| 3.3 Strap strength          |  | > 44.5 N   |

\* Smaller particle may result in lower filtration.

\*\* High resistance can cause bypass of the mask. Unfiltered air will leak out the sides or around the nose if that is the easier path.

**Fit: shape and sizing**

Fit is the third essential parameter, and takes into consideration coverage, seal, sizing, and strap strength. Fit of masks currently is not defined by any standard except for the anthropometric considerations of facial dimensions (ISO/TS 16976-2) or simplified to height mask (South Korean standard for KF-AD). It is important to ensure that the mask can be held in place comfortably with as little adjustment of the elastic bands or ties as possible.

Mask shapes typically include flat-fold or duckbill and are designed to fit closely over the nose, cheeks and chin of the wearer. Snug fitting designs are suggested as they limit leaks of unfiltered air escaping from the mask (148). Ideally the mask should not have contact with the lips, unless hydrophobic fabrics are used in at least one layer of the mask (148). Leaks where unfiltered air moves in and out of the mask may be attributed to the size and shape of the mask (171).

**Additional considerations**

Optional parameters to consider in addition to the essential performance parameters include if reusable, biodegradability for disposal masks, antimicrobial performance where applicable and chemical safety (see Table 2).

Non-medical masks intended to be reusable should include instructions for washing and must be washed a minimum of five cycles, implying initial performance is maintained after each wash cycle.

Advanced fabrics may be biodegradable or compostable at the end of service life, according to a recognized standard process (e.g., UNI EN 13432, UNI EN 14995 and UNI / PdR 79).

Manufacturers sometimes claim their NM masks have antimicrobial performance. Antimicrobial performance may be due to coatings or additives to the fabric fibres. Treated fabrics must not come into direct contact with mucous membranes; the innermost fabric should not be treated with

antimicrobial additives, only the outermost layer. In addition, antimicrobial fabric standards (e.g., ISO 18184, ISO 20743, AATCC TM100, AATCC 100) are generally slow acting. The inhibition on microbial growth may take full effect after 2- or 24-hour contact time depending on the standard. The standards have generally been used for athletic apparel and substantiate claims of indoor control performance. These standards are not appropriate for non-medical cloth masks and may provide a false sense of protection from infectious agents. If claims are made, manufacturers should specify which standard supports antimicrobial performance, the challenge organism and the contact time.

Volatile additives are discouraged as these may pose a health risk when inhaled repeatedly during wear. Certification according to organizations including OEKO-TEX (Europe) or SEK (Japan), and additives complying with REACH (Europe) or the Environmental Protection Agency (EPA, United States of America) indicate that textile additives are safe and added at safe levels.

**Table 2. Additional parameters for manufactured non-medical masks**

| Additional parameters                               | Minimum thresholds  |
|---|---|
| If reusable, number of wash cycles                  | 5 cycles  |
| Disposal  | Reusable<br>If biodegradable (CFC-BIO), according to UNI EN 13432, UNI EN 14995           |
| Antimicrobial (bacteria, virus, fungus) performance | ISO 18184 (virus)<br>ISO 20743 (bacteria)<br>ISO 13629 (fungus)<br>AATCC TM100 (bacteria) |
| Chemical safety                                     | Comply with REACH regulation, including inhalation safety                                 |

# Advice on the use of masks in the context of COVID-19

49

Interim guidance

5 June 2020



This document is an update of the guidance published on 6 April 2020 and includes updated scientific evidence relevant to the use of masks for preventing transmission of Coronavirus disease 2019 (COVID-19) as well as practical considerations. The main differences from the previous version include the following:

- Updated information on transmission from symptomatic, pre-symptomatic and asymptomatic people infected with COVID-19, as well as an update of the evidence of all sections of this document;
- New guidance on the targeted continuous use of medical masks by health workers working in clinical areas in health facilities in geographical areas with community transmission<sup>1</sup> of COVID-19;
- Updated guidance and practical advice for decision-makers on the use of medical and non-medical masks by the general public using a risk-based approach;
- New guidance on non-medical mask features and characteristics, including choice of fabric, number and combination of layers, shape, coating and maintenance.

Guidance and recommendations included in this document are based on previous WHO guidelines (in particular the WHO Guidelines on infection prevention and control of epidemic- and pandemic-prone acute respiratory infections in health care) (1) and the evaluation of current evidence by the WHO ad hoc COVID-19 IPC Guidance Development Group (COVID-19 IPC GDG) that meets at least once a week. The process of interim guidance development during emergencies consists of a transparent and robust process of evaluation of the available evidence on benefits and harms, synthesized through expedited systematic reviews and expert consensus-building facilitated by methodologists. This process also considers, as much as possible, potential resource implications, values and preferences, feasibility, equity, ethics and research gaps.

## Purpose of the guidance

This document provides guidance to decision makers, public health and IPC professionals, health care managers, and health workers on the use of medical and non-medical masks in health care (including long-term care and residential)

settings, for the general public, and during home care. It will be revised as more data become available.

## Background

The use of masks is part of a comprehensive package of the prevention and control measures that can limit the spread of certain respiratory viral diseases, including COVID-19. Masks can be used either for protection of healthy persons (worn to protect oneself when in contact with an infected individual) or for source control (worn by an infected individual to prevent onward transmission).

However, the use of a mask alone is insufficient to provide an adequate level of protection or source control, and other personal and community level measures should also be adopted to suppress transmission of respiratory viruses. Whether or not masks are used, compliance with hand hygiene, physical distancing and other infection prevention and control (IPC) measures are critical to prevent human-to-human transmission of COVID-19.

This document provides information and guidance on the use of masks in health care settings, for the general public, and during home care. The World Health Organization (WHO) has developed specific guidance on IPC strategies for health care settings (2), long-term care facilities (LTCF) (3), and home care.(4)

## Transmission of COVID-19

Knowledge about transmission of the COVID-19 virus is accumulating every day. COVID-19 is primarily a respiratory disease and the spectrum of infection with this virus can range from people with very mild, non-respiratory symptoms to severe acute respiratory illness, sepsis with organ dysfunction and death. Some people infected have reported no symptoms at all.

According to the current evidence, COVID-19 virus is primarily transmitted between people via respiratory droplets and contact routes. Droplet transmission occurs when a person is in close contact (within 1 metre) with an infected person and exposure to potentially infective respiratory droplets occurs, for example, through coughing, sneezing or very close personal contact resulting in the inoculation of entry portals such as the mouth, nose or conjunctivae

<sup>1</sup> Defined by WHO as "experiencing larger outbreaks of local transmission defined through an assessment of factors including, but not limited to: large numbers of cases not linkable to transmission chains; large numbers of cases from sentinel

surveillance; and/or multiple unrelated clusters in several areas of the country/territory/area" (<https://www.who.int/publications-detail/global-surveillance-for-covid-19-caused-by-human-infection-with-covid-19-virus-interim-guidance>)

community transmission, consider additional precautions, including the wearing of a medical mask, when community health workers provide essential routine services (Table 2).

When a patient is suspected or confirmed to have COVID-19 infection, community health workers should use contact and droplet precautions. Contact and droplet precautions include the use of a medical mask, gown, gloves and eye protection.(53)

## Guidance on the use of masks for the general public

### Available evidence

Studies of influenza, influenza-like illness, and human coronaviruses (not including COVID-19) provide evidence that the use of a medical mask can prevent the spread of infectious droplets from a symptomatic infected person (source control) to someone else and potential contamination of the environment by these droplets.(54, 55) There is limited evidence that wearing a medical mask by healthy individuals in households, in particular those who share a house with a sick person, or among attendees of mass gatherings may be beneficial as a measure preventing transmission.(41, 56-61) A recent meta-analysis of these observational studies, with the intrinsic biases of observational data, showed that either disposable surgical masks or reusable 12–16-layer cotton masks were associated with protection of healthy individuals within households and among contacts of cases.(42)

This could be considered to be indirect evidence for the use of masks (medical or other) by healthy individuals in the wider community; however, these studies suggest that such individuals would need to be in close proximity to an infected person in a household or at a mass gathering where physical distancing cannot be achieved, to become infected with the virus.

Results from cluster randomized controlled trials on the use of masks among young adults living in university residences in the United States of America indicate that face masks may reduce the rate of influenza-like illness, but showed no impact on risk of laboratory-confirmed influenza.(62, 63) At present, there is no direct evidence (from studies on COVID-19 and in healthy people in the community) on the effectiveness of universal masking of healthy people in the community to prevent infection with respiratory viruses, including COVID-19.

WHO regularly monitors all emerging evidence about this important topic and will provide updates as more information becomes available.

### Guidance

#### 1) WHO recommends that persons with any symptoms suggestive of COVID-19 should (1, 2):

- wear a medical mask, self-isolate, and seek medical advice as soon as they start to feel unwell with potential symptoms of COVID-19, even if symptoms are mild. Symptoms can include: fever, cough, fatigue, loss of appetite, shortness of breath and muscle pain. Other non-specific symptoms such as sore throat, nasal congestion, headache, diarrhoea, nausea and vomiting, have also been reported. Loss of smell and taste preceding the onset of respiratory symptoms have also been

reported.(64, 65) Older people and immunosuppressed patients may present with atypical symptoms such as fatigue, reduced alertness, reduced mobility, diarrhoea, loss of appetite, delirium, and absence of fever.(26, 66, 67) It is important to note that early symptoms for some people infected with COVID-19 may be very mild and unspecific;

- follow instructions on how to put on, take off, and dispose of medical masks and perform hand hygiene;(68)
- follow all additional measures, in particular respiratory hygiene, frequent hand hygiene and maintaining physical distance of at least 1 metre (3.3 feet) from other persons.(42)

In the context of the COVID-19 pandemic, it is recommended that all persons, regardless of whether they are using masks or not, should:

- avoid groups of people and crowded spaces (follow local advice);
- maintain physical distance of at least 1 metre (3.3 feet) from other persons, especially from those with respiratory symptoms (e.g. coughing, sneezing);
- perform hand hygiene frequently, using an alcohol-based handrub if hands are not visibly dirty or soap and water;
- use respiratory hygiene i.e. cover their nose and mouth with a bent elbow or paper tissue when coughing or sneezing, dispose of the tissue immediately after use, and perform hand hygiene;
- refrain from touching their mouth, nose, and eyes.

#### 2) Advice to decision makers on the use of masks for the general public

Many countries have recommended the use of fabric masks/face coverings for the general public. At the present time, the widespread use of masks by healthy people in the community setting is not yet supported by high quality or direct scientific evidence and there are potential benefits and harms to consider (see below).

However, taking into account the available studies evaluating pre- and asymptomatic transmission, a growing compendium of observational evidence on the use of masks by the general public in several countries, individual values and preferences, as well as the difficulty of physical distancing in many contexts, WHO has updated its guidance to advise that to prevent COVID-19 transmission effectively in areas of community transmission, governments should encourage the general public to wear masks in specific situations and settings as part of a comprehensive approach to suppress SARS-CoV-2 transmission (Table 2).

WHO advises decision makers to apply a risk-based approach focusing on the following criteria when considering or encouraging the use of masks for the general public:

1. **Purpose of mask use:** if the intention is preventing the infected wearer transmitting the virus to others (that is, source control) and/or to offer protection to the healthy wearer against infection (that is, prevention).

- reminding people to be compliant with other measures (e.g., hand hygiene, not touching nose and mouth). However, this can also have the reverse effect (see below);
- potential social and economic benefits. Amidst the global shortage of surgical masks and PPE, encouraging the public to create their own fabric masks may promote individual enterprise and community integration. Moreover, the production of non-medical masks may offer a source of income for those able to manufacture masks within their communities. Fabric masks can also be a form of cultural expression, encouraging public acceptance of protection measures in general. The safe re-use of fabric masks will also reduce costs and waste and contribute to sustainability.

### Potential harms/disadvantages

The likely disadvantages of the use of mask by healthy people in the general public include:

- potential increased risk of self-contamination due to the manipulation of a face mask and subsequently touching eyes with contaminated hands;(48, 49)
- potential self-contamination that can occur if non-medical masks are not changed when wet or soiled. This can create favourable conditions for microorganism to amplify;
- potential headache and/or breathing difficulties, depending on type of mask used;
- potential development of facial skin lesions, irritant dermatitis or worsening acne, when used frequently for long hours;(50)
- difficulty with communicating clearly;
- potential discomfort;(41, 51)
- a false sense of security, leading to potentially lower adherence to other critical preventive measures such as physical distancing and hand hygiene;
- prior compliance with mask wearing, in particular by young children;
- waste management issues; improper mask disposal leading to increased litter in public places, risk of contamination to street cleaners and environment hazard;
- difficulty communicating for deaf persons who rely on lip reading;
- disadvantages for or difficulty wearing them, especially for children, developmentally challenged persons, those with mental illness, elderly persons with cognitive impairment, those with asthma or chronic respiratory or breathing problems, those who have had facial trauma or recent oral maxillofacial surgery, and those living in hot and humid environments.

If masks are recommended for the general public, the decision-maker should:

- clearly communicate the purpose of wearing a mask, where, when, how and what type of mask should be worn. Explain what wearing a mask may achieve and what it will not achieve, and communicate clearly that this is one part of a package of measures along with hand hygiene, physical distancing and other measures that are all necessary and all reinforce each other;
- inform/train people on when and how to use masks safely (see mask management and maintenance sections), i.e. put on, wear, remove, clean and dispose;

- consider the feasibility of use, supply/access issues, social and psychological acceptance (of both wearing and not wearing different types of masks in different contexts);
- continue gathering scientific data and evidence on the effectiveness of mask use (including different types and makes as well as other face covers such as scarves) in non-health care settings;
- evaluate the impact (positive, neutral or negative) of using masks in the general population (including behavioral and social sciences).

WHO encourages countries and community adopting policies on masks use in the general public to conduct good quality research to assess the effectiveness of this intervention to prevent and control transmission.

### 3) Types of mask to consider

#### Medical mask

Medical masks should be certified according to international or national standards to ensure they offer predictable product performance when used by health workers, according to the risk and type of procedure performed in a health care setting. Designed for single use, a medical mask's initial filtration (at least 95% droplet filtration), breathability and, if required, fluid resistance are attributed to the type (e.g. spunbond or meltblown) and layers of manufactured non-woven materials (e.g. polypropylene, polyethylene or cellulose). Medical masks are rectangular in shape and comprise three or four layers. Each layer consists of fine to very fine fibres. These masks are tested for their ability to block droplets (3 micrometres in size; EN 14683 and ASTM F2100 standards) and particles (0.1 micrometre in size; ASTM F2100 standard only). The masks must block droplets and particles while at the same time they must also be breathable by allowing air to pass. Medical masks are regulated medical devices and categorized as PPE.

The use of medical masks in the community may divert this critical resource from the health workers and others who need them the most. In settings where medical masks are in short supply, medical masks should be reserved for health workers and at-risk individuals when indicated.

#### Non-medical mask

Non-medical (also referred to as "fabric" in this document) masks are made from a variety of woven and non-woven fabrics, such as polypropylene. Non-medical masks may be made of different combinations of fabrics, layering sequences and available in diverse shapes. Few of these combinations have been systematically evaluated and there is no single design, choice of material, layering or shape among the non-medical masks that are available. The unlimited combination of fabrics and materials results in variable filtration and breathability.

A non-medical mask is neither a medical device nor personal protective equipment. However, a non-medical mask standard has been developed by the French Standardization Association (AFNOR Group) to define minimum performance in terms of filtration (minimum 70% solid particle filtration or droplet filtration) and breathability (maximum pressure difference of 0.6 mbar/cm<sup>2</sup> or maximum

F. No. Z.28016/133/2021-DM Cell  
Government of India  
Ministry of Health & Family Welfare  
(DM Cell)

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Nirman Bhavan, New Delhi.  
Dated the 27th May 2021.

To

Saurav Bysack  
Saradapally Mathurdingi, Mrigalal,  
Tantipara Haspu, Dankuni, Pin: 712311  
bysack.saurav@gmail.com

Subject: Request for information under RTI Act 2005.

With reference to your online RTI application bearing registration no. MOHFW/R/E/21/01528 dated 15/04/2021 for providing information on the above-mentioned subject. The point wise reply is as under:-

| S No. | Question  | Answer  |
|-------|---|---|
| 1.    | Is face Masks are mandatory for everyone.   | Use of mask/face cover has been advised to all in various SOPs/Guidelines issued by MoHFW. However as per these guidelines/SOPs its use has not been explicitly made mandatory.   |
| 2.    | what are the side effects of face mask.   | No such information is available in records of DM Cell, MoHFW   |
| 3.    | how long use of face mask is safe.  | Mask has to be worn for a maximum of 8 hours of use or earlier if it becomes wet or visibly soiled.   |
| 4.    | if a person feel very uncomfortable while using face mask then what he/she should do.           | No such information is available in records of DM Cell, MoHFW   |
| 5.    | Is face masks lower the oxygen saturation level in blood.                                       | As per MoHFW's Guidelines on Preventive Measures to Contain Spread of COVID-19 in Yoga Institutes & Gymnasiums issued on 1st March 2021 (available at: <a href="https://www.mohfw.gov.in/pdf/GuidelinesonPreventiveMeasuresToContainSpreadofCOVID19inYogaInstitutes&amp;Gymnasiums.pdf">https://www.mohfw.gov.in/pdf/GuidelinesonPreventiveMeasuresToContainSpreadofCOVID19inYogaInstitutes&amp;Gymnasiums.pdf</a> ), use of mask (in particular N-95 masks) during exercise may cause difficulty in breathing. No further information is available in records of DM Cell, MoHFW. |
| 6.    | Is government of India conducted any trial/study on using face mask and face mask side effects. | No such information is available in records of DM Cell, MoHFW.  |
| 7.    | what type of mask is  | No such information is available in records of DM Cell, MoHFW.  |



Ministry of Health and Family Welfare  
Directorate General of Health Services  
[Emergency Medical Relief]

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Novel Coronavirus Disease (COVID-19)

**Guidelines on use of masks by public**

**1. Introduction**

A new disease named novel coronavirus (COVID-19) emerged in early December 2019 in China and has now spread to over 90 countries. As on 9<sup>th</sup> March 2020, India has reported 42 cases mostly among those who had travelled from affected countries. It causes a minor illness in majority of patients with symptoms of fever and or cough. A small proportion of such persons may progress to severe disease with difficulty in breathing.

It is spread by an infected person with COVID coughing and the droplets from his cough infecting others in close vicinity (less than 1 metre).

Any such new disease invariably related to cough leads to suggestions from various quarters, especially in social media, to use mask by general public to prevent the disease.

**2. Purpose of this document**

The purpose of this document is to give correct evidence based information to general public on use of mask.

**3. Medical masks**

Medical masks of different size and shapes are available in the market. The common ones are flat pleated masks of woven fabric which covers the nose and mouth and affixed behind the head with straps/ elastic fasteners. There are also conical or duck bill shaped masks with valves (or without valves) that fit in the contour of face over the nose and mouth, but are costlier.

**4. Use of masks by general public**

**4.1. Persons having no symptoms are not to use mask**

Medical masks should not be used by healthy persons who are not having any symptoms because it create a false sense of security that can lead to neglecting other essential measures such as washing of hands.

Further, there is no scientific evidence to show health benefit of using masks for non-sick persons in the community. In fact erroneous use of masks or continuous use of a disposable mask for longer than 6 hours or repeated use of same mask may actually increase risk of getting an infection. It also incurs unnecessary cost.

In such situation, more effective steps are:

- i. Wash hands frequently with soap and water for 40 seconds. An alcohol based hand sanitizer with 70% alcohol must be used for 20 seconds. If hands are dirty or soiled, do not use alcohol based hand sanitizer, but wash hands preferably with soap and water.
- ii. While coughing or sneezing cover nose and mouth with handkerchief, paper tissue. If handkerchief or tissue paper is not available cough into the flexed elbow. Dispose of tissue immediately after use and wash hands.
- iii. Refrain from touching face, mouth, nose and eyes.
- iv. Stay at least a metre away from those coughing or sneezing.
- v. Monitor your body temperature.

#### **4.2. When and who should use medical masks (apart from health care worker).**

##### **4.2.1. When a person develops cough or fever.**

- ☼ Use of medical three layer masks when ill, will prevent your infection from spreading to others. However you also need to wash your hands frequently to avoid spreading infection to others.

##### **4.2.2. While visiting a healthcare facility.**

##### **4.2.3. When you are caring for an ill person.**

4.2.4. Close family contacts of such suspect/confirmed cases undergoing home care should also use Triple layer medical mask.

#### **4.3. Duration for which a medical mask will remain effective**

A medical mask, if properly worn, will be effective for 8 hours. If it gets wet in between, it needs to be changed immediately.

#### **4.4. Correct procedure of wearing triple layer mask**

While wearing a medical mask, the steps given below needs to be followed. If you do not follow them, you may get infected from the mask itself. These steps are:

- Unfold the pleats; make sure that they are facing down.
- Place over nose, mouth and chin.
- Fit flexible nose piece (a metallic strip that can easily be located) over nose-bridge.

- Secure with tie strings (upper string to be tied on top of head above the ears – lower string at the back of the neck.)
- Ensure there are no gaps on either side of the mask, adjust to fit.
- While in use, avoid touching the mask.
- Do not let the mask hanging from the neck.
- Change the mask after six hours or as soon as they become wet.
- Disposable masks are never to be reused and should be disposed off.
- While removing the mask great care must be taken not to touch the potentially contaminated outer surface of the mask
- To remove mask first untie the string below and then the string above and handle the mask using the upper strings.

#### **4.5. Disposal of used masks**

Used mask should be considered as potentially infected. Masks used by patients / care givers/ close contacts during home care should be disinfected using ordinary bleach solution (5%) or sodium hypochlorite solution (1%) and then disposed of either by burning or deep burial.



Select Language: English

Annexure P6

Public Authorities Available

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RTI Online

An Initiative of Department of Personnel &amp; Training, Government of India

[Home](#) [Submit Request](#) [Submit First Appeal](#) [View Status](#) [View History](#) [User Manual](#) [FAQ](#)Final Status of INCMR/R/E/21/00355

|                           |  |
|---------------------------|--|
| Applicant Name            | Amit Chouhan   |
| Date of receipt           | 19/05/2021   |
| Request Filed With        | Indian Council of Medical Research   |
| Text of Application       | 1. What are the side effects of using Face Mask<br>2. If a person feel uncomfortable while using face mask what he should do<br>3. is oxygen saturation level fall in blood for using face mask<br>4. Is face mask are mandatory for everyone<br>5. was government of India asses the side effects long term use of face mask.<br>6. is government of India have any evidence/proof/trial regarding use of face mask and virus |
| Request document (if any) | document not provided  |
| Status                    | RTI REQUEST APPLICATION RETURNED TO APPLICANT as on 19/05/2021   |
| Date of Action            | 19/05/2021   |
| Remarks                   | Remarks :- For face mask related issues, please visit link<br><a href="https://www.mohfw.gov.in/pdf/Useofmaskbypublic.pdf">https://www.mohfw.gov.in/pdf/Useofmaskbypublic.pdf</a> and<br><a href="https://www.mohfw.gov.in/pdf/Poster4GHFGA.pdf">https://www.mohfw.gov.in/pdf/Poster4GHFGA.pdf</a> Regards   |

Print

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No. MHOME/R/E/20/02079 (41)  
Government of India  
Ministry of Home Affairs  
(Disaster Management Division)

Hall-B, 3<sup>rd</sup> Floor, NDCC-II Building,  
Jai Singh Road, New Delhi,  
Dated the 3<sup>rd</sup> May, 2020.

To,

Shri Sujit Chakraborty  
35 Mohammad Roque Road, Bagachi Para,  
Santipur, Nadia-741404 (West Bengal)  
Email-sujit.ok1234@gmail.com

Sub : Information under Right to Information Act, 2005.

Sir,

Please refer to your online RTI application registration's No. MHOME/R/E/20/02079 dated 18.04.2020 received under RTI Act, 2005.

2. Based on the information available on record with this Division, MHA against your RTI application is as under:

| Point No. | Information sought  | Information provided   |
|-----------|---|--|
| 1.        | What are the fundamental rights we the citizen of India can enjoy under the present lock down imposed by Govt. of India. Do we have the right to protest and demonstrate. What freedom of speech we have in this period of lock down.   | The National Disaster Management Authority (NDMA) vide order dated 24 <sup>th</sup> March, 2020, after assessing the threatening situation of spreading of COVID-19 in the country directed inter-alia the National Executive Committee (NEC) to issue the necessary guidelines to the Ministries/Department of Government of India, State Governments and State Authorities to take measures for ensuring social distancing. In compliance of NDMA's above order, the Home Secretary in his capacity as Chairperson of the NEC issued an order dated 24 <sup>th</sup> March, 2020 under Section 10(2)(i) of Disaster Management Act 2005 along with the guidelines on the measures to be taken by the Ministries/Departments, Govt. (State/UT) Governments, State/UT authorities for containment of COVID-19 epidemic country. Vide this order lockdown measures were implemented in the country for a period of 21 days i.e. 25 <sup>th</sup> March, 2020. The lockdown measures were/are being extended from time to time to contain spread of COVID-19. Both the above orders are available on our website i.e. <a href="http://www.mha.gov.in">www.mha.gov.in</a> . |
| 2.        | Is it mandatory for all citizens of India to wear mask outside their residence and in public places during this period of imposed lock down. If yes, on what basis of research the mask has been made compulsory to wear. Is it guaranteed that corona virus will not be spread if the mask is worn. What if the person finds it difficult to breathe if mask is worn by him or her. Based on which law the mask is made mandatory if it has been made mandatory. | The Ministry of Health & Family Welfare have also issued guidelines on use of mask etc. by public, which is available at the link: <a href="https://www.mohfw.gov.in/pdf/33sofmaskbypublic.pdf">https://www.mohfw.gov.in/pdf/33sofmaskbypublic.pdf</a>   |
| 3.        | Is it mandatory to use sanitizer compulsorily to wash hands as pushed by many public offices like banks both private and govt for the visiting clients. Based on which law this has been made mandatory if it has been made mandatory.  |  |

3. If you are not satisfied with this reply, you may prefer an appeal under Section 19(1) of the RTI Act, 2005 within thirty days from the receipt of this letter to:-

Shri Sanjeev Kumar Jindal, Joint Secretary/Appellate Authority,  
DM Division, Ministry of Home Affairs,  
Hall-B, 3<sup>rd</sup> Floor, NDCC-II Building,  
Jai Singh Road, New Delhi-110001.

Yours faithfully,

*(Signature)*  
(Rohas Bhankhar)  
Deputy Secretary (DM-III) & CPIO  
T.No.23438071

Copy for Information to:-

SO, IT Cell, MHA, North Block, New Delhi (w.r.t. to RTI Section's OM No.A-43020/61/2013-OTI (D.D. Dated 20/03/2020) dated 20/03/2020)

Annexure P7 1

IN THE SUPREME COURT OF INDIA  
CIVIL ORIGINAL JURISDICTION  
WRIT PETITION (CIVIL) NO. 580 OF 2021

-58-

IN THE MATTER OF:

EVARA FOUNDATION

... PETITIONER

VERSUS

UNION OF INDIA & ORS.

... RESPONDENTS

AFFIDAVIT DATED 13.01.2022  
ON BEHALF OF THE UNION OF INDIA

PAPER-BOOK  
(FOR INDEX KINDLY SEE INSIDE)

ADVOCATE FOR THE UNION OF INDIA: G S MAKKER

**ADVOCATE FOR THE UNION OF INDIA: G S MAKKER**  
**IN THE SUPREME COURT OF INDIA**  
**CIVIL ORIGINAL JURISDICTION**  
**WRIT PETITION (CIVIL) NO. 580 OF 2021**

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... RESPONDENTS

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| 1.           | Affidavit dated 13.01.2022 on behalf of the Union of India.   | <b>1-16</b>     |
| 2.           | <b>ANNEXURE- R/1:</b><br>A true copy of letter dated 01.11.2021 for the Har Ghar Dastak Campaign is annexed herewith and marked as ANNEXURE- R/1.                               | <b>17</b>       |
| 3.           | <b>ANNEXURE- R/2:</b><br>A true copy of the SOP for COVID-19 vaccination of persons without prescribed ID cards through Co-WIN is annexed herewith and marked as ANNEXURE - R2. | <b>18-20</b>    |

IN THE SUPREME COURT OF INDIA  
CIVIL ORIGINAL WRIT JURISDICTION  
WRIT PETITION (CIVIL) NO.580 OF 2021

- 60 -

EVARA FOUNDATION

...PETITIONER

VERSUS

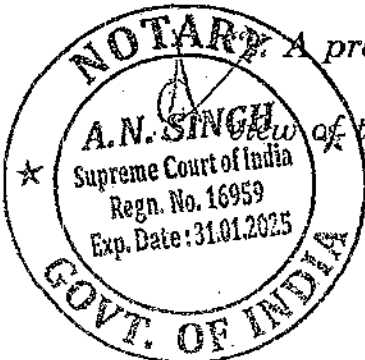
UNION OF INDIA &amp; ANR.

...RESPONDENTS


AFFIDAVIT DATED 13.01.2022 ON BEHALF OF THE UNION  
OF INDIA

I, Dr. Veena Dhawan, Wife of Dr. Puneet Dhawan, aged 56 years, working as Joint Commissioner (UIP) in the Ministry of Health & Family Welfare, Government of India, the deponent herein, do hereby solemnly affirm and state on oath as under:-

1. That I am Joint Commissioner (UIP) in the Ministry of Health & Family Welfare, Government of India (MoHFW). I am filing this affidavit in furtherance of this Hon'ble Court's order dated 03.12.2021 wherein this Hon'ble Court was pleased to observe as under:



A preliminary affidavit has been filed by the Union of India. In view of the contents of the affidavit which has been filed on behalf of

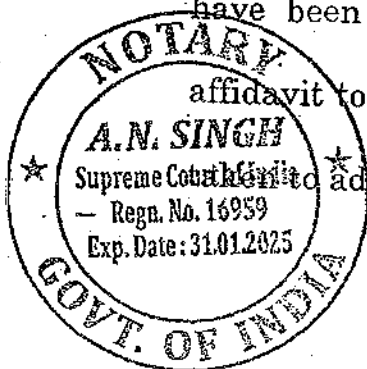
  
(डा. वीणा धवन)  
(DR. VEENA DHAWAN)  
संयुक्त आयुक्त (एम.)  
Joint Commissioner (Imm.)  
स्वास्थ्य एवं परिवार कल्याण विभाग  
Ministry of Health & F.W.  
Govt. of India



the Union of India, we grant liberty to the Petitioner to formulate any concrete suggestions which they may have to strengthen the existing framework for facilitating the vaccination of the disabled and to ensure that they have proper access to vaccination against COVID-19.

Mr. Pankaj Sinha, Counsel appearing on behalf of the Petitioner, together with other counsel appearing for the Petitioner, would, after due consultation, prepare a set of suggestions which can be emailed to the following email id: cmvc.dyc@gmail.com. A copy of the suggestions shall also be emailed to Ms. Aishwarya Bhati, Additional Solicitor General appearing on behalf of the Union of India. Once the suggestions are emailed, they would be the subject matter of further deliberations, with a view to consider if the existing framework for vaccination of the disabled needs to be suitably strengthened by incorporating additional safeguards or facilities. Ms. Aishwarya Bhati may respond to the suggestions with proposed measures."

2. That in furtherance of the above order, the Union of India received a list of suggestions from the Petitioner on 09.12.2021, which have been duly considered and the deponent is filing the present affidavit to apprise this Hon'ble Court about the steps that have been taken to address the suggestions given by the Petitioner.

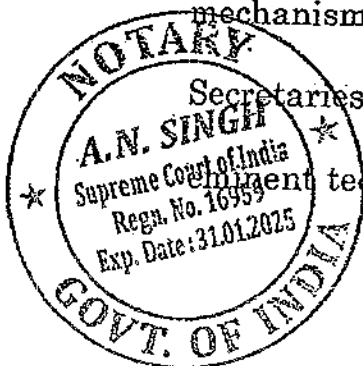


(डा. वीणा धवन)  
(DR. VEENA DHAWAN)  
संयुक्त न्यायाधीश (न्याय)  
Joint Commissioner (Judicial)  
राजस्थान एवं पश्चिम बंगाल में  
Ministry of Health & F.W.  
भारत सरकार / Govt. of India  
जयपुर / Jaipur

3. India's COVID-19 vaccination programme is the largest vaccination programme in the world. As on 11.01.2022, a total of 1,52,95,43,602 doses have been administered wherein, 90.84% of eligible adult population has received their first dose of the vaccine and 61% has received their second doses. Furthermore, a total of 23678 doses have been administered to disabled persons who have voluntarily chosen to be identified as such by using their Unique Disability ID Card/Disability Certificate for registration at the time of their vaccination.

#### PRELIMINARY SUBMISSIONS

4. At the outset, it is most respectfully submitted that India's COVID-19 vaccination drive is being guided by scientific and domain knowledge experts through a National Expert Group on Vaccine Administration for COVID-19 (NEGVAC). NEGVAC provides guidance on all aspect of COVID-19 vaccination including prioritization of population groups, procurement and inventory management, vaccine selection, vaccine delivery and tracking mechanism etc. The NEGVAC comprises of subject matter experts, Secretaries of all pertinent Ministries of Government of India, eminent technical experts and State Governments' representatives for

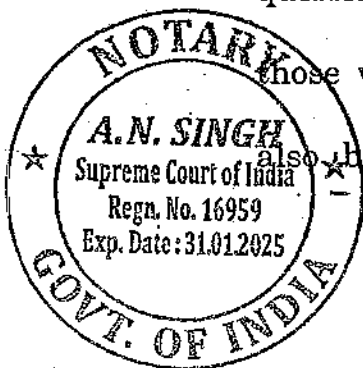


(डॉ. वीना धवन)  
(DR. VEENA DHAWAN)  
संयुक्त आयुक्त (स्वा.)  
Joint Commissioner (Imm.)  
जनसंख्या एवं परिवार कल्याण विभाग  
Population & F.V.

evidence based and collaborative decision making that is adaptive to local needs. On technical aspects pertaining to COVID-19 vaccination, the NEGVAC is guided by the National Technical Advisory Group of Immunisation (NTAGI) which is India's apex advisory body on immunisation. The NTAGI examines the technical aspects like usage of different varieties of COVID-19 Vaccines, interval between vaccine doses, contraindications etc. and recommends the same to NEGVAC. NEGVAC in turn provides overall guidance and recommendations on all aspects of COVID-19 vaccination to MoHFW including prioritization of population groups, procurement and inventory management, vaccine selection, vaccine delivery and tracking mechanism etc.

#### RESPONSE TO SUGGESTIONS MADE BY THE PETITIONER

5. Helpline numbers: It is humbly submitted that this suggestion has already been implemented. The Government of India has a toll-free 24x7 national helpline number 1075 which caters to queries on COVID-19 vaccination from every individual, including those with disabilities. A Technical Helpline (0120-4473222) has also been established to specifically handle Co-WIN software



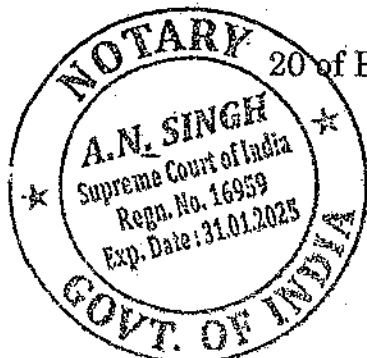
(Dr. Veena Dhanwan)  
(Dr. VEENA DHANWAN)  
जुनियन काउन्सिलर (स्वास्थ्य)  
Joint Commissioner (Health)  
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नया दिल्ली

related queries. The personnel administering these helplines are aware of advisories and guidance documents issued by MoHFW in regard to differently abled people. There is also a State 104 Helpline number, which is primarily intended to provide medical assistance for several minor illnesses, ailments, and mental distresses, along with details on health schemes. The GoI has also provided guidance for augmenting the capacity of 104 Helpline for addressing queries on COVID-19 vaccination including grievance redressal related to vaccination process as well as linking to concerned facilities for management of any adverse event (available at:

<https://www.mohfw.gov.in/pdf/COVID19VaccineOG111Chapter16.pdf>).

Further guidance has been provided by Government of India by way of letter dated 11.06.2021 for orientation of 104 helpline personnel so as to facilitate the provision of requisite information to differently abled persons so as to facilitate their proper care and vaccination.

Ref: Letter dated 11.06.2021 issued by Secretary, MoHFW at page 20 of Preliminary Affidavit dated 30.09.2021.

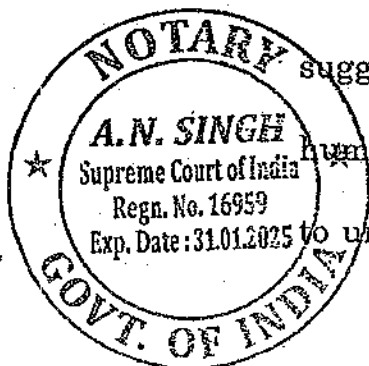


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New Delhi

Furthermore, for medical query related assistance, MoHFW has established a patient to doctor telemedicine platform. Accordingly, a National Telemedicine Service by the name of eSanjeevaniOPD (<https://www.esanjeevaniopd.in/>) was rolled out nationally by MoHFW on 13.04.2020 in the early stage of the COVID-19 pandemic. Since then, eSanjeevaniOPD (National Telemedicine Service) has been rolled out by 30 States and around 25,000 doctors have been on-boarded on eSanjeevaniOPD. Over 531 online OPDs are functional on eSanjeevaniOPD of which over 480 are specialist and super-specialist OPDs and 51 are General OPDs. Till now 63,56,743 consultations have been effected on eSanjeevaniOPD. eSanjeevaniOPD is citizen-friendly safe medium to seek health services by citizens in the confines of their homes. In many states eSanjeevaniOPD services are available round the clock and even on holidays.

**6. Door to door vaccination and other measures relating to vaccination centers:** It is most respectfully submitted that

suggestions in this regard have already been implemented. It is humbly submitted that guidance has been provided to States/UTs to undertake meticulous, need-based micro-planning so that Near



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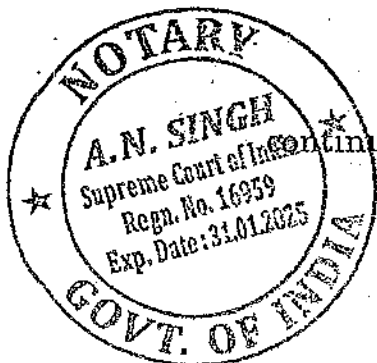
to Home Vaccination Centre (NHCVC) strategy is undertaken at block/urban area level and identification of NHCVC sites done as per Guidelines. The location of NHCVCs is to be done by district/urban task forces so as to ensure maximum reach of services to the eligible population.

Guidelines on NHCVC suggest utilizing of line lists already available with health or other departments (like department of Social Welfare) at state/district level. Provisions have already been made to consider scenarios where there is a group of target beneficiaries under one roof such as institutions serving differently abled people, old age homes etc; wherein the NHCVC can be organized at that site as per operational guidelines.

NHCVC Guidelines also details the steps that may be taken for making the vaccination centre friendly to the elderly and persons with special needs. The Guidelines further mention that vaccination team will facilitate on-site registration of the targeted beneficiaries in the Co-WIN portal, if they are not already registered.

States have been advised that while NHCVCs should

continue to be functional, at the same time, it must also be



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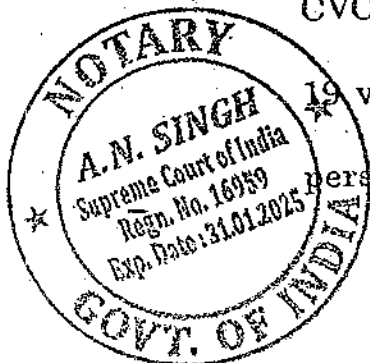
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ensured that other CVCs are also fully accessible to persons with disabilities as per the accessibility standards mandated under Rights of Persons with Disabilities Act 2016.

Ref: Annexure R/2 at pages 13-19 and Annexure R/4 at pages 22-23 of the Preliminary Affidavit dated 30.09.2021.

Keeping in view the need of all persons who might be bed ridden or have extremely restricted mobility or disability and/or special needs that may hamper their accessibility even to Near to Home Vaccination Centres (NHCVCs), Government of India in its letter dated 22.09.2021 has advised all States/UTs for preparing a line-list of all such potential beneficiaries and their care givers and subsequently vaccinate all such beneficiaries at their place of residence using mobile vaccination teams. Furthermore, on 03.11.2021, the Government of India launched the "Har Ghar dastak Abhiyan" campaign to ensure 100% coverage of eligible beneficiaries with first dose and vaccination of due beneficiaries with second dose of the COVID-19 vaccines. Due beneficiaries identified by the team are vaccinated on the spot or mobilized to CVC, if one is operational in close vicinity. This brings the Covid

19 vaccination to the door step of all due beneficiaries, including persons with disabilities. Spot registration of all beneficiaries and



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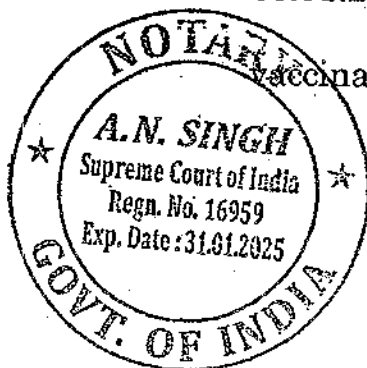
vaccination doses in Co-WIN in door-to-door campaigns and through mobile teams is facilitated by the vaccinators.


A true copy of letter dated 01.11.2021 for the Har Ghar Dastak Campaign is annexed herewith and marked as ANNEXURE- R/1.

**7. Vaccination access for persons with disabilities without ID**

**cards:** It is most respectfully submitted that suggestions in this regard have already been implemented. Provisions have been made for persons who do not have any of the prescribed ID cards for availing Covid-19 vaccinations by following Facilitated Cohort Registration process on Co-WIN. Co-WIN system provides the facility for creation of special vaccination sessions for this purpose and these sessions will have the features of registration of as many beneficiaries as are to be covered (subject to the limit of session capacity), without mandatory capturing of Mobile Number and Photo ID Card, through facilitated cohort registration and all vaccination slots in such special sessions will be reserved for vaccination of such facilitated cohorts. It may be noted that as on 06.01.2022, a total of 58,81,979 persons without any IDs have been

vaccinated under the National COVID-19 vaccination programme.



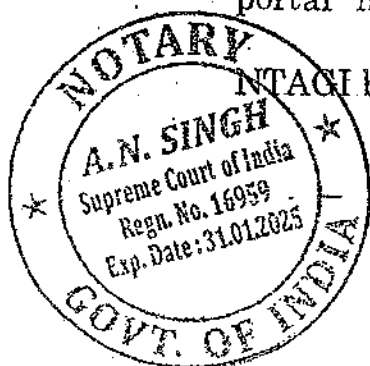
  
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Joint Commissioner (WOMEN)  
जलदायक एवं परिवार कल्याण विभाग  
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A true copy of the SOP for COVID-19 vaccination of persons without prescribed ID cards through Co-WIN is annexed herewith and marked as ANNEXURE - R2.

8. **Definition of disability:** It is most respectfully submitted that the scope of the National COVID-19 vaccination programme is to vaccinate all eligible population, including all persons with different types of disabilities. For the purposes of the COVID-19 vaccination programme, the definition of disability under the Rights of Persons with Disabilities Act, 2016 and the contours thereof are immaterial.

9. **Data collection of persons with disabilities:** It is most respectfully submitted that the scope of the National COVID-19 Vaccination Programme is to facilitate self-registration and vaccination of all eligible population in the shortest possible time, taking into consideration the needs of vulnerable sections of society. The framework for data collection/recording on Co-WIN portal is decided by technical groups such as NEGVAC and NTAGI based on scientific necessity.

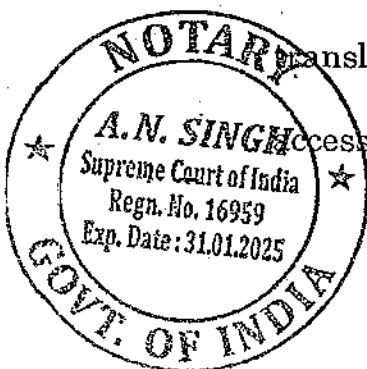


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**10. Nodal Officers:** As previously submitted in the Preliminary Affidavit dated 30.09.2021, this suggestion has already been implemented by the Government of India. It is most respectfully submitted that in its letter dated 11.06.2021, Government of India has advised that District level officer of Disability/Social Welfare department is to be considered as designated Nodal Officer for the purpose of dealing with redressal of grievances of differently abled persons in connection with COVID-19. She/he will work in close co-ordination with Chief Medical Officer of the district for the said purpose.

Ref: Annexure R/3 at pages 20-21 of Preliminary Affidavit dated 30.09.2021.

**11. Information related to COVID-19 vaccination be available in accessible/disabled-friendly formats and vernacular languages:** It is most respectfully submitted that the Co-WIN public interface is available in 11 regional languages in addition to English. It is also submitted that open files of awareness materials have been shared with the States for translation, publication and dissemination in any language / accessible format. It may be noted that any information pertaining

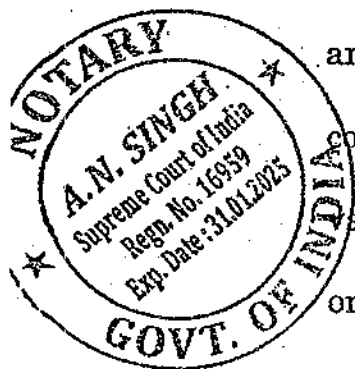


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to COVID-19 vaccination may also be sought from the multiple helplines mentioned earlier.

**12. Awareness campaigns:** It is most respectfully submitted that information on all aspects of COVID-19 vaccination programme is disseminated by Government of India and State/UTs through websites, print media, AV radio and television and also through other social media platforms. The Har Ghar Dastak Campaign in particular is a pan India campaign which will increase this reach even further. The Ministry has regularly promoted the National helpline number 1075 for all COVID-19 related queries.

**13. Consent of persons with disabilities:** It is humbly submitted that the directions and guidelines released by Government of India and Ministry of Health and Family Welfare, do not envisage any forcible vaccination without obtaining consent of the concerned individual. It is further humbly submitted that vaccination for COVID-19 is of larger public interest in view of the ongoing pandemic situation. It is duly advised, advertised and communicated through various print and social media platforms that all citizens should get vaccinated and systems and processes



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नई दिल्ली, New Delhi

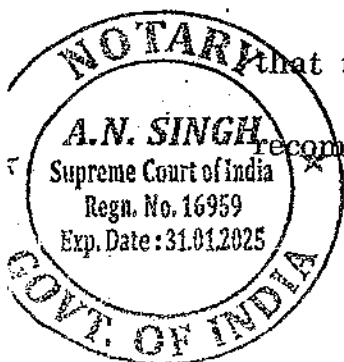
have been designed to facilitate the same. However, no person can be forced to be vaccinated against their wishes.

**14. Exemption from vaccination certificates for persons with disabilities:** It is most respectfully submitted that the Government of India has not issued any SOPs which make carrying of vaccination certificate mandatory for any purpose.

**15. Care providers as essential workers:** It is most respectfully submitted that the National COVID-19 vaccination program endeavours to vaccinate the entire eligible population in the least amount of time. As such, Government of India in its letter dated 22.09.2021 has advised all States/UTs to vaccinate bed ridden or beneficiaries with extremely restricted mobility or disability and/or special needs along with their care givers at their place of residence using mobile vaccination teams.

Ref: Annexure R/4 at page 22 of Preliminary Affidavit dated 30.09.2021.

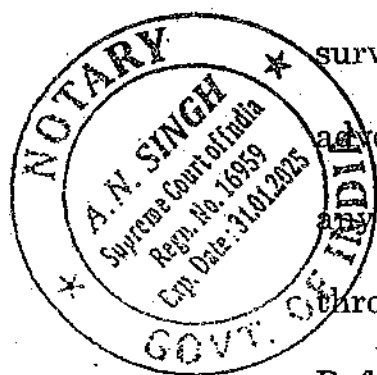
**16. Exemption from masks/face-cover:** It is humbly submitted that the practice of using masks/face cover is in line with the recommendation of the W.H.O (World Health Organization) and



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Ministry of Health & F.W.

other prominent public health agencies globally and is being advocated and followed universally as one of the most important methods to prevent the spread of COVID-19 infection. Asymptomatic or pre-asymptomatic infected person who may feel well and are unaware of their infectiousness to others are also likely to transmit infections to others. Similarly, persons with disabilities are just as likely to get infected with COVID-19 and transmit the same around them as any other person. In view of the same, in larger public interest, it is advisable that use of mask/face covers be universally followed.

**17. Post vaccination monitoring:** It is respectfully submitted that the Adverse Event Following Immunization (AEFIs) are monitored through a well-structured & robust AEFI surveillance system which has stood the test of time. As per the AEFI



surveillance guidelines for COVID-19 vaccine, any suspected adverse events, following COVID-19 vaccine may be reported by any vaccine-recipient or his/her caregiver on COWIN portal through the vaccinator or the District Immunization Officer (DIO)

Ref: Covid-19 Vaccine Operational Guidelines available at MoHFW website at:

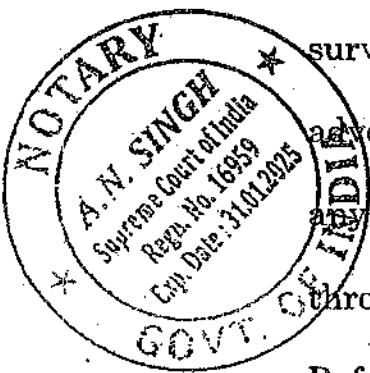
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नई दिल्ली, Govt. of India  
New Delhi

<https://www.mohfw.gov.in/pdf/COVID19VaccineOG111Chapter16.pdf>.

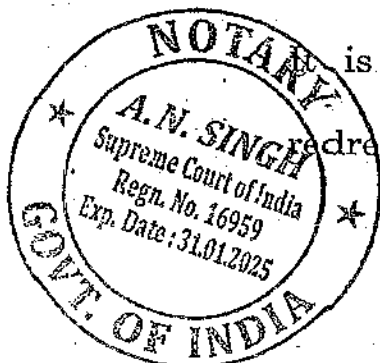
18. Co-WIN app and portal to be fully accessible: It is most respectfully submitted that Government of India is already implementing features in Co-WIN portal to make it more accessible to persons with disabilities as mentioned in the Preliminary Affidavit dated 30.09.2021.

19. Counselling before vaccination: It is humbly submitted that Government of India has formulated Operational Guidelines for COVID-19 vaccination. As per these Guidelines, all beneficiaries are to be informed about adverse events which may occur after COVID-19 vaccine.

Ref: Covid-19 Vaccine Operational Guidelines available at MoHFW website at:  
<https://www.mohfw.gov.in/pdf/COVID19VaccineOG111Chapter16.pdf>.

20. Accountable assessment/feedback of vaccination process:

It is humbly submitted that there already exists a grievance redressal mechanism wherein all grievances received, including



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those received from persons with disabilities, are redressed in a timely manner. In addition, as mentioned earlier, nodal officers in each State have been advised to look into grievance redressal for persons with disabilities in particular.

21. The present affidavit is filed bona fide and in the interest of justice. The present affidavit is filed to apprise this Hon'ble Court on the steps taken by the Union of India in regard to issues highlighted by the Petitioner and the same may be read in conjunction with the earlier Preliminary Affidavit dated 30.09.2021 for receiving an exhaustive view on the matter.

I identify the deponent who has signed/put T.I. in my presence. MAH/433/2016

ATTESTED  
A.M. SINGH, Notary Public  
Govt. of India, Delhi  
Mob.: 9718139501, 7902529115

DEPONENT  
(Dr. Veena Chawan)  
संयुक्त आयुर्वेद (अन्य)  
Joint Commissioner (Imm.)  
स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
Ministry of Health & F.W.  
भारत सरकार / Govt. of India  
नई दिल्ली / New Delhi

**VERIFICATION**

I, the deponent above named, do hereby verify that the contents of Para 1 to 20 of my above affidavit are prepared on the basis of instructions received by me and on the basis of legal advice received and no part of it is false and nothing material has been concealed therefrom to the best of my knowledge.



\*Verified at New Delhi on this 13 JAN 2022

Certified that the above Named Deponent identify by Shri/Smt. ...  
Solemnly affirmed before me at Delhi  
S. No. 33611  
The contents of the affidavit which have been read & explained to me are true and correct  
Notary

DEPONENT  
(Dr. Veena Chawan)  
संयुक्त आयुर्वेद (अन्य)  
Joint Commissioner (Imm.)  
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नई दिल्ली / New Delhi





राजेश भूषण, आईएएस  
सचिव

**RAJESH BHUSHAN, IAS**  
SECRETARY

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सत्यमेव जयते

~~Annexure R/L~~

17

भारत सरकार  
स्वास्थ्य एवं परिवार कल्याण विभाग  
स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
Government of India  
Department of Health and Family Welfare  
Ministry of Health and Family Welfare

D.O No. 2088847/2021/Imm

1<sup>st</sup> November 2021

*Dear Colleague,*

Let me take this opportunity to appreciate the efforts of the States/UTs in achieving the milestone of administering 100 crore COVID-19 vaccine doses across our vast country, which is a significant feat in the fight against COVID-19 pandemic.

2. To sustain this momentum, the Hon'ble Union Minister of Health & Family Welfare had urged all States/UTs on 27<sup>th</sup> October 2021 during the meeting with Hon'ble Health Ministers of States/UTs at Delhi, to initiate 'Har Ghar Dastak Campaign' from 3<sup>rd</sup> to 30<sup>th</sup> November, 2021 to accelerate the coverage of 1<sup>st</sup> and 2<sup>nd</sup> dose. All States/UTs were primed towards a house-to-house campaign approach vide letter of even no. dated 9<sup>th</sup> October 2021.

3. The healthcare workers are to reach out, counsel, mobilise and vaccinate all missed-out and dropped-out eligible beneficiaries to complete the vaccination schedule for adequate protection. The details for door to door vaccination has already been shared vide letter no. 2319278/2021/Imm dated 22<sup>nd</sup> September, 2021.

4. For this activity, a comprehensive plan at district level should be prepared to approach the missed out and left out beneficiaries of Covid-19 vaccination & ensure they are vaccinated with the vaccine dose as due. Such district level plan has to be formulated by the District Magistrates and District Immunization Officers and then implementation has to be reviewed on a daily basis not only by the DMs but also by the State Health Department.

5. The due list for the 2<sup>nd</sup> dose can be extracted from CoWIN and can be used to reach house-to-house to identify and mobilize dropped out beneficiaries. A micro plan may be prepared and human resource from the partner agencies could be deployed to specific districts to provide support in such planning. All Panchayati Raj functionaries, NGOs may be involved for mobilization.

6. I am looking forward to your effective leadership in this massive public campaign-- "Har Ghar Dastak".

*Warm Regards*

Yours sincerely,

*True  
Copy*

*[Signature]*


(Rajesh Bhushan)

To: Additional Chief Secretary/Principal Secretary/Secretary (Health), All States/UTs

SOPs on  
COVID-19 Vaccination of Persons without prescribed Identity Cards  
through CoWIN

77-

1. India's National Covid-19 Vaccination Strategy is based on scientific and epidemiological evidence and focuses on systematic end-to-end planning. Phase-I of the National Covid-19 Vaccination Strategy was launched on 16th January 2021 and focussed on protecting Health Care Workers (HCWs) and Front Line Workers (FLWs). Phase-II was initiated from 1st March 2021 and 1st April 2021 and focussed on protecting the most vulnerable i.e. population more than 45 years of age. Liberalised Pricing and Accelerated National Covid-19 Vaccination Strategy came in effect from 1st May 2021 under which COVID-19 Vaccination was opened for persons 18-44 years of age groups.
2. In all these phases, it has been prescribed that the beneficiary must either self-register or be registered in Co-WIN portal and that the identity and eligibility of the beneficiary be verified by vaccinator through one of the following seven prescribed individual Photo ID Proof prior to vaccination, namely -
  - i. Aadhar Card
  - ii. Electoral Photo Identity Card (EPIC) - Voter ID
  - iii. Passport
  - iv. Driving License
  - v. PAN Card
  - vi. NPR Smart Card
  - vii. Pension Document with photograph.
3. Ministry is cognizant of the need for facilitating COVID-19 vaccination for all people, and especially the vulnerable groups who may not possess any of the seven prescribed Identity Cards. The Ministry has also received several representations from various state governments and agencies/organizations regarding COVID-19 Vaccination of such people who do not have any of the seven prescribed Identity Cards, required for verification before vaccination.
4. In this context, there is need to provide special consideration to vulnerable population of the country, as these beneficiaries are also at risk of exposure to COVID-19 infection and the consequent sequelae and outcomes of the disease, during the pandemic. Further they may not have any official Photo ID card like other citizens, but COVID-19 Vaccination services may not be denied in absence of Identity Proofs.
5. In view of the above, following procedure, developed in consultation with the technical experts, is hereby prescribed for providing vaccination coverage to people who do not possess any of the seven Identity Cards prescribed for availing COVID vaccination services-
  - i. Such groups of people include nomads (including sadhu/saints from various religions), prison inmates, inmates in Mental Health Institutions, citizens in Old Age Homes, road side beggars, people residing in rehabilitation

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centres/camps and any other identified eligible persons, aged 18 years or more, and not having any of the seven prescribed individual Photo ID Cards.

- ii. District Task Force may identify such groups of persons in respective districts not having any of the prescribed individual Photo ID Cards with assistance from concerned government department/ organisation like department of minority affairs, social justice, social welfare etc.
- iii. The information regarding the identified groups and the number of beneficiaries to be covered, must be collated at the state level and the state government must issue clear instructions for implementation of these SOPs along with the district-wise estimated maximum number of doses to be administered using this special dispensation. A copy of such instructions must be displayed in public domain and should also be endorsed to the Ministry.
- iv. A Key Facilitator may also be identified for each such group. The Key Facilitator must have a valid and active mobile phone and must also have at least one of the seven mandated ID cards. These could be officials of the institutions (both public or private) which normally provide care and services to people in the identified groups, e.g. Prison officials for prison inmates, Executive Officer/Superintendent of and Old Age Home etc.
- v. A district nodal officer may be designated by the DTF, for identification of Key Facilitators, preparation of vaccination plan, identification of CVCs where vaccination sessions are to be organised, preparation of vaccination schedule, communication of vaccination schedule to the identified groups/beneficiaries and mobilization of beneficiaries as per vaccination plan.
- vi. District Immunization Officer (DIO) will be responsible for organization of vaccination sessions at identified CVCs for providing coverage to the identified groups.
- vii. The CoWIN system will provide the facility for creation of special vaccination sessions for this purpose. The session will have following features -
  - i. Registration of as many beneficiaries as are to be covered (subject to the limit of session capacity), without mandatory capturing of Mobile Number and Photo ID Card, through facilitated cohort registration.
  - ii. All vaccination slots in such special sessions will be reserved for vaccination of such facilitated cohorts.
  - iii. This facility will only be available at government CVCs.
  - iv. Information such as name, year of birth (as provided by the beneficiary) and gender will be entered in the CoWIN system for the beneficiaries.
  - v. The Key Facilitator shall verify the identity of the beneficiaries.
  - vi. Digital vaccination certificates are to be provided to the beneficiaries, preferably at the Vaccination Center itself.
- viii. The District Nodal Officer will be personally responsible to ensure that the special dispensation provided through these instructions, is extended only to

cover such persons who do not have any of the seven mandated Photo ID Cards.

- ix. Vaccine doses made available through the Government of India channel may be used for vaccination of beneficiaries aged 45 years or more and the vaccine doses procured by the State/UT Government may be used for those aged 18 years to 44 years.
- x. All technical protocols as prescribed in the Guidelines of the Ministry regarding vaccination centres and AEFI management etc., must be followed.

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Has no Aachhar / Nos. ... of pages nos. NO

Full Sign. with date: Sayan Pal  
(Full Name: ...) 11.2.22

Advocate / Clerk ✓

DISTRICT: NORTH 24 PARGANAS  
IN THE HIGH COURT AT CALCUTTA  
CONSTITUTIONAL WRIT JURISDICTION  
(APPELLATE SIDE)

W.P.A. (P) NO. 65 OF 2022

In the matter of :

An application under Article 226 of the  
Constitution of India;

AND

In the matter of

SRI JAGADISH CHANDA

... Petitioner

-Versus-

THE STATE OF WEST BENGAL & ORS.

... Respondents

WRIT PETITION

Advocate on record

YASHRAJ ROY

Advocate

GD-10, Sector-III, Salt Lake

P.S. Bidhannagar South

Kolkata - 700106

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