SECTION - PIL(W)

IN THE SUPREME COURT OF INDIA

CIVIL ORIGINAL JURISDICTION

I.A. NO. _____ OF 2021

IN

SUO MOTU WRIT PETITION (C) NO.3 OF 2021

IN THE MATTER OF:

IN RE: DISTRIBUTION OF ESSENTIAL SUPPLIES AND SERVICES DURING PANDEMIC

IN THE MATTER OF:

KARNATAKA RAJYA VIKALACHETHANARA
RAKSHANA SAMITHI
#3/6, MODULIAR COMPOUND, 2ND MAIN ROAD,
CHAMARAJPET, BANGALORE-560018 ...INTERVENOR/APPLICANT

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FILED BY:

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ADVOCATE FOR THE INTERVENOR/APPLICANT
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NEW DELHI-110001
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Clerk: I.C. No.6418
DURGESWARKALITA

FILED ON: 02.06.2021

IN THE SUPREME COURT OF INDIA

CIVIL ORIGINAL JURISDICTION

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W I T H

I. A. NO _____ OF 2021

[APPLICATION FOR INTERVENTION ON BEHALF OF KARNATAKA RAJYA VIKALACHETHANARA RAKSHANA SAMITHI]

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W I T H

I. A. NO _____ OF 2021

[APPLICATION ON BEHALF OF APPLICANT SEEKING EXEMPTION FROM FILING DULY ATTESTED AFFIDAVIT]

P A P E R B O O K
(FOR INDEX KINDLY SEE INSIDE)

ADVOCATE FOR THE INTERVENOR/APPLICANT: KUMAR DUSHYANT SINGH

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IN THE SUPREME COURT OF INDIA

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IN THE MATTER OF:

KARNATAKA RAJYA VIKALACHETHANARA
RAKSHANA SAMITHI
#3/6, MODULIAR COMPOUND, 2ND MAIN ROAD,
CHAMARAJPET, BANGALORE-560018 ...INTERVENOR/APPLICANT

APPLICATION FOR INTERVENTION ON BEHALF OF KARNATAKA RAJYA VIKALACHETHANARA RAKSHANA SAMITHI

TO,

THE HON'BLE CHIEF JUSTICE
AND HIS COMPANION JUDGES OF
THE HON'BLE SUPREME COURT OF INDIA

THIS HUMBLE APPLICATION ON BEHALF OF APPLICANTS / INTERVENORS

MOST RESPECTFULLY SHOWETH:

1. That the Intervenor in the instant case seeks to intervene in order to bring to the notice of this Hon'ble Court the issues of persons with disabilities in procuring vaccines, which have not been taken into account by the central government.

2. That the Applicant Intervenor, is a registered trust, registered under the Karnataka Cooperative Societies Registration Act, 1960, working under its President Mr. Chandrashekar Puttappa. It bears Registration Number DRB-C/SOR/73/2011-12 and has its offices at 3/6, Modaliar Compound, Second Main Road, Chamarajapet Bangalore – 560 019.The trust is actively engaged in working for the rights of persons with disabilities. It has filed several PILs regarding implementation and enforcement of the Rights of Persons with Disabilities Act, 2016 in the High Court of Karnataka. True Copy of Registration Certificate dated 15.07.2011 of the Applicant is annexed herewith as **ANNEXURE-A-1** (Pg-6)

3. That the Applicant is filing an accompanying application for directions and seeks to rely upon the contents of the same at the time of arguments.

4. It is submitted that persons with disabilities are at greater risk of contracting COVID and having fatal consequences as a result. Therefore, it is imperative that allowances and priorities in vaccination be provided to them as well as their caregivers.

5. That the system of registering for vaccinations on CoWin is also not accessible to all persons with disabilities. Captcha requirements pose a challenge for those with visual impairment and cognitive impairment. Many cannot travel to vaccination centres due to their disability.

6. That the Applicant will be greatly prejudiced if the Main petition regarding essential supplies and services during the pandemic was heard without these issues being taken into account. Therefore the Applicant seeks the liberty from this Hon'ble Court to intervene in the Present petition.

7. The Applicant submits that in the interest of justice and equity that the present application be allowed. The Applicant further submits that grave harm and prejudice would be caused if the application is not allowed, whereas no harm or prejudice would be caused if the application were allowed.

PRAYER

In these circumstances, the Applicant prays that this Hon'ble Court may be pleased to:

(A) Allow the present application and permit the Applicant to intervene in the present Suo Motu petition bearing WP (C) No. 3 of 2021; and

(B) Pass such other orders as this Hon'ble Court may deem fit and just.

AND FOR THIS ACT OF KINDNESS THE APPLICANT AS IN DUTY BOUND SHALL EVER PRAY.

DRAWAN BY: FILED BY:

[ROHIT SHARMA] & [SHEERENE MOHAMED] [KUMAR DUSHYANT SINGH]
ADVOCATES ADVOCATE FOR THE INTERVENOR/ APPLICANT

NEW DELHI
FILED ON: 02.06.2021

IN THE SUPREME COURT OF INDIA
CIVIL ORIGINAL JURISDICTION
I.A. No. _____ OF 2021
IN
SUO MOTU WRIT PETITION (C) No. 3 OF 2021

IN THE MATTER OF:

IN RE : DISTRIBUTION OF ESSENTIAL SUPPLIES AND SERVICES DURING PANDEMIC

IN THE MATTER OF:

KARNATAKA RAJYA VIKALACHETHANARA
RAKSHANA SAMITHI
REGD OFFICE AT: 3/6 1ST FLOOR, MADALIYAR COMPOUND,
IIND MAIN, AZAD NAGAR BANGALORE-560018
THROUGH ITS PRESIDENT
SRI. CHANDRASHEKHAR PUTTAPPA ...INTERVENOR/APPLICANT

AFFIDAVIT

I, CHANDRASHEKHAR PUTTAPPA, PRESIDENT, KARNATAKA RAJYA VIKALACHETHANARA RAKSHANA SAMITHI, REGD OFFICE AT: 3/6 1ST FLOOR, MADALIYAR COMPOUND, IIND MAIN, AZAD NAGAR BANGALORE-560018, DO HEREBY SOLEMNLY AFFIRM AND STATE AS UNDER:-

1. That I am the President of the Applicant/Intervenor and am duly authorized to swear and affirm this affidavit on behalf of the applicant/Intervenor.
2. That the contents of accompanying applications(s) are true and correct to my knowledge and belief and nothing material has been concealed therein.
3. That the annexures annexed herewith are true copies of their respective originals.

KARAAVIRS (R)
3/6, Moduliar Compound,
2nd Main Road, Chamarajpet,
Bangalore - 560 018.

For KARAAVIRS (R)
Working President
DEPONENT

VERIFICATION:

Verified at Bangalore on the 26th day of May, 2021, that the contents of above affidavit are true and correct to my knowledge and belief and nothing material has been concealed therefrom.

For KARAAVIRS (R)
DEPONENT
Working President

KARAAVIRS (R)
3/6, Moduliar Compound,
2nd Main Road, Chamarajpet,
Bangalore - 560 018.

6

ANNEXURE-A-1

GOVERNMENT OF KARNATAKA
[emblem of Government of Karnataka]
Department of Cooperation

[Seal of 'Office of District Registrar of Societies
Societies, Central Circle
Bengaluru Urban District, Bengaluru.]

Cooperative

Office of the District Registrar of

Bangalore Urban District, Central Circle
No. 146, 3rd main road, 8th cross
Magrath Road, Malleswaram

Societites Building
Malleswaram, Bengaluru-560 003.

Date: 15.07.2011

CERTIFICATE OF REGISTRATION

Registration No. DRB-C/SOR/73/2011-12.

In accordance with 'Karnataka Societies Registration Act 1960 (1960 year's 17th Order number of Karnataka's Act) upon which the below named

---

Karnataka State Disabled Persons Protection Association
(Karnataka Rajya Vikalachetanara Rakshana Samiti)
No. 3/6, Mudhaliar Compound
9th Cross, 2nd Main Road
Chamarajapete
Bengaluru-560 018.

this Association has been registered of which I certify so.

Registration fee of Rupees (in figures) Rs. 1,000.00 (in words rupees one thousand only) has been collected.

On the two thousand and eleven year's July month's fifteenth day under my seal and signature this certificate has been issued.

Sd/-

Office of the Registrar of Societies
Bengaluru Urban District, Central Circle, Bengaluru
Bengaluru.

TRUE COPY

7

IN THE SUPREME COURT OF INDIA

CIVIL ORIGINAL JURISDICTION

I.A. NO. _____ OF 2021

IN

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IN THE MATTER OF:

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IN THE MATTER OF:

KARNATAKA RAJYA VIKALACHETHANARA
RAKSHANA SAMITHI ...APPLICANT

APPLICATION FOR DIRECTIONS ON BEHALF OF KARNATAKA RAJYA VIKALACHETHANARA RAKSHANA SAMITHI

TO,

THE HON'BLE CHIEF JUSTICE
AND HIS COMPANION JUDGES OF
THE HON'BLE SUPREME COURT OF INDIA

THIS HUMBLE APPLICATION ON BEHALF OF APPLICANTS / INTERVENORS

MOST RESPECTFULLY SHOWETH:

1. That the Applicant is filing the present Application seeking directions from this Hon'ble Court on the rights of persons with disabilities in access to vaccination which are not taken into account by the central government in the current pandemic, and pray that the same may be considered.

2. In this regard, the Applicants seeks to submit as follows:

I. Persons with Disabilities are at higher risk of contracting COVID-19

3. It is respectfully submitted that the COVID-19 pandemic has had a disproportionately severe impact on persons living with disabilities. These persons are at a much higher risk of contracting the virus, and are further disadvantaged in recovering from the effects of infection. Since persons with disabilities often rely on a caregiver to help them with their daily needs, such as eating, bathing or dressing themselves, it is extremely difficult for them to cope with social distancing guidelines, mask-wearing, etc. Similarly, people with visual disabilities rely on "touch functions for mobility and work", thereby increasing their risk of infection.

4. In fact, the World Health Organization (WHO) has expressly recognized the greater risk for persons with disabilities in contracting the Corona virus and the difficulties in accessing health related information and communications from Governmental authorities. In its Report titled, "Disability Concerns during the Covid-19 Outbreak", the WHO has recommended actions for Governments so as to protect persons with disabilities from the corona virus. Some of these include:

- Ensuring access to public health information and communication.
- Undertaking targeted measures for people with disability and their support networks.
- Identifying persons with disabilities in jails, prisons, correctional facilities, etc. and putting in place contingency plans for their protection from the virus.

True Copy of the World Health Organisation Report, "Disability Concerns during the Covid-19 Outbreak" is annexed herewith and marked as **ANNEXURE-A-1**.(Page No. 19-32).

II. Persons with Disabilities and their caregivers to be prioritised for Vaccination along with persons aged 45 years and above

5. It is respectfully submitted that due to the above factors, it is imperative that persons with disabilities and their caregivers are recognised as priority groups for vaccination. They need to be given priority in the vaccination drive, as they are very much in the high risk category along with the elderly and those with co-morbidities.

6. According to Section 25(1)(a) of the Rights of Persons with Disabilities Act, 2016, the appropriate Government is required to provide health-care near and in the vicinity of persons with disabilities. Further, Section 25 (1) (c) of the Act mandates that persons with disabilities

should be given priority and preference in attendance and treatment.

Section 25 of the RPWD Act is quoted as under:

"25. Healthcare.—(1) The appropriate Government and the local authorities shall take necessary measures for the persons with disabilities to provide,—

(a) free healthcare in the vicinity especially in rural areas subject to such family income as may be notified;

(b) *barrier-free access in all parts of Government and private hospitals and other healthcare institutions and centres;*

(c) *priority in attendance and treatment."*

7. It is thus respectfully submitted that it is the statutory duty of the Government to ensure that COVID-19 vaccinations are accessible, free and administered with priority to persons with disabilities.

8. The United Kingdom has recognised the need for priority vaccination among persons with disabilities. In deciding who should receive the vaccines first, the United Kingdom's Joint Committee on Vaccination and Immunisation (JCVI; a group made up of independent experts who advise the Government on COVID-19 vaccines) identified priority groups. They are:

1. Residents in a care home for older adults and staff working in care homes for older adults.

2. All those 80 years of age and over and frontline health and social care workers.

3. All those 75 years of age and over.

4. All those 70 years of age and over and clinically extremely vulnerable individuals (not including pregnant women and those under 16 years of age)

5. All those 65 years of age and over.
6. Adults aged 16 to 65 years in an at-risk group.
7. All those 60 years of age and over.
8. All those 55 years of age and over.
9. All those 50 years of age and over.

Disabled people in the first four priority groups, which includes those who are clinically extremely vulnerable, will be included in this first wave of vaccinations. The Joint Committee held that people with certain underlying health conditions such as people with certain disabilities increase the risk of morbidity and mortality from COVID-19 and hence they were included in the first 4 priorities. The NHS listed the clinically vulnerable groups to include persons with the following disabilities: epilepsy, motor neurone disease, multiple sclerosis, Huntington's disease, Parkinson's disease, dementia, cerebral palsy. Learning disability, Down's Syndrome and Severe mental illness. The UK government's vaccine advisory committee has also said that all people who are present on the learning disability register and those with cerebral palsy should also be invited for vaccination on priority. True Copy of the JCVI Advice on Priority Groups for COVID-19 vaccination dated 30.12.2020 is annexed herewith and marked as **ANNEXURE-A-2**.(Page No. 33 - 45).

True Copy of the webpage from the NHS titled "COVID-19 Population Risk Assessment" is annexed herewith and marked as **ANNEXURE-A-3.** (Page No. 46 - 52).

True Copy of the article titled "Covid-19: All adults on learning disability register should be prioritised for vaccination, says advisory committee" in the British Medical Journal is annexed herewith and marked as **ANNEXURE-A-4.** (Page No. 53).

9. Similarly, the Center for Disease Control and Prevention ("CDC") in the United States has also advised states administering the vaccine to give importance to those persons with disabilities and high risk individuals, regardless of age with their new vaccine rollout. While broadening access to these vaccines, the CDC stated that people with disabilities or cognitive decline especially need to be vaccinated. True Copy of the CDC vaccine recommendations is annexed herewith and marked as **ANNEXURE-A-5**.(Page No. 54 - 56).

10. Lastly, it is submitted that the WHO has identified persons with disabilities as persons who are in need of priority vaccines. The WHO has advised governments to "Consider persons with disabilities according to WHO guidance when prioritizing sociodemographic groups for initial phases of immunization" especially in the context of limited supply. True Copy of the WHO and UNICEF Policy Brief,

"Disability Considerations during the Covid-19 Vaccinations" dated 19.04.2021is annexed herewith as **ANNEXURE-A-6.** (Page No. 57 - 73).

11. However, the Union of India has at present made no mention of persons with disabilities in its vaccine plans and strategy. Priority is presently being accorded only to persons above 45 years of age, and persons engaged in providing services related to amelioration of the effects of the pandemic, etc. However, persons with disabilities and their care-givers have not received any preferential treatment despite a clear statutory mandate to that effect.

III. **Accessibility of Vaccination registration, non-requirement of registration for persons with disabilities for vaccinations and Barrier Free vaccination sites including door to door vaccination:**

12. It is submitted that presently, the system of registering for vaccinations which has to be done online on the CoWin platform, is not accessible to all persons with disabilities. It is not in an accessible format. The CoWin platform has captcha requirements and other measures that are not at all accessible for persons with visual impairment. Section 42 of the RPWD Act mandates that all information by the government shall be in accessible formats. Section 42 states as follows:

42. Access to information and communication technology.—The appropriate Government shall take measures to ensure that,— (i) all contents available in audio, print and electronic media are in accessible format; (ii) persons with disabilities have access to electronic media by providing audio description, sign language interpretation and close captioning; (iii) electronic goods and equipment which are meant for every day use are available in universal design.

Further, Rule 17 of the Rights of Persons with Disabilities Rules 2017 state that all websites should follow w3c standards for accessibility, and state as follows:

17. Rules for Accessibility.- Every establishment shall comply with the following standards - physical environment, transport and information and communication technology, namely:-
c. (i) website - w3c standards guidelines of the Government of India, Ministry of Electronics and Information Technology;

13. Due to these technical barriers in access to even register, many older adults with disabilities, who would be at the highest risk and should be at highest priority for inoculation have been unable to register for vaccinations because of lack of access and also lack of Internet access. Thus many persons with different types of disabilities, are not able to even register themselves to get vaccinated. If all vaccinations are conditional on registration, then there would be thousands of persons with disabilities all over the country who would be at a higher risk of getting infected and will slip through the vaccination programme and not be vaccinated.

14. Further, many disabled persons cannot travel to vaccination sites due to their disability. Many persons are severely disabled and are not mobile enough to travel to vaccination centres. Hence, it is crucial that persons with disabilities should be vaccinated at home through mobile health teams of the government and this can be done in collaboration with non-governmental organizations across the state.

15. The WHO and UNICEF Policy Brief states that it is imperative that vaccination steps are made accessible for persons with disabilities and mandate the following measures to be taken:

(i) ***Make vaccination registration processes and forms screen-reader accessible; and provide options for telephone registration, video-relay, national sign language interpretation, and COVID-safe in-person registration.***

(ii) ***Conduct an accessibility audit of vaccination sites, involving organizations of persons with disabilities, to identify barriers and appropriate strategies, including transportation access and availability***

(iii) ***Ensure that local sign language interpretation services are made available at vaccination sites, and that information is available in a range of formats to ensure that there is accessible information and communication about vaccination against COVID-19.***

(iv) ***Provide safe and accessible transportation to persons with disabilities and their support people to vaccination sites, noting that some may require modified transportation, extra travel time or financial support.***

(v) ***Ensure that vaccination sites are accessible to wheelchair users, with appropriate ramps, rails, and space for them to move independently, and wheelchair accessible water and sanitation facilities. Tactile markers on floors and walls may***

also assist people with vision impairments to move around health facilities.

(vi) ***Ensure that there is enough space for persons with disabilities to attend with support people and assistants***

(vii) ***Provide home visit or mobile clinic options for individuals who cannot safely travel to the vaccination site.***

16. None of the above measures have been taken by the Union of India in its vaccination policies, nor have such instructions been given to State governments. All these measures are requirements of reasonable accommodation to be taken for persons with disabilities to ensure that vaccination registration, information about vaccination and the actual vaccination is accessible and barrier free for persons with disabilities. Due to the complete lack of these measures, persons with disabilities have been completely denied equal access to health care and the right to life in this pandemic.

17. It is submitted that it is a guarantee of Article 21 and Article 14 that disabled persons are able to live a healthy life, and have reasonable accommodations for their disability equally as all other persons. Further, the Right to Persons with Disabilities Act, 2016 casts an affirmative obligation on the government to ensure that persons with disabilities enjoy the right to equality; a life with dignity; and respect for their integrity equally with others. This Hon'ble Court held in ***Vikash Kumar v. UPSC & Others, 2021 SCCOnline SC 84*** that the need for

reasonable accommodation for persons with disabilities is long held and intrinsic to the right to equality. The principle of reasonable accommodation acknowledges that if disability as a social construct has to be remedied, conditions have to be affirmatively created for facilitating the rights of persons with disabilities.

18. The Applicant humbly submits that it would be in the interests of justice and equity that the present Application be allowed. The Applicant further submits that grave harm and prejudice would be caused to the Applicant if the present application is not allowed, whereas no harm or prejudice would be caused if the present Application is allowed.

19. That the present application is bonafide and filed in the interest of justice.

PRAYER

Wherefore in light of the above facts and circumstances, it is respectfully prayed that this Hon'ble Court may be pleased to:

A. Direct the Union of India to include persons with disabilities in the list of priority for vaccination along with the population of 45 years and above; AND

B. Direct the Union of India to make the CoWin application for online registration be made fully accessible as per the accessibility guidelines as required under the RPWD Act and Rules; AND

C. Pass directions that persons with disabilities who are not able to register on the CoWin application have other means of registering such as phone registrations and in-person walk-in registrations for vaccination; AND

D. Direct that all vaccination sites are made accessible and barrier free; AND

E. Direct the Union of India and other Respondents that for those who are severely disabled and cannot reach vaccination sites, there should be at home vaccinations for COVID-19 provided to them and their carers; AND

F. Direction the Union of India to take steps such that all information about vaccination should be made available in accessible formats and sign language across all media; AND

G. Pass any such further orders that this Hon'ble Court may deem fit in the interest of justice and equity.

AND FOR THIS ACT OF KINDNESS THE APPLICANT AS IN DUTY BOUND SHALL EVER PRAY.

DRAWAN BY:

[ROHIT SHARMA] & [SHEERENE MOHAMED]
ADVOCATES

FILED BY:

[KUMAR DUSHYANT SINGH]
ADVOCATE FOR THE APPLICANT

NEW DELHI
FILED ON: 02.06.2021

19
ANNEXURE-A-1

World Health Organization

Disability considerations during the COVID-19 outbreak

COVID-19
www.who.int/emergencies/diseases/novel-coronavirus-2019

NCDs and mental health
www.who.int/ncds
www.who.int/mental_health

Disability
www.who.int/health-topics/disability

On 30 January 2020, the World Health Organization (WHO) declared the outbreak of a novel coronavirus disease, COVID-19, to be a Public Health Emergency of International Concern (PHEIC), due to the speed and scale of transmission.

WHO and public health authorities around the world are taking action to contain the COVID-19 outbreak.[1] Certain populations, such as those with disability, may be impacted more significantly by COVID-19. This impact can be mitigated if appropriate actions and protective measures are taken by key stakeholders.

1 https://www.who.int/publications-detail/critical-preparedness-readiness-and-response-actions-for-covid-19

Why are additional considerations needed for people with disability during the COVID-19 outbreak?

Actions need to be taken to ensure that people with disability can always access the health-care services, water and sanitation services and public health information they require, including during the COVID-19 outbreak.

People with disability may be at greater risk of contracting COVID-19 because of:

- Barriers to implementing basic hygiene measures, such as hand-washing (e.g. handbasins, sinks or water pumps may be physically inaccessible, or a person may have physical difficulty rubbing their hands together thoroughly);
- Difficulty in enacting social distancing because of additional support needs or because they are institutionalized;
- The need to touch things to obtain information from the environment or for physical support;
- Barriers to accessing public health information.

People with disability may be at greater risk of developing severe disease if they become infected because of:

- The pre-existing health condition underlying the disability; and
- Barriers to accessing health care.

People with disability may also be disproportionately impacted by the outbreak because of serious disruptions to the services they rely on.

The barriers experienced by people with disability can be reduced if key stakeholders take appropriate action.

COVID-19

Considerations for actors

Actions for people with disability and their household

Reduce your potential exposure to COVID-19

Everyone with disability and their household should follow the WHO guidance on basic protection measures during the COVID-19 outbreak, such as hand hygiene, respiratory etiquette and physical distancing.[2] If you have any difficulty following these basic protection measures (for example, you are not able to access a handbasin/sink/water pump to wash your hands regularly), work with your family, friends and caregivers to identify adaptations. In addition

- Practice physical distancing of at least one meter from others.
- Avoid crowded environments to the maximum extent possible and minimize physical contact with other people. Consider making necessary visits to the supermarket or pharmacy, outside of peak time periods. Take advantage of special opening hours of stores for people with disability where these are offered.
- Make purchases online or over the telephone or request assistance from family, friends, or caregivers to avoid needing to access crowded environments.
- Consider buying in bulk items you need such as food, cleaning supplies, medication or medical supplies to reduce the frequency with which you need to access public places.
- Work from home if possible, especially if you typically work in a busy or crowded environment.
- Ensure that assistive products, if used, are disinfected frequently; these include wheelchairs, walking canes, walkers, transfer boards, white canes, or any other product that is frequently handled and used in public spaces.

Put a plan in place to ensure continuation of the care and support you need

- If you rely on caregivers, consider increasing the pool of those you can call upon, in preparation of one or more becoming unwell or needing to self-isolate.

2 https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public

- If you organize caregivers through an agency, find out what contingency measures they have in place to compensate for a potential workforce shortage. You may want to talk to family and friends about what additional support they can provide, and the scenarios in which you may need to call upon them.
- Identify relevant organizations in your community that you can access if you need help.

Prepare your household for the instance you should contract COVID-19

- Make sure those in your household, including the friends and family you trust, know of any important information they would need should you become unwell.[3] This may include information about your health insurance, your medication, and the care needs of any of your dependants (children, elderly parents or pets).
- Follow local advice regarding calling health care professionals or health care hotlines.
- Make sure everybody in your household knows what they should do should you contract COVID-19 or require assistance.
- If they are not already connected, introduce people in your support network so that they can communicate effectively should you become unwell.
- Know the telephone number of relevant telehealth[4] services and hotlines, should you have questions or require non-urgent medical assistance.

The mental and physical health of household members and caregivers

- Ensure all members of the household and caregivers enact the basic protection measures, such as hand wash, against contracting COVID-19.
- Follow the WHO guidance on mental health considerations and guidance on managing existing noncommunicable diseases during the COVID-19 outbreak.[5,6]
- Encourage children with disability to continue playing, reading, learning, and connecting with friends using telephone calls, texts or social media.

3 https://apps.who.int/iris/bitstream/handle/10665/330987/WHO-nCov-IPC_Masks-2020.1-eng.pdf?sequence=1&isAllowed=y

4 Telehealth involves the use of telecommunications and virtual technology to deliver health care outside of traditional health-care facilities

5 https://www.who.int/docs/default-source/coronaviruse/mental-health-considerations.pdf?sfvrsn=6d3578af_2

6 https://www.who.int/who-documents-detail/covid-19-and-ncds

COVID-19

- If anyone in the household is suspected to have the virus, the person should be isolated, instructed to wear a mask, and must access testing as soon as possible.[7] All surfaces need to be disinfected, and everyone in the household monitored for symptoms. If possible, anyone with an underlying health condition or reduced immunity needs to be moved to a separate location until the completion of isolation periods.

7 https://apps.who.int/iris/bitstream/handle/10665/330987/WHO-nCov-IPC_Masks-2020.1-eng.pdf?sequence=1&isAllowed=y

Actions for governments

Ensure public health information and communication is accessible

- Include captioning and sign language for all live and recorded events and communications. This includes national addresses, press briefings, and live social media.
- Convert public materials into "Easy Read" format so that they are accessible for people with intellectual disability or cognitive impairment.
- Develop accessible written information products by using appropriate document formats, (such as "Word"), with structured headings, large print, braille versions and formats for people who are deafblind.
- Include captions for images used within documents or on social media. Use images that are inclusive and do not stigmatize disability.
- Work with disability organizations, including advocacy bodies and disability service providers to disseminate public health information.

Undertake targeted measures for people with disability and their support networks

Work with people with disability and their representative organizations to rapidly identify fiscal and administrative measures, such as:

- Financial compensation for families and caregivers who need to take time off work to care for loved ones. This could include paying, for a time-limited period, family members for support provided during normal working hours.
- Financial compensation for families and caregivers who are part of the casual and self-employed disability workforce, who may need to self-isolate, and where coming to work would place people with disability at greater risk of infection.
- Adoption of flexible, work-from-home policies, along with financial compensation for the technology required to do so.
- Financial measures (commonly within a broader-based economic stimulus package) that include people with disability, such as lump sum payments for qualifying individuals, tax relief, subsidization of items and/or leniency and allowable deferral of common expenses.
- Appropriate action by schools and other educational facilities to ensure continued education for students with disability who may be required to study from home for longer periods.

- Provision of a hotline in multiple formats (e.g. telephone and email) for people with disability to communicate with the government, ask questions, and raise concerns.

Undertake targeted measures for disability service providers in the community[8]

Work with the disability service providers to identify actions for the continuation of services and priority access to protective equipment:

- Ensure that agencies providing disability caregivers have continuity plans for situations in which the number of available caregivers may be reduced.
- Work with disability service providers to reduce bureaucratic recruitment barriers while still maintaining protection measures, such as police checks for caregivers.
- Consider short-term financial support for disability services to ensure they remain financially sustainable if they experience a downturn in their operations.
- Provide a hotline for disability services to communicate with government and raise concerns.
- Prioritize disability caregiver agencies for access to no-cost personal protective equipment, including masks, aprons, gloves and hand sanitizers.
- Ensure that caregivers of people with disability have access to COVID-19 testing alongside other identified priority groups.

Increase attention given to people with disability living in potentially higher risk high-risk settings of developing the disease

Work with people with disability and their representative organizations to identify actions to protect people with disability who may be in high-risk situations:

- Ensure that agencies providing services to people with disability in institutional settings[9] develop and implement service continuity plans.
- Identify people with disability in prisons, jails and correctional facilities, and work with relevant authorities to implement infection control measures and identify possible contingencies.

8 Disability service providers in the community may include agencies that provide caregiver services, specialized employment opportunities, or specialized therapies and consultation to people with disability.

9 Institutional settings include prisons, psychiatric hospitals and care homes.

- Ensure that people with disability who are homeless are provided with water, food, shelter and health care on an equal basis with others and are able to exercise basic protective measures against contracting COVID-19.
- Ensure that the needs of people with disability are considered in readiness and response operations for the COVID-19 outbreak in humanitarian settings, including those living in situations of forced displacement, in refugee or migrant camps, informal settlements and urban slums.

Ensure that emergency measures include the needs of people with disability

Work with people with disability and their representative organizations to ensure that emergency declarations based on the COVID-19 outbreak include their needs:

- Ensure that disability caregivers are considered as essential workers and exempted from curfews and other lockdown measures that may affect the continued provision of support services.
- Grant exemptions, so that people with disability who may experience significant distress with home confinement are permitted to leave their homes for short periods and in a safe way during curfews and other lockdown measures.
- Ensure that emergency measures do not discriminate on the basis of disability. Human rights protection mechanisms for people with disability placed ~~in~~ institutional settings should not be reduced as part of emergency measures.

Actions for health-care

Ensure COVID-19 health care is Accessible, Affordable and Inclusive

- Work to ensure all clinics providing testing and services related to COVID-19 are completely accessible. Address physical barriers (such as uneven pathways, stairs, hard-to-reach spaces or hard-to-use equipment); attitudinal barriers (such as social stigma against disability and the denial of essential services); and financial barriers (such as high costs related to treatment or accessing the facility). Ensure that information about the accessibility of COVID-19 health services is disseminated to people with disability and their caregivers.
- Deliver information in understandable and diverse formats to suit different needs. Do not rely solely on either verbal or written information, and adopt ways to communicate that are understandable to people with intellectual, cognitive and psychosocial impairments.
- Deliver home-based consultations for people with disability, including for their general health needs and, where appropriate, for COVID-19 related needs.
- Develop and disseminate information to health workers so that they are aware of the potential health and social consequences of COVID-19 for people with disability.
- Deliver sufficient support for people with disability with more complex needs, particularly if quarantined or isolated. When needed, coordinate care between health and social services, families, and caregivers.
- Ensure that decisions on the allocation of scarce resources (e.g. ventilators) are not based on pre-existing impairments, high support needs, quality of life assessments, or medical bias against people with disability. Follow WHO guidance to prioritize those at high risk.[10]

Deliver telehealth for people with disability

- Provide telephone consultations, text messaging and video conferencing for the delivery of health care and psychosocial support for people with disability. This may be for their general health, and include rehabilitation needs and, where appropriate, COVID-19 related needs.

10 https://www.who.int/ethics/publications/infectious-disease-outbreaks/en/

Actions for disability service providers in the community

Develop and implement service continuity plans

- Plan for a scenario in which the workforce is reduced, and identify actions for scaling up administration and technical staff, as well as caregivers, where appropriate.
- Identify actions and work with government to reduce recruitment barriers, while continuing to maintain protection measures, such as police checks for caregivers.
- Hold additional trainings and if possible, develop online modules to prepare a new workforce and those who will take on expanded roles.
- Work with other local disability and caregiver agencies to undertake the prioritization of the most critically needed disability services and those that are essential to be kept open. Identify the clients most vulnerable to a reduction in services.

Communicate frequently with people with disability and their support networks

- Provide additional targeted information on COVID-19, highlighting information relevant to people with disability and their support networks. This may include information on continuity plans; telehealth and hotline phone numbers; locations of accessible health services; and locations where hand sanitizer or sterilizing equipment can be accessed when their supplies are low, or in situations where they may be required to self-isolate.
- Use a variety of communication platforms such phone calls, text and social media to share information, and convert existing information to accessible formats where necessary.

Reduce potential exposure to COVID-19 during provision of disability services in the community

- Provide training, and rapidly upskill the disability care workforce regarding infection control.[11]
- Ensure that disability caregivers and service providers have access to personal protective equipment including masks, gloves and hand sanitizers; consider increasing orders of these products.[12]

11 https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected-20200125

12 https://apps.who.int/iris/bitstream/handle/10665/331695/WHO-2019-nCov-IPC_PPE_use-2020.3-eng.pdf

- Deliver appropriate disability services through home-based consultation or through similar platforms as used in telehealth.

Provide sufficient support for people with disability who have complex needs

- Identify people with disability with more complex needs, and work with them, their families, and community support agencies, to identify contingencies for when the number of caregivers is limited or there are none available.
- Identify the potential for increased violence, abuse and neglect against people with disability because of social isolation and disruption to daily routines; support mitigation of these risks, for example providing an accessible hotline to report.

Actions for institutional settings

Reduce potential exposure to COVID-19

Undertake immediate action to reduce potential exposure to COVID-19 in institutional settings[13]:

- Identify those most at risk and work with them, their families and staff to implement infection control measures.
- Ensure that facilities are clean and hygienic, and that sanitation, washing facilities and supplies are available and accessible.
- Reduce crowding to the maximum extent possible by modifying the distribution of spaces.
- Reduce the number of people in psychiatric hospitals, wherever possible, by implementing schemes of early discharge, together with provision of adequate support for living in the community.
- Ensure that residents can access information about COVID-19 and know how to follow the basic protection measures.[14]
- Implement protective measures to prevent the spread of infections during visiting hours, and facilitate different methods of communication with families and the outside world (e.g. telephone, internet, video communication).

Prepare for COVID19 infections in institutions[15]

- Provide testing and medical care to residents when needed; refer residents to appropriate medical facilities as necessary.
- Prepare for an increased need of support staff to care for those who contract mild cases of COVID-19 but do not need hospitalization.
- Provide appropriate personal protective equipment when needed to residents with disability and staff.
- Implement infection control measures for residents with COVID-19 who do not need hospitalization (e.g. instruct them to wear a mask and limit contact with other residents).

Provide sufficient support for residents with disability

- Ensure that sufficient staff and supplies are maintained to safeguard the continuation of care and support for residents.

13 https://apps.who.int/iris/bitstream/handle/10665/331508/WHO-2019-nCoV-IPC_long_term_care-2020.1-eng.pdf

14 https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public

15 http://www.euro.who.int/__data/assets/pdf_file/0019/434026/Preparedness-prevention-and-control-of-COVID-19-in-prisons.pdf?ua=1

COVID-19

- Provide access to psychosocial support for residents experiencing distress during the outbreak, including through call-in and online psychosocial services and peer support.

Guarantee the rights of residents during the COVID-19 outbreak

- Check and guarantee that residents are not being abused or neglected and that coercive measures are not being used or escalated during the outbreak.
- Ensure that the existing monitoring and complaints mechanisms remain functioning and effective.

Actions for the community

Basic protection measures to be adopted by the general public

- Follow the guidance prepared by WHO on basic protection measures against COVID-19.[16] Take the risk of COVID-19 seriously; even if you, yourself, may not be at high risk of serious symptoms, you may pass the virus on to someone that is.

Flexible work arrangements and infection control measures to be supported by employers

- Follow WHO guidance on getting your workplace ready for the COVID-19 outbreak.[17]
- Where possible, implement flexible working arrangements that allow people with disability to telework. Ensure they have the technology they need, including any assistive products typically available in the workplace.
- If teleworking is not possible, consider allowing people with disability at high risk of severe symptoms to take leave (including paid leave) until the risk of infection is reduced. Explore government policy and support that may be available to employers to enable the implementation of these measures.
- Ensure the accessibility of workplace infection control measures, such as hand sanitization stations.

Increased access to stores to be provided by store owners for vulnerable populations

- Consider providing allocated hours for people with disability or other potentially vulnerable people to access the store; or consider alternative ways to allow people with disability to shop (e.g. delivery, online).

Extra support to be provided by family, friends and neighbours for a person with disability

- Check in regularly with a person with disability to provide emotional and practical support, respecting social isolation restrictions that may be in place.
- Know the facts, be informed and don't spread rumors related to COVID-19.[18]

WHO reference number: WHO/2019-nCoV/Disability/2020.1

16 https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public

17 https://www.who.int/docs/default-source/coronaviruse/getting-workplace-ready-for-covid-19.pdf?sfvrsn=359a81e7_6

18 https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public/myth-busters

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ANNEXURE-A-2

GOV.UK

1. Home (https://www.gov.uk/)
2. Coronavirus (COVID-19) (https://www.gov.uk/coronavirus-taxon)
3. Vaccinations for coronavirus (https://www.gov.uk/coronavirus-taxon/vaccinations)
4. Priority groups for coronavirus (COVID-19) vaccination: advice from the JCVI, 30 December 2020 (https://www.gov.uk/government/publications/priority-groups-for-coronavirus-covid-19-vaccination-advice-from-the-jcvi-30-december-2020)

- Department of Health & Social Care (https://www.gov.uk/government/organisations/department-of-health-and-social-care)

Independent report

Joint Committee on Vaccination and Immunisation: advice on priority groups for COVID-19 vaccination, 30 December 2020

Updated 6 January 2021

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This publication is available at https://www.gov.uk/government/publications/priority-groups-for-coronavirus-covid-19-vaccination-advice-from-the-jcvi-30-december-2020/joint-committee-on-vaccination-and-immunisation-advice-on-priority-groups-for-covid-19-vaccination-30-december-2020

Introduction

This advice is provided to facilitate the development of policy on COVID-19 vaccination in the UK.

The Joint Committee on Vaccination and Immunisation (JCVI) advises that the first priorities for the current COVID-19 vaccination programme should be the prevention of COVID-19 mortality and the protection of health and social care staff and systems. Secondary priorities could include vaccination of those at increased risk of hospitalisation and at increased risk of exposure, and to maintain resilience in essential public services. This document sets out a framework for refining future advice on a national COVID-19 vaccination strategy.

This advice has been developed based on:

- a review of UK epidemiological data on the impact of the COVID-19 pandemic so far (see reference 1)
- data on demographic and clinical risk factors for mortality and hospitalisation from COVID-19 (see references 2 and 3)
- data on occupational exposure (see references 4 to 7)
- a review on inequalities associated with COVID-19 (see reference 8)
- Phase 1, 2 and 3 data on the Pfizer-BioNTech mRNA vaccine and the AstraZeneca vaccine, and Phase 1 and 2 data on other developmental COVID-19 vaccines (see references 9 to 20)
- mathematical modelling on the potential impact of different vaccination programmes (see reference 21)

Considerations

Pfizer-BioNTech vaccine

The committee has reviewed published and unpublished Phase 1, 2 and 3 safety and efficacy data for the Pfizer BioNTech mRNA vaccine. The vaccine appears to be safe and well-tolerated, and there were no clinically concerning safety observations. The data indicates high efficacy in all age groups (16 years and over), including protection against severe disease and encouraging results in older adults. The committee advises that this vaccine be used in the first phase of the programme, according to the priority order set out below. While there is some evidence to indicate high levels of short-term protection from a single dose of vaccine, a 2-dose vaccine schedule is currently advised as this is likely to offer longer lasting protection. (See below).

AstraZeneca vaccine

The committee has reviewed published and unpublished Phase 1, 2 and 3 safety and efficacy data for the AstraZeneca vaccine. The vaccine appears to have a good safety profile, and the data indicates high efficacy in adults aged 18 years and over, including protection against severe disease and encouraging results in older adults. Existing data is consistent with high levels of short-term protection following the first dose of vaccine, with further protection obtained following the second dose of vaccine which may be given between 4 to 12 weeks after the first dose. The committee advises that this vaccine be used in the first phase of the programme, according to the priority order set out below. A 2-dose vaccine schedule is currently advised as this is likely to offer longer lasting protection. (See below)

Vaccine schedule

For both Pfizer-BioNTech and AstraZeneca vaccines, a 2-dose schedule is advised. 36

In the context of the epidemiology of COVID-19 in the UK in late 2020, the JCVI places a high priority on promoting rapid, high levels of vaccine uptake among vulnerable persons.

Therefore, given data indicating high efficacy from the first dose of both Pfizer-BioNTech and AstraZeneca vaccines, the committee advises that delivery of the first dose to as many eligible individuals as possible should be initially prioritised over delivery of a second vaccine dose. This should maximise the short-term impact of the programme. The second dose of the Pfizer-BioNTech vaccine may be given between 3 to 12 weeks following the first dose. The second dose of the AstraZeneca vaccine may be given between 4 to 12 weeks following the first dose.

JCVI advises that the second vaccine dose should be with the same vaccine as for the first dose. Switching between vaccines or missing the second dose is not advised as this may affect the duration of protection.

Vaccine choice

There have been no clinical trials directly comparing the Pfizer-BioNTech and AstraZeneca vaccines. In Phase 3 trials of the respective vaccines, efficacy against symptomatic disease for the Pfizer-BioNTech vaccine was higher than for the AstraZeneca vaccine. Differences in study setting, study design, study population (age, ethnicity, social demographics, etc), and efficacy endpoints may account for some of the observed differences. Both vaccines give very high protection against severe disease, which is the primary aim of the first phase of the programme, and both vaccines have good safety profiles.

The logistical challenges posed by the storage and distribution requirements for the Pfizer-BioNTech vaccine mean that in some populations, the AstraZeneca vaccine is the only vaccine which can be deployed rapidly, and without substantial vaccine wastage.

JCVI does not advise a preference for either vaccine in any specific population. For operational and programmatic reasons, such as to enable more extensive and timely vaccine coverage, one vaccine may be offered in certain settings in preference over another vaccine.

This statement will be updated following consideration of Phase 3 safety and efficacy data on other COVID-19 vaccines.

Direct protection vs transmission reduction

JCVI has considered a number of different vaccination strategies, including those targeting transmission and those targeted at providing direct protection to persons most at risk.

In order to interrupt transmission, mathematical modelling indicates that we would need to vaccinate a large proportion of the population with a vaccine which is highly effective at preventing infection (transmission). At the start of the vaccination programme, good evidence on the effects of vaccination on transmission will not be available, and vaccine availability will be more limited. The best use of available vaccine will also, in part, be dependent on the point in the pandemic the UK is at.

Given the current epidemiological situation in the UK, the best option for preventing morbidity and mortality in the initial phase of the programme is to directly protect persons most at risk of morbidity and mortality.

Age

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Current evidence strongly indicates that the single greatest risk of mortality from COVID-19 is increasing age and that the risk increases exponentially with age (see references 1 to 3). Mathematical modelling indicates that the optimal strategy for minimising future deaths or quality adjusted life year (QALY) losses is to offer vaccination to older age groups first. These models assume an available vaccine is both safe and effective in older adults (see reference 21). Data also indicates that the absolute risk of mortality is higher in those over 65 years than that seen in the majority of younger adults with an underlying health condition (see below). Accordingly, the committee's advice largely prioritises based on age.

Age-based programmes are usually easier to implement and therefore achieve higher vaccine uptake. An age-based programme is also likely to increase uptake in those with clinical risk factors as the prevalence of these increases with age.

Older adults resident in care homes

There is clear evidence that those living in residential care homes for older adults have been disproportionately affected by COVID-19 (see references 22 to 25) as they have had a high risk of exposure to infection and are at higher clinical risk of severe disease and mortality. Given the increased risk of outbreaks, morbidity and mortality in these closed settings, these adults are considered to be at very high risk. The committee's advice is that this group should be the highest priority for vaccination. Vaccination of residents and staff at the same time is considered to be a highly efficient strategy within a mass vaccination programme with the greatest potential impact (see below).

Health and social care workers

Frontline health and social care workers are at increased personal risk of exposure to infection with COVID-19 and of transmitting that infection to susceptible and vulnerable patients in health and social care settings. The committee considers frontline health and social care workers who provide care to vulnerable people a high priority for vaccination. Protecting them protects the health and social care service and recognises the risks that they face in this service. Even a small reduction in transmission arising from vaccination would add to the benefits of vaccinating this population, by reducing transmission from health and social care workers to multiple vulnerable patients and other staff members. This group includes those working in hospice care and those working temporarily in the COVID-19 vaccination programme who provide face-to-face clinical care.

There is evidence that infection rates are higher in residential care home staff (see references 22 to 25), than in those providing domiciliary care or in healthcare workers. Care home workers are therefore considered a very high priority for vaccination.

Prioritisation among health and social care workers

Frontline health and social care workers at high risk of acquiring infection, at high individual risk of developing serious disease, or at risk of transmitting infection to multiple vulnerable persons or other staff in a healthcare environment, are considered of higher priority for vaccination than those at lower risk. This prioritisation should be taken into account during vaccine deployment.

Clinically extremely vulnerable (shielding patients)

Individuals considered extremely clinically vulnerable have been shielding for much of the pandemic (see reference 26). This means that available data is likely to underestimate the risk in this group. Many of those who are clinically extremely vulnerable are in the oldest age groups and will be among the first to receive vaccine. Considering data from the first wave in the UK, the overall risk of mortality for clinically extremely vulnerable younger adults is estimated to be roughly the same as the risk to persons aged 70 to 74 years. Given the level of risk seen in this group as a whole, JCVI advises that

persons aged less than 70 years who are clinically extremely vulnerable should be offered vaccine alongside those aged 70 to 74 years of age. There are 2 key exceptions to this, pregnant women with heart disease and children (see below).

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Many individuals who are clinically extremely vulnerable will have some degree of immunosuppression or be immunocompromised and may not respond as well to the vaccine. Therefore, those who are clinically extremely vulnerable should continue to follow government advice on reducing their risk of infection. Consideration has been given to vaccination of household contacts of immunosuppressed individuals. However, at this time there is no data on the size of the effect of COVID-19 vaccines on transmission. Evidence is expected to accrue during the course of the vaccine programme, and until that time the committee is not in a position to advise vaccination solely on the basis of indirect protection. Once sufficient evidence becomes available the committee will consider options for a cocooning strategy for immunosuppressed individuals, including whether any specific vaccine is preferred in this population.

Women who are pregnant

There is no known risk associated with giving non-live vaccines during pregnancy. These vaccines cannot replicate, so they cannot cause infection in either the woman or the unborn child.

Although the available data does not indicate any safety concern or harm to pregnancy, there is insufficient evidence to recommend routine use of COVID-19 vaccines during pregnancy.

JCVI advises that, for women who are offered vaccination with the Pfizer-BioNTech or AstraZeneca COVID-19 vaccines, vaccination in pregnancy should be considered where the risk of exposure to Severe Acute Respiratory Syndrome coronavirus 2 (SARS-CoV2) infection is high and cannot be avoided, or where the woman has underlying conditions that put them at very high risk of serious complications of COVID-19. In these circumstances, clinicians should discuss the risks and benefits of vaccination with the woman, who should be told about the absence of safety data for the vaccine in pregnant women.

JCVI does not advise routine pregnancy testing before receipt of a COVID-19 vaccine. Those who are trying to become pregnant do not need to avoid pregnancy after vaccination.

Women who are breastfeeding

There is no known risk associated with giving non-live vaccines whilst breastfeeding. JCVI advises that breastfeeding women may be offered vaccination with the Pfizer-BioNTech or AstraZeneca COVID-19 vaccines.

The developmental and health benefits of breastfeeding should be considered along with the woman's clinical need for immunisation against COVID-19, and the woman should be informed about the absence of safety data for the vaccine in breastfeeding women.

Children less than 16 years of age

Following infection, almost all children will have asymptomatic infection or mild disease. There is very limited data on vaccination in adolescents, with no data on vaccination in younger children, at this time. The committee advises that only those children at very high risk of exposure and serious outcomes, such as older children with severe neuro-disabilities that require residential care, should be offered vaccination with either the Pfizer-BioNTech or the AstraZeneca vaccine. Clinicians should discuss the risks and benefits of vaccination with a person with parental responsibility, who should be told about the paucity of safety data for the vaccine in children aged under 16 years. More detail on vaccination in children is set out in the Green Book – Immunisation Against Infectious Disease (https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book).

Persons with underlying health conditions

There is good evidence that certain underlying health conditions increase the risk of morbidity and mortality from COVID-19. When compared to persons without underlying health conditions, the absolute increased risk in those with underlying health conditions is considered generally to be lower than the increased risk in persons over the age of 65 years (with the exception of the clinically extremely vulnerable – see above). The committee's advice is to offer vaccination to those aged 65 years and over followed by those in clinical risk groups aged 16 years and over. The main risk groups identified by the committee are set out below:

- chronic respiratory disease, including chronic obstructive pulmonary disease (COPD), cystic fibrosis and severe asthma
- chronic heart disease (and vascular disease)
- chronic kidney disease
- chronic liver disease
- chronic neurological disease including epilepsy
- Down's syndrome
- severe and profound learning disability
- diabetes
- solid organ, bone marrow and stem cell transplant recipients
- people with specific cancers
- immunosuppression due to disease or treatment
- asplenia and splenic dysfunction
- morbid obesity
- severe mental illness

Other groups at higher risk, including those who are in receipt of a carer's allowance, or those who are the main carer of an elderly or disabled person whose welfare may be at risk if the carer falls ill, should also be offered vaccination alongside these groups.

Individuals within these risk groups who are clinically extremely vulnerable are discussed separately (see above). Further advice on risk groups, including clear definitions, are set out in the Green Book - Immunisation Against Infectious Disease (https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book).

Mitigating inequalities

Multiple social and societal drivers are recognised to contribute towards increased risk from COVID-19. JCVI considered it important to understand the factors underlying health inequalities in COVID-19 giving due consideration to relevant scientific evidence, ethical principles and vaccine programme deliverability. The issues considered are set out in Annex A (https://www.gov.uk/government/publications/priority-groups-for-coronavirus-covid-19-vaccination-advice-from-the-jcvi-30-december-2020/annex-a-covid-19-vaccine-and-health-inequalities-considerations-for-prioritisation-and-implementation)).

There is clear evidence that certain Black, Asian and minority ethnic (BAME) groups have higher rates of infection, and higher rates of serious disease, morbidity and mortality. There is no strong evidence that ethnicity by itself (or genetics) is the sole explanation for observed differences in rates of severe illness and deaths. What is clear is that certain health conditions are associated with increased risk of serious disease, and these health conditions are often overrepresented in certain

BAME groups. It is also clear that societal factors, such as occupation, household size, deprivation, and access to healthcare can increase susceptibility to COVID-19 and worsen outcomes following infection. These factors are playing a large role in the inequalities being seen with COVID-19.

Good vaccine coverage in BAME groups will be the most important factor within a vaccine programme in reducing inequalities for this group. Prioritisation of persons with underlying health conditions (see above) will also provide for greater vaccination of BAME communities who are disproportionately affected by such health conditions.

The committee's advice is for NHS England and Improvement, the Department of Health and Social Care, Public Health England (PHE) and the devolved administrations to work together to ensure that inequalities are identified and addressed in implementation. This could be through culturally competent and tailored communications and flexible models of delivery, aimed at ensuring everything possible is done to promote good uptake in BAME groups and in groups who may experience inequalities in access to, or engagement with, healthcare services. These tailored implementation measures should be applied across all priority groups during the vaccination programme.

Occupational vaccination (other than frontline health and social care workers)

The committee considered evidence on the risk of exposure and risk of mortality by occupation. Under the priority groups advised below, those over 50 years of age, and all those 16 years of age and over in a risk group, would be eligible for vaccination within the first phase of the programme. This prioritisation captures almost all preventable deaths from COVID-19, including those associated with occupational exposure to infection. As such, JCVI does not advise further prioritisation by occupation during the first phase of the programme.

Occupational prioritisation could form part of a second phase of the programme, which would include healthy individuals from 16 years of age up to 50 years of age, subject to consideration of the latest data on vaccine safety and effectiveness.

The impact of vaccine delivery on non-pharmaceutical interventions.

In a situation of constrained vaccine supply, population level protection will not be achievable immediately.

Once we have evidence of the impact of the programme on morbidity and mortality among vulnerable persons, the initial phase of the vaccination programme could allow the subsequent relaxation of non-pharmaceutical interventions in some sectors of the population. Government advice on non-pharmaceutical interventions should continue to be followed.

Vaccine priority groups: advice on 30 December 2020

Phase 1 – direct prevention of mortality and supporting the NHS and social care system

JCVI advises that the first priorities for the COVID-19 vaccination programme should be the prevention of mortality and the maintenance of the health and social care systems. As the risk of mortality from COVID-19 increases with age, prioritisation is primarily based on age. The order of priority for each group in the population corresponds with data on the number of individuals who would need to be vaccinated to prevent one death, estimated from UK data obtained from March to June 2020 (see reference 3):

1. residents in a care home for older adults and their carers
2. all those 80 years of age and over and frontline health and social care workers

3. all those 75 years of age and over
4. all those 70 years of age and over and clinically extremely vulnerable individuals[footnote 1]
5. all those 65 years of age and over
6. all individuals aged 16 years[footnote 2] to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality[footnote 3]
7. all those 60 years of age and over
8. all those 55 years of age and over
9. all those 50 years of age and over

It is estimated that taken together, these groups represent around 99% of preventable mortality from COVID-19.

JCVI advises that implementation of the COVID-19 vaccine programme should aim to achieve high vaccine uptake. An age-based programme will likely result in faster delivery and better uptake in those at the highest risk. Implementation should also involve flexibility in vaccine deployment at a local level with due attention to:

- mitigating health inequalities, such as might occur in relation to access to healthcare and ethnicity
- vaccine product storage, transport and administration constraints
- exceptional individualised circumstances
- availability of suitable approved vaccines, for example for specific age cohorts

JCVI appreciates that operational considerations, such as minimising wastage, may require a flexible approach, where decisions are taken in consultation with national or local public health experts. To be assured that outcome is maximised however, JCVI would like to see early and regular comprehensive vaccine coverage data so that the committee can respond if high priority risk groups are unable to access vaccination in a reasonable time frame.

The next phase – further reduction in hospitalisation and targeted vaccination of those at high risk of exposure and/or those delivering key public services

As the first phase of the programme is rolled out in the UK, additional data will become available on the safety and effectiveness of COVID-19 vaccines. This data will provide the basis for consideration of vaccination in groups that are at lower risk of mortality from COVID-19.

The committee is currently of the view that the key focus for the second phase of vaccination could be on further preventing hospitalisation.

Vaccination of those at increased risk of exposure to SARS-CoV-2 due to their occupation could also be a priority in the next phase. This could include first responders, the military, those involved in the justice system, teachers, transport workers, and public servants essential to the pandemic response. Priority occupations for vaccination are considered an issue of policy, rather than for JCVI to advise on. JCVI asks that the Department of Health and Social Care consider occupational vaccination in collaboration with other government departments.

Wider use of COVID-19 vaccines will provide a better understanding of whether they can prevent infection and onward transmission in the population. Data on vaccine impact on transmission, along with data on vaccine safety and effectiveness, will potentially allow for consideration of vaccination across the rest of the population.

As trials in children and pregnant women are completed, we will also gain a better understanding of the safety and effectiveness of the vaccines in these persons.

Further work

JCVI will continually monitor data on vaccines in development. As more Phase 3 data becomes available on candidate COVID-19 vaccines the committee will be able to prepare further advice for policy makers in the UK.

JCVI will review data on vaccine coverage, in particular focusing on inequalities, and the impact of actions being undertaken to mitigate inequalities. Vaccine safety will be continually monitored by the Medicines and Healthcare products Regulatory Agency (MHRA) and PHE, and JCVI will regularly review data on vaccine safety as the programme rolls out. Vaccine efficacy and any potential impacts on transmission will be monitored by PHE. Data will be considered at the earliest opportunity to facilitate discussions on prioritisation after the first phase of the programme.

Background

JCVI met to consider COVID-19 vaccination on:

- 7 May
- 3 June
- 6 July
- 1 September
- 29 November
- 30 November
- 1 December
- 22 December
- 29 December 2020

Between 24 September 2020 and 22 December 2020, a JCVI COVID-19 sub-committee met most weeks to consider key issues in greater depth. The advice provided is to support the government in development of a vaccine strategy for the procurement and delivery of a vaccination programme to the population.

SARS-CoV-2 (COVID-19)

COVID-19 disease first emerged as a cause of severe respiratory infection in Wuhan, China in late 2019. The first 2 cases in the UK were seen in late January 2020. In March 2020, the World Health Organization declared a SARS-Cov-2 pandemic.

In adults, the clinical picture varies widely. A significant proportion of individuals are likely to have mild symptoms and may be asymptomatic at the time of diagnosis. Symptoms are commonly reported as a new onset of cough and fever, but may include headache, loss of smell, nasal obstruction, lethargy, myalgia, rhinorrhoea, taste dysfunction, sore throat, diarrhoea, vomiting and confusion. Fever may not be reported in all symptomatic individuals. Progression of disease, multiple organ failure and death will occur in some individuals.

As with other coronaviruses, SARS-CoV-2 is an RNA virus which encodes 4 major structural proteins. Most vaccine candidates focus on immunisation with the spike glycoprotein, which is the main target for neutralising antibodies following infection. Neutralising antibodies that block viral entry into host

cells by preventing interaction between the spike protein and the host cell are expected to be protective.

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Pfizer-BioNTech vaccine

The Pfizer-BioNTech vaccine is a lipid nanoparticle-formulated mRNA vaccine. The mRNA encodes the SARS-CoV-2 full length spike protein. The mRNA in the vaccine is translated and transcribed by the body to produce the spike protein. The protein then acts as an intracellular antigen to stimulate the immune response. The mRNA in the vaccine is normally degraded within a few days and cannot incorporate into the host genome. Data from the Pfizer-BioNTech vaccine trials undertaken in over 40,000 individuals indicate high vaccine efficacy, with no serious safety concerns observed.

AstraZeneca COVID-19 vaccine

The AstraZeneca COVID-19 vaccine uses a replication deficient chimpanzee adenovirus as a vector that encodes the full-length SARS-CoV2 spike protein. Chimpanzee adenoviruses are non-enveloped viruses, meaning that the glycoprotein antigen is not present on the surface of the vector, but is only expressed at high levels once the vector enters the target cells. Genes are deleted from the adenovirus to render the virus replication incompetent, and to enhance immunogenicity. Once the vector is in the nucleus, mRNA encoding the spike protein is produced that then enters the cytoplasm. This leads to translation of the target protein which acts as an intracellular antigen. Data from vaccine trials undertaken indicate high vaccine efficacy, with no serious safety events related to the vaccine.

Other vaccines in development

Other COVID-19 vaccines are in development, with some in late stage trials. When sufficient data on vaccine safety and efficacy are available, these will be considered by JCVI and this statement will be updated.

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1. See description of Clinically extremely vulnerable individuals (https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19). This advice on vaccination does not include all pregnant women or those under the age of 16 years (see above).

2. The Pfizer-BioNTech vaccine is authorised in those aged 16 years and over. The AstraZeneca vaccine is only authorised for use in those aged 18 years and over.
3. This also includes those who are in receipt of a carer's allowance, or those who are the main carer of an elderly or disabled person whose welfare may be at risk if the carer falls ill.

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ANNEXURE-A-3
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NHS Digital

COVID-19 Population Risk Assessment

We've used the University of Oxford's QCovid® risk prediction model to identify additional people to be added to the Shielded Patient List (SPL).

Gestational diabetes

Detailed information about gestational diabetes to support clinicians.

Read about shielding letters and what to do if you think you should not have been identified as high risk.

If you have a question about the COVID-19 Population Risk Assessment that is not answered here, please email risk.strat.spl@nhs.net.

We have used QCovid® to develop the COVID-19 Population Risk Assessment. This combines a number of factors such as age, sex registered at birth, ethnicity, body mass index (BMI) and specific health conditions and treatments to estimate the risk of a person catching coronavirus and becoming seriously unwell.

We have used patient data held centrally to identify people who might be at high risk and generated risk assessment results for these people. People whose results are above the agreed threshold for high risk (clinically extremely vulnerable) of severe illness from coronavirus have been added to the Shielded Patient List (SPL) in England.

Coronavirus information can be found on GOV.UK, including guidance for high risk (clinically extremely vulnerable) people.

Our use of QCovid® in the COVID-19 Population Risk Assessment using patient data held centrally has been registered by NHS Digital as a Class 1 medical device with the Medicines and Healthcare products Regulatory Agency (MHRA).

Read more about QCovid®, how it works and how the NHS is using it.

How we've identified people as being potentially at high risk (clinically extremely vulnerable)

We worked with the University of Oxford to identify the pieces of information about people and their health that are needed by the risk assessment model to generate as accurate risk assessment results as possible.

We identified where this information could be found in existing datasets held by NHS Digital. We then gathered the specific pieces of information from the records of people who could potentially be considered high risk (clinically extremely vulnerable). As the national information and technology partner to the health and social care system in England, we have legal permission to securely collect and analyse this data.

The relevant coded data was found to be recorded in 7 national datasets:

- GPES (General Practice Extraction Service) v3: COVID-19 at-risk Patients data collection version 3
- GPES data for pandemic planning and research (COVID-19)
- HES: Hospital Episodes Statistics datasets
- PDS: Personal Demographics Service
- SACT: Systemic Anti-Cancer Therapy dataset
- RTDS: Radiotherapy Dataset
- SPL: Shielded Patient List

We then ran this data securely through QCovid® to generate risk assessment results. The people whose risk assessment results were above the agreed threshold for high risk (clinically extremely vulnerable) were then added to the SPL.

Read more about how QCovid® works and the risk factors used to estimate risk assessment results.

More detailed information about the datasets used, the information we've used from those datasets and processing rules is now available.

Health conditions and treatments

We have used data about the following conditions and treatments to generate population risk assessments.

Cardiovascular diseases

Respiratory diseases and treatment

Metabolic (diabetes), renal and liver conditions

Neurological and psychiatric conditions

Immune and haematological conditions

Immunosuppressants, cancer conditions and treatments

Gestational diabetes

Some people with previous gestational diabetes have been identified by the QCovid® model as being at high risk. This will be appropriate for many as the model performs an individual assessment based on a wide range of risk factors, and also considers a person's risk in comparison to others of the same age and sex.

However, because the risk assessment is based on routinely coded data from multiple systems, some people may have been identified as having diabetes when in fact they had gestational diabetes. Others may have incomplete data, in which case the risk assessment may have

defaulted, on a precautionary basis, to a higher level of risk for that category and this may influence the overall assessment results.

If a person has been identified as being at high risk due to previous gestational diabetes only (no other significant conditions) and both:

- has a Body Mass Index (BMI) between 16 and 41
- has had a HbA1c (a test to check average blood glucose/sugar levels) since delivery and within the last 12 months which is normal or in the pre-diabetes or non-diabetic hyperglycaemia range

they do not need to be included in the Shielded Patient List (SPL) and can be removed if they request this. They will still be called for an earlier vaccine. Shielding is advisory and people who have received a letter can choose whether or not to shield. Clinicians should always use their clinical judgement and discuss any decision to remove a patient from the SPL.

Where a person with previous gestational diabetes, and a normal HbA1c in the previous 12 months, has a BMI below 16 or above 41, the COVID-19 Clinical Risk Assessment Tool can be used to generate the patient's risk assessment results. These results should be used to inform an individual assessment of risk to determine, in consultation with the patient, whether they should remain on the Shielded Patient List (SPL) or be removed.

Importantly, people with previous gestational diabetes have an increased risk of developing Type 2 diabetes (which would put them at higher risk from coronavirus) and they should continue to undergo the recommended annual checks for this.

The Royal College of General Practitioners (RCGP) has developed a flow chart to support GPs when considering risk for patients with a history of gestational diabetes.

Who has been risk assessed

Risk assessment results have only been generated for:

- people who could potentially meet the threshold for being considered at high risk (clinically extremely vulnerable)
- people who have not previously been identified by existing SPL processes

This means we have not generated risk assessment results for some people, including:

- people who are already on the SPL
- people who were previously on the SPL, but have been removed by a clinician involved in their care
- people whose combined risk factors could not possibly meet the agreed threshold
- people who have already been assessed individually by a clinician and identified as low or medium risk
- people under the age of 19, or over 100, because QCovid® is not designed for use on these groups

- people coded with Down's syndrome in their record who had not already been identified through the national SPL. This is due to Down's syndrome already being included in the national SPL ruleset and a known coding issue.

Agreed threshold for adding people to the Shielded Patient List

England's Chief Medical Officer (CMO), in consultation with senior clinicians, looked at the results of the QCovid® research conducted by the University of Oxford to work out what risk threshold should be used to decide if someone may be high risk (clinically extremely vulnerable) and added to the SPL as a result.

The research showed that most people included in the study who died from coronavirus would have had risk assessment results that placed them in approximately the top 2% of the population in England that are at the highest risk. For the combined risk of catching and dying of coronavirus, most results were higher than or equal to:

- an absolute risk of 0.5% (or 5 in 1,000)
- a relative risk of 10 (or 10 times the baseline risk)

The CMO and senior clinicians decided that these thresholds should be used to help protect people who may be high risk.

> Absolute risk is the overall risk, based on what happened to other people with the same characteristics and risk factors who caught coronavirus and went to hospital or died as a result.
>
> Relative risk is the level of risk compared to a person who is the same age and sex registered at birth, but without any other risk factors.

Missing or unknown data

If certain information is missing from a record held by NHS Digital or has been recorded as unknown, then default values are used by the COVID-19 Population Risk Assessment as a substitute.

We have taken a precautionary approach to how we handle information which might be missing from records. This is to make sure that we do not underestimate people's risk and exclude them from the high risk (clinically extremely vulnerable) group who will be added to the SPL.

Where data is missing, we have used some default values that have higher than average risk associated with them, according to QCovid®. This means that we are likely to be overestimating the level of risk for some people with information missing from their records and therefore identifying more people as potentially high risk (clinically extremely vulnerable).

As a result, some people may be advised to shield based on these default values. Based on advice from clinical advisors, the Department of Health and Social Care has determined that this precautionary approach is clinically the most appropriate.

The patient's GP record will indicate that they have been added to the SPL using the COVID-19 Population Risk Assessment, and whether a default value was applied. Read more about how this is shown in GP IT systems.

Default values

Body Mass Index (BMI)

Sex registered at birth

Ethnicity

Postcode

Validating additions to the SPL generated by the population risk assessment

To act as quickly as possible and reduce GP workload, patients identified as potentially high risk have been added directly to the SPL. Clinicians can follow existing processes to review, add and remove patients from the SPL where this is appropriate at any time.

Clinicians should continue to review individual patients on an ongoing basis, according to clinical judgement and patient request. Guidance about how to identify this cohort of patients in IT systems is available for general practice and hospital trusts.

Clinicians can use the COVID-19 Clinical Risk Assessment Tool to validate additions to the SPL from the COVID-19 Population Risk Assessment. The tool uses the same QCovid® model used in the COVID-19 Population Risk Assessment and can be used to generate results for individual patients. Because the population risk assessment uses data from a number of

national datasets and may include different default values, there may be some variation between results. Detailed guidance for clinicians is available within the online tool.

Patients not added to the SPL

GP practices can access details of their patients who were risk assessed, but whose risk assessment results did not meet the agreed threshold to be added to the SPL. Some of these patients may have been close to the threshold for addition to the SPL and GPs may wish to review these individually. The information will reflect whether default values were used.

Clinicians can use the COVID-19 Clinical Risk Assessment Tool to review these patients, alongside their clinical judgement, as they may have access to more up-to-date information.

This list will not include every patient registered at the practice that may be close to the threshold because we did not risk assess all patients. GPs should therefore still consider using the risk assessment tool on an individual basis for patients they believe may be at risk.

GP practices can use the COVID-19 Population Risk Assessment Viewer to view these patients.

Transparency notice

This explains how personal information may be used by NHS Digital in relation to the COVID-19 Population Risk Assessment.

View the COVID-19 Population Risk Assessment transparency notice.

Last edited: 19 April 2021 8:52 am

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The BMJ

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Covid-19: All adults on learning disability register should be prioritised for vaccination, says advisory committee

Elisabeth Mahase

The UK government's vaccine advisory committee has said that all people on the GP Learning Disability Register should now be invited for a covid-19 vaccine as part of priority group 6.

The Joint Committee on Vaccination and Immunisation (JCVI) said that adults with other related conditions such as cerebral palsy should also be invited and that local authorities should help to identify adults with learning disabilities in residential and nursing care, as well as those who require assisted living support and those in shared accommodation with multiple occupancy.

This will mean that at least 150 000 more people with learning disabilities should be offered the vaccine more quickly.

The announcement comes after some local GP groups decided to prioritise all patients with learning disabilities for covid-19 vaccination, in response to evidence that disabled patients were at much higher risk from the disease.[1]

Recent figures from the Office for National Statistics showed that 60% of people in England who died from covid-19 from January to November 2020 had a disability.[2]

The JCVI had previously recommended that adults with severe and profound learning disabilities, and those with learning disabilities in long stay nursing and residential care settings, should be offered the vaccine in priority group 6. However, there were concerns that people would be missed, as GP systems do not always capture the severity of someone's disability. As such, the committee has now decided that the GP Learning Disability Register should be used, as this is more likely to capture the right people.

Simpler and faster

Helen Whately, minister for care, said, "I have heard first hand how tough this pandemic has been for people with learning disabilities and their families. We are determined those more at risk from covid should be vaccinated as soon as possible.

"Following the JCVI's updated advice and to make this process simpler and faster, we will be inviting everyone for vaccination who is on their GP's learning disability register. This will mean those who are at a higher risk from the virus can get the protection they need."

Jackie O'Sullivan, executive director of communication, advocacy and activism at the learning disability charity Mencap, called the announcement "fantastic news for people with a learning disability."

She added, "It's now crucially important that everyone with a learning disability checks that they are on the register and asks to go on it if they are not. Being on the register has many benefits and entitles people to annual health checks and prioritisation for future vaccinations, as well as allowing them to get the covid vaccine and be confident they are protected."

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2 Office for National Statistics. Updated estimates of coronavirus (COVID-19) related deaths by disability status, England: 24 January to 20 November 2020. 11 Feb 2021. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronaviruscovid19relateddeathsbydisabilitystatusenglandandwales/24januaryto20november2020.

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ANNEXURE-A-5

The Washington Post
Democracy Dies in Darkness

CDC: States should prioritize people with disabilities as they broaden vaccine access

J&J's one-shot vaccine 'might be desirable' for people who move frequently and for prisoners and people who are in homeless shelters, the agency advises

By Lena H. Sun
March 3, 2021 at 6:16 a.m. GMT+5:30

With the nationwide demand for coronavirus shots continuing to far outstrip supply, the Centers for Disease Control and Prevention said Tuesday states should consider prioritizing people with disabilities or cognitive decline as officials broaden access to vaccines.

The guidance is part of the agency's latest recommendations for administering doses now that three vaccines are authorized and recommended for use to combat covid-19, the disease caused by the coronavirus. Any of the three can be used during these initial phases when supply is sharply limited, officials say.

The newest addition to the pandemic arsenal — the one-shot Johnson & Johnson vaccine that does not need to be kept frozen — might be best for people who want to be immunized quickly or would have difficulty returning for a second shot. The other two authorized vaccines — one from pharmaceutical giant Pfizer and German biotech company BioNTech, and the other from U.S. biotech firm Moderna — require two doses.

The Johnson & Johnson vaccine may be most suitable for people who move frequently or those who live and work in homeless shelters or correctional facilities, the CDC said.

Experts noted that the latest guidance reflects more attention to the real-world challenges that have surfaced throughout the country as many people who are prioritized for the shots are unable to make appointments online. States and localities have adopted widely differing approaches, resulting in a patchwork of guidelines governing who should get early access to the vaccines as more transmissible and possibly more dangerous variants circulate in this country. State officials announce changes to those priorities frequently, causing further confusion.

Many older adults designated as the highest priority for inoculation have been unable to register for vaccinations because of glitchy online systems or lack of Internet access. That has often left children and grandchildren spending

those in congregate settings outside of long-term care facilities, and those who have technological or geographic barriers," said Jennifer Kates, a senior vice president at the Kaiser Family Foundation, which has been tracking how states have prioritized groups for vaccination.

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"Whether states will follow this guidance remains to be seen," she added.

The guidance gives flexibility to local officials, and "many real-world care providers would really welcome this," said Jeanne Marrazzo, the director of the infectious-diseases division at the University of Alabama at Birmingham.

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The potential downside, she said, is that it does not provide as much specificity as some might like when supply is scarce and many people are clamoring for a first dose and assurances they will get their second.

"The solution to all of this debate is to get more vaccine out there, period," she said. "We don't have time to quibble about the nuances of who deserves to get it first."

The latest CDC guidance urges states to consider the "unique needs" of people with disabilities or cognitive decline and their caretakers, and "those with limited access to technology," as appointments open to new groups. After health-care workers and nursing home staff and residents, the CDC vaccine advisory panel has recommended the next priority groups include adults 65 and older, essential workers, and those 16 to 64 with medical conditions that put them at high risk for severe cases of covid-19. Many states are already vaccinating those 65 and older. Fewer states have begun inoculating those with high-risk conditions.

Advocates for people with disabilities say the updated guidance is a step in the right direction but does not go far enough.

"It doesn't resolve the overall uncertainty and lack of clarity for people with disabilities and their families," said Peter V. Berns, chief executive officer for the Arc of the United States, which advocates for people with intellectual and developmental disabilities.

The implementation guidance said the easier-to-use Johnson & Johnson vaccine might be the best fit for certain populations. Because it does not have to be frozen, it can be used in mobile clinics or sites that do not have freezer capacity and "may be desirable" for mobile populations or populations with high turnover, such as homeless shelters or correctional facilities.

One of every five prisoners in state and federal corrections facilities has tested positive for the coronavirus, a rate more than four times that of the general population, according to data collected by the Associated Press and the Marshall Project. In some states, more than half of prisoners have been infected.

"It's not just that the covid-19 virus spreads faster behind bars, it's that the preexisting medical conditions that make covid-19 more dangerous are more common behind bars, not to mention that you have people in prison working jobs like the kitchen and the laundry room that are essential to the prison itself being able to function," said Wanda Bertram, a spokeswoman for the Prison Policy Initiative, a nonprofit research and advocacy group for criminal justice reform.

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Updated April 19, 2021

Vaccines: J&J vaccine pause | Tracker by state | Guidance for vaccinated people | How long does immunity last? | County-level vaccine data

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Are you planning a long-awaited reunion after you get vaccinated? We want to hear from you

By Lena H. Sun

Lena H. Sun is a national reporter for The Washington Post covering health with a special focus on public health and infectious disease. A longtime reporter at The Post, she has covered the Metro transit system, immigration, education and was a Beijing bureau chief. Twitter

ANNEXURE 57 A-6

World Health Organization

unicef
for every child

Disability considerations for COVID-19 vaccination

WHO & UNICEF Policy Brief
19 April 2021

Note: This document has been drafted at a time when the authorization and availability of vaccine products against COVID-19 is rapidly evolving and when vaccine supply is limited. It is aligned with, and complements, other WHO COVID-19 vaccination guidance, including the WHO SAGE roadmap for prioritizing uses of COVID-19 vaccines in the context of limited supply and Guidance on developing a national deployment and vaccination plan for COVID-19 vaccines. The document will be updated as new information and guidance on vaccination against COVID-19 becomes available.

Introduction

On 30 January 2020, WHO declared the COVID-19 outbreak a Public Health Emergency of International Concern, and called upon all countries to take urgent measures to reduce the transmission and impact of the disease. As safe and effective COVID-19 vaccines become available, governments are now developing and updating their national deployment and vaccination plans (NDVPs) *(1)*. Equitable access must be a guiding principle for all immunization programmes. Vaccine prioritization within countries should "take into account the vulnerabilities, risks and needs of groups who, because of underlying societal, geographic or biomedical factors, are at risk of experiencing greater burdens from the COVID-19 pandemic" *(2)*. As such, during the initial phases of vaccine roll-out, WHO is advising countries to target health workers, who are at higher risk of contracting COVID-19 infection than the general population due to the nature of their work; older people (for whom the specific age cut-off will be decided at the country level); and those with underlying health conditions who are at higher risk of serious health outcomes and mortality due to COVID-19 *(1)*. WHO and UNICEF also advise that NDVPs include actions to address barriers to vaccination, and ensure that persons with disabilities who meet the criteria for vaccination, have access on an equal basis with others.

This document presents considerations and actions for the following stakeholders to ensure equity in access to vaccination against COVID-19 for persons with disabilities:

- Persons with disabilities and their support networks
- Governments
- Health service providers delivering vaccinations
- Organizations of persons with disabilities
- Disability service providers
- Residential institutions and long-term care facilities
- Community

COVID-19

The document and considerations outlined were developed through a two-step approach including:

1. A rapid scoping review of literature to identify the potential barriers that persons with disabilities may face when accessing COVID-19 vaccination; and
2. An expert consultation process with WHO and UNICEF focal points for disability, immunization, ageing and mental health, as well as experts from other UN agencies. The draft document also received feedback from civil society organizations, including non-governmental organizations and organizations of persons with disabilities.

It is essential that all actions to prevent and contain the spread of virus (e.g. mask use, physical distancing, etc.) continue to be inclusive of persons with disabilities, especially in the early phases of vaccine roll-out when immunization is not widespread. All stakeholders should take steps to ensure that information shared about vaccination against COVID-19 is accurate and from reputable sources (such as health-care providers), and that misinformation, where present, is addressed.

(Further information is available at: https://www.who.int/emergencies/diseases/novel-coronavirus-2019.)

Why does disability need to be considered in COVID-19 vaccination?

Persons with disabilities are disproportionately impacted by COVID-19, both directly because of infection, and indirectly because of restrictions to reduce the spread of the virus *(3)*. Persons with disabilities are a diverse group, and the risks, barriers and impacts faced by them will vary in different contexts according to, among other factors, their age, gender identity, type of disability, ethnicity, sexual orientation, and migration status.

1. Persons with disabilities are at greater risk of contracting COVID-19 due to:

- barriers to implementing basic hygiene measures; for example, handbasins, sinks or water pumps for handwashing may be physically inaccessible, or a person may have physical difficulty rubbing their hands together thoroughly when washing;
- difficulty enacting physical distancing; this is especially relevant for people who require physical assistance and/or are living in residential institutions which may have the added challenges of staff shortages and infection control;
- a reliance on touch to obtain information from the environment (e.g. for those who are blind or deafblind) or for physical support (e.g. for those with physical disabilities); and
- physical, attitudinal, and communication barriers which reduce their access to COVID-19 public health information *(4)*.

These risks may be further increased in resource-limited and humanitarian contexts where persons with disabilities live in crowded shelters or accommodation; have reduced access to water, sanitation, and hygiene facilities; where public health information is available in limited formats; or where supplies of personal protective equipment (PPE) may be limited *(5)*.

2. Persons with disabilities may be at greater risk of severe disease and death if they become infected with COVID-19 due to:

- health conditions that underlie their disability *(6, 7)*; and
- barriers to accessing appropriate and timely health care, which arise from difficulty in communicating symptoms; inaccessibility of transportation, health facilities and telehealth services; gaps in support and assistant services *(4)*; and discriminatory triage procedures *(3)*. These barriers may also reduce access to vaccination for persons with disabilities.

COVID-19

3. Persons with disabilities may be at risk of new or worsening health conditions due to:

- health facilities prioritizing the treatment and support of those with COVID-19 over the treatment of other health conditions; and
- disruptions in support and assistance services, and efforts to reduce potential exposure to the virus; these may result in fewer opportunities for persons with disabilities to exercise, interact with others, or continue regular health management, all of which can be detrimental to their mental health and well-being *(3)*.

The experience of COVID-19 for women and girls with disabilities is shaped by both gender- and disability-related factors. Gender-related barriers reduce access to health care, testing and vaccination for women and girls *(1, 8)*. Furthermore, not only may women with disabilities face the added risk of domestic violence, exacerbated by economic stress, health shocks and prolonged periods of isolation in confined spaces, they may also encounter reduced access to appropriate gender-based violence services. Isolation often experienced by persons with disabilities is also encountered by family caregivers, who are predominantly women and girls *(9)*.

(Further information is available at: Policy brief: a disability-inclusive response to COVID-19.)

The actions for different stakeholders to consider when ensuring equitable access to vaccination against COVID-19 include the following:

Actions for persons with disabilities and their support networks:[1]

- Seek information about the vaccine and vaccination processes from reputable sources, such as your health-care provider. Participate in discussion groups and online information sessions to learn more about the vaccine, in your local language.
- Consult with your doctor about the criteria for vaccination and any relevant underlying health conditions which may put you at greater risk of developing severe COVID-19-related illness or add to the risk of experiencing side effects (e.g. if you have a history of severe allergic reactions to specific ingredients in the vaccine).
- Maintain regular contact with your local health provider, through telehealth or home visit services, where available, to obtain information about vaccination activities and schedules.
- Discuss with health-care providers the barriers you may face in reaching the vaccination site, and determine appropriate strategies to address this. If required, identify individuals in your support network (e.g. family members and assistants) who might be available at short notice to assist you to reach and navigate the vaccination site.
- Connect with local disability organizations, including organizations of persons with disabilities and disability service providers, that can support you in identifying accessible vaccination sites, and assist with transportation or self-advocacy, where needed.
- If you experience or witness discrimination when accessing vaccination, report this through appropriate feedback mechanisms or to your local organization for persons with disabilities.

1 Support networks include personal assistants, family caregivers, interpreters, guides and other people who provide support and who play a key role in the health, dignity, and well-being of persons with disabilities *(10)*.

COVID-19

Actions for governments:

- Consider persons with disabilities according to WHO guidance when prioritizing sociodemographic groups for initial phases of immunization. Prioritize older persons with disabilities and persons with disabilities with relevant underlying health conditions, and consider staff working for disability support services[2] when prioritizing frontline workers in health and social care settings. (Further information is available at: WHO SAGE roadmap for prioritizing uses of COVID-19 vaccines in the context of limited supply.)
- Consult with persons with disabilities, their support networks, and representative organizations when developing and implementing an NDVP to identify and address barriers to accessing vaccination activities. Specific attention needs to be given to identifying and consulting with marginalized groups, who may face different barriers in different contexts according to, among other factors, their age, gender identity, type of disability, ethnicity, sexual orientation, and migration status.
- Include persons with disabilities, including those living in residential institutions, in estimations of different target populations. Estimates may already exist through census data and national disability surveys; or the global estimate (15% of any population having some form of disability) could be used *(11)*. It is important to note that the prevalence of disability may be higher in humanitarian contexts *(12)*, as well as among women and older persons *(11)*.
- Ensure that immunization monitoring systems collect age, sex, and disability disaggregated data[3] to measure equitable uptake and coverage over time by geography, population group, and risk group *(1)*.
- Provide information about the vaccine, as well as vaccination prioritization, registration, and other processes, in a range of accessible formats and languages, including sign languages (see Box 1. Accessible information and communication about vaccination against COVID-19).
- Work with communities and organizations of persons with disabilities to identify and address any stigma and misconceptions that may prevent persons with disabilities from accessing vaccination (e.g. perceptions that persons with disabilities do not need vaccination or are at greater risk of side effects).

2 Examples of disability support services include personal assistants, support staff for people with intellectual disabilities, and sign language interpreters.

3 See the Washington Group on Disability Statistics and the WHO Model Disability Survey for more information.

COVID-19

- Provide clear and accessible messaging on the criteria used for prioritization of vaccination, noting that decisions should not be based on assumptions or bias, including regarding the quality of life of persons with disabilities *(4)*.
- Ensure accessibility of a feedback mechanism whereby community members can report concerns relating to vaccination discrimination, access, miscommunication, or misinformation, and any experiences of abuse.

COVID-19

Box 1.
Accessible information and communication about vaccination against COVID-19: actions for relevant stakeholders

- Provide captioning and national sign language interpretation for live and recorded events and communications, such as national addresses, press briefings, live social media, and public awareness campaigns.
- Convert information about the vaccination process into "Easy Read" and pictorial formats, so that they are accessible for persons with intellectual or cognitive impairments and those who are illiterate.
- Produce written information products in screen-reader accessible formats (such as "Word"), with structured headings, colour contrast, large print, braille versions and other formats for people who are deafblind.
- Use alternative text for images, photographs, and illustrations in documents or on social media.
- Information telephone lines should include options for video-calling, video-relay, and text messaging to ensure these are accessible for people who are deaf or hard of hearing.
- Represent persons with disabilities in a positive way – as empowered members of their community – in images, photographs, videos and illustrations relating to vaccination.
- Conduct discussion groups with women, men, and gender-diverse persons with disabilities which can be held online and in physically-distanced settings, to share information in local languages, including sign languages, and answer specific questions. Consider other information channels that may be accessed by those who are isolated in their home.
- Work with local organizations, including organizations of persons with disabilities, and disability service providers to disseminate information to persons with disabilities and appropriate support networks. This is especially relevant for persons with disabilities from resource-limited settings, women and older people with disabilities who may lack the infrastructure, devices, financial resources, or digital literacy to access information through online and mobile modalities.
- Consider information channels for children with disabilities, their parents/caregivers and families who may not be reached through school-based awareness raising; and people living in residential institutions who may not be reached through public health information campaigns.

Actions for health service providers delivering vaccinations:[4]

- Build partnerships with local disability organizations, including organizations of persons with disabilities and disability service providers, to share vaccination information with persons with disabilities and obtain advice on context-specific strategies to address barriers identified.
- Provide accessible targeted information for persons with disabilities and their support networks about the COVID-19 vaccine and vaccination processes, so that they can decide whether to proceed with vaccination and know how to access it.
- Integrate modules on disability inclusion and accessibility into all training for health workers on vaccination registration and delivery, including communication and informed consent processes with persons with disabilities (see Box 2. Free and informed consent for vaccination). Address negative attitudes and assumptions which could lead to discrimination.
- Recruit persons with disabilities who have appropriate qualifications or training as staff members in the vaccination programme; they can be key vaccine messengers for other persons with disabilities and the entire community.

Box 2.
Free and informed consent for vaccination

As a basic right available to all persons, persons with disabilities have the right to choose or reject health services (unless otherwise provided for by law in a particular country). Health workers should ensure they have full and informed consent from a person with disability prior to providing the vaccination. Some persons with disabilities may require information in different formats and languages, including sign languages; and/or a support person (chosen by the individual) to assist them in understanding the options, risks, and benefits of vaccination. "Easy Read" materials and other visual tools should be made available, to help explain the vaccination process and to support informed consent.

4 *The Disability Inclusive Health Services Toolkit* provides practical guidance for managers and staff of health-care facilities and services, health policy-makers, and nongovernmental organizations on identifying and addressing barriers to health information and services. https://iris.wpro.who.int/handle/10665.1/14639

- Make vaccination registration processes and forms screen-reader accessible; and provide options for telephone registration, video-relay, national sign language interpretation, and COVID-safe in-person registration.
- Conduct an accessibility audit of potential vaccination sites, involving organizations of persons with disabilities, to identify barriers and appropriate strategies, including transportation access and availability (see Box 3. Considerations for a barrier-free vaccination site).
- Ensure that local sign language interpretation services are made available at vaccination sites, and that information is available in a range of formats (see Box 1. Accessible information and communication about vaccination against COVID-19).

Box 3. Considerations for a barrier-free vaccination site

- Consult with national or local organizations of persons with disabilities to identify the potential barriers to accessing vaccination sites, as well as context-appropriate strategies and resources to address these barriers.
- Provide safe and accessible transportation to persons with disabilities and their support people to vaccination sites, noting that some may require modified transportation, extra travel time or financial support.
- Ensure that vaccination sites are accessible to wheelchair users, with appropriate ramps, rails, and space for them to move independently, and wheelchair accessible water and sanitation facilities. Tactile markers on floors and walls may also assist people with vision impairments to move around health facilities. Further information about accessibility and Universal Design is available at: http://universaldesign.ie/what-is-universal-design/
- Ensure that there is enough space for persons with disabilities to attend with support people, assistants, and service animals (as per national regulations).
- Provide home visit or mobile clinic options for individuals who cannot safely travel to the vaccination site.

Actions for organizations of persons with disabilities:

- Consult with the Ministry of Health and other relevant government agencies about how you can contribute to the development, implementation, or revision of the NDVP, including through participation in relevant advisory bodies and working groups.
- Establish a strategy to ensure that women, men, and people of diverse gender identities, of different ages and different types of disabilities are represented in any advocacy on vaccination against COVID-19. Consider that vaccination activities, as well as the barriers faced, will vary among rural and urban settings, and among migrant populations and displaced persons.
- Share information about vaccination prioritization and schedules with your members and their support networks. Collaborate with health providers to conduct information sessions with your members, either online or in physically-distanced settings, so that they can ask questions and learn more about the planned activities.
- Create a list of organizations that may be able to assist with transportation, telephone credit, PPE, and other support for persons with disabilities to successfully register for vaccination and then access vaccination sites.
- Raise awareness among persons with disabilities and their support networks about their rights, the principles of equal access, and informed consent processes (see Box 2. Free and informed consent for vaccination). Gather information about barriers to access and freedom of choice for future advocacy and human rights monitoring.

Actions for disability service providers:

- Consult with the Ministry of Health and other relevant government agencies about how you can contribute to the development, implementation or revision of the NDVP. In some settings (and dependent on availability), disability service providers may have accessible spaces available which can be equipped as COVID-19 vaccination sites.
- Share information about vaccination prioritization and schedules with your clients and their families/caregivers. Collaborate with health providers to conduct information sessions with your clients, either online or in physically-distanced settings, so that they can ask questions and learn more about the vaccination process.
- Support clients who are interested in registering for vaccination, either by coordinating directly with immunization programmes or by providing for communication costs.
- Where possible, facilitate transport for persons with disabilities, and their support persons to attend vaccination sites.

Actions for residential institutions and long-term care facilities:

- Consult with the Ministry of Health, through professional bodies as appropriate, on the initial phases of the vaccination schedule for staff and residents.
- Share information about the COVID-19 vaccine and vaccination processes with your staff and residents, including their families and support networks.
- Offer residents medical consultations so they can learn more about the criteria for vaccination and any underlying health conditions that may be relevant – i.e. conditions that may put them at greater risk of developing severe COVID-19-related illness or of experiencing side effects (e.g. if they have a history of severe allergic reactions to specific ingredients in the vaccine).
- Ensure that telehealth services are accessible to residents with different types of impairments, maintaining privacy and promoting autonomy and freedom of choice.
- Support residents who want to register for vaccination and then with transportation to vaccination sites. Discuss with health-care providers if home visits or mobile clinic options are available for individuals who cannot safely travel to the vaccination site.
- Establish or strengthen protection-monitoring mechanisms to ensure that violence, abuse, and neglect, as well as other coercive measures, are not being used or escalated as vaccination against COVID-19 is being rolled out. Ensure that the existing mechanisms for monitoring and complaints remain functioning and effective *(4)*.

Actions for the community:

- Be informed of the facts; learn these from trusted sources (e.g. health professionals), and do not spread misinformation related to COVID-19 vaccination *(13)*.
- Check in regularly with persons with disabilities within your social network to see if they have received information about vaccination activities, respecting any physical distancing restrictions that may be in place.
- Where possible and if requested, provide practical support for persons with disabilities to successfully register and then access vaccination sites (e.g. transportation).
- Address negative attitudes and assumptions which could lead to discrimination towards persons with disabilities during the vaccination phase. Discuss and challenge gender stereotypes that could lead families to deprioritize women, girls, and gender-diverse persons with disabilities for health care and vaccination.
- Continue to follow the guidance prepared by WHO on basic protection measures against COVID-19. It will take some time before immunization is widespread. The risk of contracting COVID-19 must be taken seriously; even if you, yourself, may not be at high risk of serious illness, you may pass on the virus to someone who is at risk and is unvaccinated.

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World Health Organization

unicef for every child

WHO reference number: WHO/2019-nCoV/Vaccination_and_disability/Policy_brief/2021.1

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IN THE SUPREME COURT OF INDIA

CIVIL ORIGINAL JURISDICTION

I.A. NO. _____ OF 2021

IN

SUO MOTU WRIT PETITION (C) NO.3 OF 2021

IN THE MATTER OF:

IN RE: DISTRIBUTION OF ESSENTIAL SUPPLIES AND SERVICES DURING PANDEMIC

IN THE MATTER OF:

KARNATAKA RAJYA VIKALACHETHANARA
RAKSHANA SAMITHI
#3/6, MODULIAR COMPOUND, 2ND MAIN ROAD,
CHAMARAJPET, BANGALORE-560018 ...INTERVENOR/APPLICANT

APPLICATION ON BEHALF OF APPLICANT SEEKING EXEMPTION FROM FILING DULY ATTESTED AFFIDAVIT

TO,

THE HON'BLE CHIEF JUSTICE
AND HIS COMPANION JUDGES OF
THE HON'BLE SUPREME COURT OF INDIA

THIS HUMBLE APPLICATION ON BEHALF OF APPLICANTS / INTERVENORS

MOST RESPECTFULLY SHOWETH:

1. That the Intervenor in the instant case seeks to intervene in order to bring to the notice of this Hon'ble Court the issues of persons with disabilities in procuring vaccines, which have not been taken into account by the central government.

2. That the Intervenor/Applicant craves leave of this Hon'ble Court to refer to and rely upon the contents of the accompanying application.

3. That due to the situation prevailing on account of corona virus pandemic, the authorized representative of the Intervenor/Applicant is unable to get his Affidavit duly attested / notarized. Accordingly, the Intervenor/Applicant is constrained to file the non-attested signed affidavit in support of the present application.

4. That in the light of the above-mentioned facts and circumstances, which are beyond the control of the Intervenor/Applicant, it is imperative that the Intervenor/Applicant is exempted from filing the duly attested Affidavit in support of the present application.

5. That the present application is made *bonafide* and deserves to be allowed in the interest of justice.

PRAYER

It is, therefore, most respectfully prayed that this Hon'ble Court may graciously be pleased to allow this application; and

(i) Exempt the Intervenor/Applicant from filing of the duly attested original Affidavit; AND

(ii) Pass such order(s) as this Hon'ble Court may deem fit and proper in the facts and circumstances of the present case.

AND FOR THIS ACT OF KINDNESS THE APPLICANT AS IN DUTY BOUND SHALL EVER PRAY.

FILED BY:

[KUMAR DUSHYANT SINGH]
ADVOCATE FOR THE INTERVENOR/APPLICANT

NEW DELHI
FILED ON: 02.06.2021

VAKALATNAMA

IN THE SUPREME COURT OF INDIA
CIVIL ORIGINAL JURISDICTION
I.A. NO. _____ OF 2021
SUO MOTU WRIT PETITION (C) NO. 3 OF 2021

IN THE MATTER OF:
IN RE : DISTRIBUTION OF ESSENTIAL SUPPLIES AND SERVICES DURING PANDEMIC

AND IN THE MATTER OF:
KARNATAKA RAJYA VIKALACHETHANARA RAKSHANA SAMITHI
3/6 1ST FLOOR, MADALIYAR COMPOUND, IIND MAIN,
AZAD NAGAR BANGALORE-560018,
THROUGH ITS PRESIDENT

...INTERVENOR/APPLICANT

I, CHANDRASHEKAR PUTTAPPA, PRESIDENT, KARNATAKA RAJYA VIKALACHETHANARA RAKSHANA SAMITHI, REGD. OFFICE AT : 3/6, 1ST FLOOR, MADALIYAR COMPOUND, IIND MAIN, AZAD NAGAR BANGALORE-560018, APPLICANT/INTERVENOR in the above Intervening Application do hereby appoint and retain:-

[KUMAR DUSHYANT SINGH]
ADVOCATE ON RECORD
27, LAWYERS CHAMBER,
SUPREME COURT OF INDIA
NEW DELHI: 110001
TEL: 011-41033999 (M) 9717268550

To act an appear for me/us in the above Suit Appeal/Petition/Reference and on my/our behalf of conduct and prosecute (or defend) the same and all proceedings that may be taken in respect of any application connected with the same of any decree or order passed therein. Including proceedings in taxation and application for Review to file and obtain return of documents and the deposit and receive money on my/our behalf is said Suit Appeal/Petition/Reference and in applications of Review, and to represent me/us and to take all necessary steps on my/our behalf in the above matter. I/we agree to ratify all acts done by the aforesaid Advocate in pursuance of the authority.

Dated this the 26 day of May, 2021

For **KARAAVIRS (R)**

[Client(s)]

Working President
KARAAVIRS (R)
3/6, Moduliar Compound,
2nd Main Road, Chamarajpet,
Bangalore - 560 018.

ACCEPTED, CERTIFIED & IDENTIFIED BY:

[KUMAR DUSHYANT SINGH]
ADVOCATE ON RECORD
27, LAWYERS CHAMBER,
SUPREME COURT OF INDIA
NEW DELHI: 110001

ADVOCATES WELFARE FUND DELHI Rs.5 1585130 FIVE RUPEES

MEMO OF APPEARANCE

To
The Registrar,
Supreme Court of India,
New Delhi.

ADVOCATES WELFARE FUND DELHI Rs.10 0817739 TEN RUPEES

ADVOCATES WELFARE FUND DELHI Rs.10 0817731 TEN RUPEES

Sir,

Please enter my appearance for the aforementioned petitioner(s)/Appellant(s)/ Respondent(s) in the aforesaid case.
Thanking you,

Yours faithfully

[KUMAR DUSHYANT SINGH]
ADVOCATE FOR THE APPLICANT/INTERVENOR

Date: 01.06.2021

ನೋಂದಣಿ ಸಂಖ್ಯೆ: ಡಿಆರ್‌ಬಿ-ಪಿ/ಎಸ್‌ಓಆರ್/73/2011-12

KARNATAKA RAJYA VIKALACHETHANARA RAKSHANA SAMITHI (R)
[ರಾಜ್ಯ ಮಟ್ಟದ ವಿಕಲಚೇತನರ ಪರ ಸಮಾನ ಹಕ್ಕು ಮತ್ತು ಅವಕಾಶಗಳ ರಕ್ಷಣಾ-ಶ್ರಯಾಸಮಿತಿ
ಹಾಗೂ ರಾಜ್ಯ ವಿಕಲಚೇತನರ ಪರ ವಿವಿಧೋದ್ದೇಶ ಮಹಾ ಸಂಘಟನೆಗಳ (ಸಮನ್ವಯ) ಒಕ್ಕೂಟ.]

Ref: KARAAVIRS/570/05/2021-22

Dated: 21-05-2021
BANGALORE.

TO WHOMSOEVER THIS MAY CONCERN

AUTHORIZATION to Mr. Chandrashekar Puttappa

Resolved That, Mr. Chandrashekar Puttappa as the Working President of the **KARNATAKA RAJYA VIKALACHETHANARA RAKSHANA SAMITHI ®** be and is authorized to represent the trust in all Courts of law in India including all the High Courts and the Supreme Court of India, all judicial bodies and to deal with matters connected with any litigation in all Courts/Tribunals/Quasi-judicial bodies in India.

RESOLVED FURTHER THAT Mr. Chandrashekar Puttappa be and is authorized to engage Advocates to represent the **KARNATAKA RAJYA VIKALACHETHANARA RAKSHANA SAMITHI ®** and to issue, sign and submit all documents, affidavits and Vakalatnamas, memoranda, powers of attorney and execute all documents in related matters in the matter to be filed before the Hon'ble Supreme Court of India.

for Karnataka Rajya Vikalachethanara Rakshana Samithi®

(N.Harinath)
General Secretary
Gen. Secretary

For KARAAVIRS (R)

(Chandrashekar Puttappa)
Working President
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