From

Director General health Services
Haryana, Panchkula.

To

All Civil Surgeons
Haryana.

No. 32/3-IDSP-2020/ 2299-2320 **Date:** 23-04-2020

Subject: **Regarding visit of Centre Rapid Response team to State.**

In reference to the subject cited above, a team consisting of three doctors i.e. Dr. Anil Kumar, DDG, Dte. GHS, Dr. J.K. Saini, Respiratory Physician, NITRD and Dr. Gavish Kumar, Microbiologist, NITRD visited state head quarter on dated 19 April 2020 and in affected districts i.e. Ambala, Panchkula, Karnal, etc. They have acknowledged the activities done in the containment zone and recommended the following points after inspection and discussion with State Health Authorities.

1. The initial survey in the containment zone should be completed in **2 to 3 days**. For this district authorities should deploy **additional field staff (if required) for active surveillance** in containment zones. The next survey in the same zone will be done after **5 to 7 days** after the completion of initial survey. Surveillance by the field staff in the containment zones will done as per **GOI guidelines** (Copy attached) by visiting each and every house needs to be implemented.
2. Districts with low prevalence of COVID-19 should survey the whole population with support of field staff and prepare themselves for high quality surveillance in venerable population like migratory population which can have increased incidence of COIVD-19.
3. Civil Surgeon to have regular meeting with the Officials of Community Medicine Department of the Medical Colleges for better coordination. Responsibility of **high-quality data analysis and interpretation** should be done by the Community Medicine Department of the Medical Colleges.
4. Need to encourage use of information technology and recent tools and technique in public health at district level.
5. Strict adherence to **infection prevention and control practices at all levels of Health Care delivery system** should be ensured by the district authorities.
6. Need to **mobilize public health manpower** to support Civil Surgeons/ District Surveillance Officers in districts. As directed vide Memo no. NHM/HR/A2/2020/ 11268-89 dated 04-04-2020 (letter attached herewith).
7. Mobilization of **District Rapid Response Team** vide letter no. 32/3-I/DSP-2020/2081-2102 dated 13-04-2020 (letter attached herewith).

So you are requested to execute the above recommendation of GOI team in your district.

Director Health Services (IDSP)
O/o Director General health Services
Haryana, Panchkula.

No. 32/3-IDSP-2020/ 2321 **Date:** 23-04-2020

A copy is forwarded to all District Surveillance Officers for information and necessary action.

Director Health Services (IDSP)
O/o Director General health Services
Haryana, Panchkula.

No. 32/3-IDSP-2020/ 2322 **Date:** 23-04-2020

A copy is forwarded to Additional Chief Secretary Health, to Govt. of Haryana for information please.

Director Health Services (IDSP)
O/o Director General health Services
Haryana, Panchkula.

[GOI Guidelines].

सत्यमेव जयते

Containment Plan

Novel Coronavirus Disease 2019

(COVID 19)

Ministry of Health & Family Welfare
Government of India

1. INTRODUCTION

1.1 Background

On 31st December 2019, the World Health Organization (WHO) China Country Office was informed of cases of pneumonia of unknown etiology (unknown cause) detected in Wuhan City, Hubei Province of China. On 7th January 2020, Chinese authorities identified a new strain of Coronavirus as the causative agent for the disease. The virus has been renamed by WHO as SARS-CoV-2 and the disease caused by it as COVID-19. The disease since its first detection has affected all the provinces of China and 40 other countries (including Hong Kong, Macau and Taiwan). As per WHO (as of 26th February, 2020), there has been a total of 81109 confirmed cases of COVID-19 worldwide including 78191 confirmed cases and 2718 deaths reported from China. Besides China, 2918 confirmed cases and 44 deaths have been reported from 37 countries.

In India, as on 26th February, 2020, three travel related cases (from Hubei province, China), were reported (all from Kerala). All these cases were clinically stable during the period of hospitalization and discharged as per the discharge policy.

1.2. Risk Assessment

The risk for spread has been assessed by World Health Organization and currently (as on 26th February, 2020) it is very high for China and high at regional and global levels. WHO on 30th January, 2020 declared the current novel coronavirus outbreak as a Public Health Emergency of International Concern (PHEIC). According to WHO, "all countries should be prepared for containment, including active surveillance, early detection, isolation and case management, contact tracing and prevention of onward spread of SARS-CoV-2 infection.

Clusters have appeared in many countries including USA, France, Germany and local transmission in Hong Kong, Singapore, Republic of Korea, Iran and Italy.

1.3. Epidemiology

Coronaviruses belong to a large family of viruses, some causing illness in people and others that circulate among animals, including camels, cats, bats etc. Rarely, animal corona viruses may evolve and infect people and then spread between people as witnessed during the outbreak of Severe Acute Respiratory Syndrome (SARS, 2003) and Middle East Respiratory Syndrome (MERS, 2014). The etiologic agent responsible for current outbreak of SARS-CoV-2 is a novel coronavirus is closely related to SARS-Coronavirus.

In humans, the transmission of SARS-CoV-2 can occur via respiratory secretions (directly through droplets from coughing or sneezing, or indirectly through contaminated objects or surfaces as well as close contacts). Nosocomial transmission has been described as an important driver in the epidemiology of SARS and MERS and has also documented in COVID-19.

Current estimates of the incubation period of COVID range from 2-14 days, and these estimates will be refined as more data become available. Most common symptoms include fever, fatigue, dry cough and breathing difficulty. Upper respiratory tract symptoms like sore throat, rhinorrhoea, and gastrointestinal symptoms like diarrhoea and nausea/ vomiting are seen in about 20% of cases.

Due to paucity of scientific literature based on community based studies, the available data on host factors is skewed towards cases requiring hospitalization. As per analysis of the biggest cohort reported by Chinese CDC, about 81% of the cases are mild, 14% require hospitalization and 5% require ventilator and critical care management. The deaths reported are mainly among elderly population particularly those with co-morbidities.

At the time of writing this document, many of the crucial epidemiological information particularly source of infection, mode of transmission, period of infectivity, etc. are still under investigation.

2. STRATEGIC APPROACH

India would be following a scenario based approach for the following possible scenarios:

i. Travel related case reported in India
ii. Local transmission of COVID-19
iii. Community Transmission of COVID-19 disease
iv. India becomes endemic for COVID-19

2.1. Strategic Approach for Current Scenario: "only travel related cases reported from India"

(i) Inter-ministerial coordination (Group of Ministers, Committee of Secretaries) and Centre-State Co-ordination been established.
(ii) Early Detection through Points of Entry (PoE) screening of passengers coming from China, Honk Kong, Indonesia, Japan, Malaysia, Republic of Korea, Singapore, Thailand and Vietnam through 21 designated airports, 12 major ports, 65 minor ports and 8 land crossings.
(iii) Surveillance and contact tracing through Integrated Disease Surveillance Programme (IDSP) for tracking travellers in the community who have travelled from affected countries and to detect clustering, if any, of acute respiratory illness.
(iv) Early diagnosis through a network of 15 laboratories of ICMR which are testing samples of suspect cases.
(v) Buffer stock of personal protective equipment maintained.
(vi) Risk communication for creating awareness among public to follow preventive public health measures.

2. 2. Local transmission of COVID-2019 disease

The strategy will remain the same as explained in para 2.1 as above. In addition cluster containment strategy will be initiated with:

- Active surveillance in containment zone with contact tracing within and outside the containment zone.
- Expanding laboratory capacity for testing all suspect samples and
- Establishing surge capacities for isolating all suspect / confirmed cases for medical care.
- Implementing social distancing measures.
- Intensive risk communication.

3. SCOPE OF THIS DOCUMENT

In alignment with strategic approach, this document provides action that needs to be taken for containing a cluster. The actions for control of large outbreaks will be dealt separately under a mitigation plan.

4. OBJECTIVES

The objective of cluster containment is to stop transmission, morbidity and mortality due to COVID-19.

5. CLUSTER CONTAINMENT

5.1. Definition of Cluster

A cluster is defined as 'an unusual aggregation of health events that are grouped together in time and space and that are reported to a health agency' (Source CDC). Clusters of human cases are formed when there is local transmission. The local transmission is defined as a laboratory confirmed case of COVID-19:

(i) Who has not travelled from an area reporting confirmed cases of COVID-19 or

(ii) Who had no exposure to a person travelling from COVID-19 affected area or other known exposure to an infected person

There could be single or multiple foci of local transmission. There may or may not be an epidemiological link to a travel related case.

5.2. Cluster Containment Strategy

The cluster containment strategy would be to contain the disease with in a defined geographic area by early detection, breaking the chain of transmission and thus preventing its spread to new areas. This would include geographic quarantine, social distancing measures, enhanced active surveillance, testing all suspected cases, isolation of cases, home quarantine of contacts, social mobilization to follow preventive public health measures.

5.3. Evidence base for cluster containment

Large scale measures to contain COVID-19 have been tried in China and Republic of Korea and also in countries that reported small clusters such as Germany, France, Singapore and Italy. Since COVID-19 is an airborne infection and there is efficient human to human transmission, success of containment operations cannot be guaranteed. Interventions to limit morbidity, mortality and social disruption associated with SARS in 2003 demonstrated that it was possible then to mobilize complex public health operation to contain SARS outbreak. Mathematical modeling studies suggest containment might be possible.

5.4. Factors affecting cluster containment

A number of variables determine the success of the containment operations. These are:

(i) Size of the cluster.
(ii) How efficiently the virus is transmitting in Indian population.
(iii) Time since first case/ cluster of cases originated. Detection, laboratory confirmation and reporting of first few cases must happen quickly.
(iv) Active case finding and laboratory diagnosis.
(v) Isolation of cases and quarantine of contacts.
(vi) Geographical characteristics of the area (e.g. accessibility, natural boundaries)
(vii) Population density and their movement (including migrant population).
(viii) Resources that can be mobilized swiftly by the State Government/ Central Government.
(ix) Ability to ensure basic infrastructure and essential services.

5.5. Assumptions

(i) The virus is not circulating in Indian Population.
(ii) Even if there is a global pandemic, there is large part of the country which remains unaffected and large population which remains susceptible.

6. ACTION PLAN FOR CLUSTER CONTAINMENT

6.1. Institutional mechanisms and Inter-Sectoral Co-ordination

At the National Level, the National Crisis Management Committee (NCMC) will be activated. The co-ordination with health and non-health sectors will be managed by NCMC, on issues, flagged by Ministry of Health. Ministry of Health and Family Welfare will activate its Crisis Management Plan.

The Concerned State will activate State Crisis Management Committee or the State Disaster Management Authority, as the case may be to manage the clusters of COVID-19.

There will be daily co-ordination meetings between the centre and the concerned State through video conference.

The State should review the existing legal instruments to implement the containment plan. Some of the Acts/ Rules for consideration could be (i) Disaster Management Act (2005) (ii) Epidemic Act (1897) (iii) Cr.PC and (iv) State Specific Public Health Acts.

6.2. Trigger for Action

The trigger could be the IDSP identifying a cluster of Influenza like Illness (ILI) or Severe Acute Respiratory syndrome (SARI), which may or may not have epidemiological linkage to a travel related case. It could also be through other informal reporting mechanisms (Media/ civil society/ hospitals (government / private sector) etc. The State will ensure early diagnosis through the ICMR/VRDL (Virus Research and Diagnostic Laboratory) Network. A positive case will trigger a series of actions for containment of the cluster.

6.3. Deployment of Rapid Response Teams (RRT)

Emergency Medical Relief (EMR) division, Ministry of Health and Family Welfare will deploy the Central Rapid Response Team (RRT) to support and advice the State. The State will deploy its State RRT and District RRT.

6.4. Identify geographically-defined Containment zone and Buffer zone

6.4.1. Containment zone

The containment zone will be defined based on:

(i) The index case / cluster, which will be the designated epicenter
(ii) The listing and mapping of contacts.
(iii) Geographical distribution of cases and contacts around the epicenter.
(iv) Administrative boundaries within urban cities /town/ rural area.

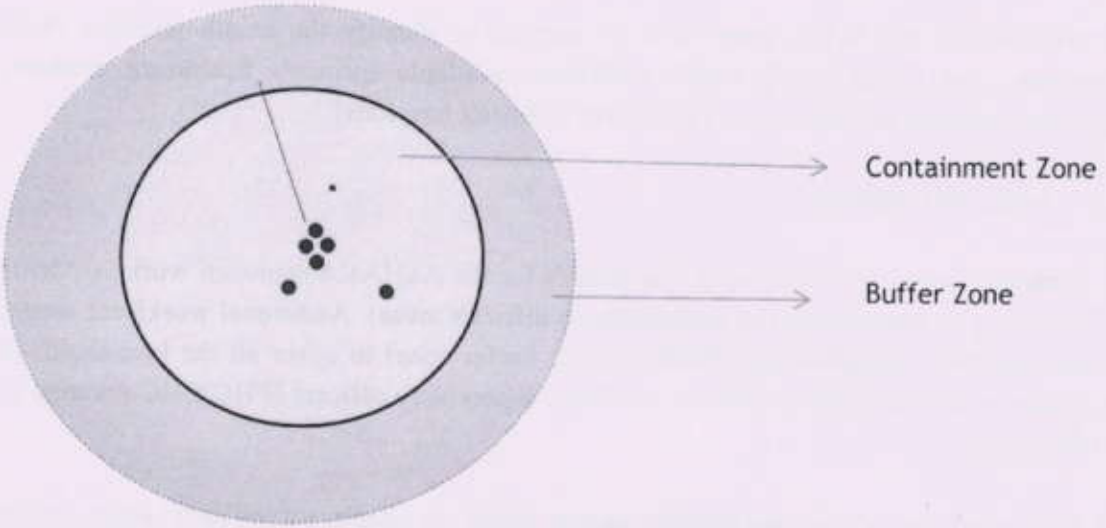
The RRT will do listing of cases, contacts and their mapping. This will help in deciding the perimeter for action. The decision of the geographic limit and extent of perimeter control will be that of the State Government. However, likely scenarios and possible characteristics of the containment and buffer zone are given in Table-1.

Table 1: Scenarios for determining containment and buffer zones

S. No.	Scenario	Containment zone characteristics
1	A small cluster in closed environment such as residential schools, military barracks, hostels or a hospital.	Containment zone will be determined by the mapping of the persons in such institution including cases and contacts. A buffer zone of additional 5 Km radius*will be identified.
2	Single cluster in a residential colony	Administrative boundary of the residential colony and a buffer zone of additional 5 Km radius.*
3	Multiple clusters in communities (residential colony, schools, offices, hospitals etc.) with in an administrative jurisdiction	Administrative boundary of the urban district and a buffer zone of neighboring urban districts.
4	Multiple clusters spatially separated in different parts administrative districts of a city	Administrative boundary of city/ town and congruent population in the peri-urban areas as the buffer zone.**
5	Cluster in a rural setting	3 Km radius of containment zone and additional 7 Kms radius of buffer zone.

* The perimeter of the containment zone will be determined by the continuous real time risk assessment.

** The decision to follow a containment protocol will be based on the risk assessment and feasibility of perimeter control.



The Central RRT will help the State/ District administration in mapping the Containment Zone.

If the epidemiological assessment process is to take time (>12-24 hrs), then a containment zone of 3 Kms and a buffer zone of 7 Kms will be decided which may be subsequently revised, if required, based on epidemiologic investigation. Except for rural settings.

6.4.2. Buffer zone

Buffer zone is an area around the containment zone, where new cases are most likely to appear. There will not be any perimeter control for the buffer zone. The activities of buffer zone are listed under paragraph 7.2.

6.4.3. Perimeter

Perimeter of the containment zone will be decided by the District administration based on criteria defined in Para 6.4.1. Clear entry and exit points will be established. The perimeter controls that need to be applied is in para 7.3.

7. SURVEILLANCE

7.1. Surveillance in containment zone

7.1.1. Contact listing

The RRTs will list the contacts of the suspect / laboratory confirmed case of COVID-19. The District Surveillance Officer (in whose jurisdiction, the laboratory confirmed case/ suspect case falls) along with the RRT will map the contacts to determine the potential spread of the disease. If the residential address of the contact is beyond that district, the district IDSP will inform the concerned District IDSP/State IDSP.

7.1.2. Mapping of the containment and buffer zones

The containment and buffer zones will be mapped to identify the health facilities (both government and private) and health workforce available (primary healthcare workers, Anganwadi workers and doctors in PHCs/CHCs/District hospitals).

7.1.3. Active Surveillance

The residential areas will be divided into sectors for the ASHAs/Anganwadi workers/ANMs each covering 50 households (30 households in difficult areas). Additional workforce would be mobilized from neighboring districts (except buffer zone) to cover all the households in the containment zone. This workforce will have supervisory officers (PHC/CHC doctors) in the ratio of 1:4.

The field workers will be performing active house to house surveillance daily in the containment zone from 8:00 AM to 2:00 PM. They will line list the family members and those having symptoms. The field worker will provide a mask to the suspect case and to the care giver identified by the family. The patient will be isolated at home till such time he/she is examined by the supervisory officer. They will also follow up contacts identified by the RRTs within the sector allocated to them.

All ILI/SARI cases reported in the last 14 days by the IDSP in the containment zone will be tracked and reviewed to identify any missed case of COVID-19 in the community.

Any case falling within the case definition will be conveyed to the supervisory officer who in turn will visit the house of the concerned, confirm that diagnosis as per case definition and will make arrangements to shift the suspect case to the designated treatment facility. The supervisory officer will collect data from the health workers under him/ her, collate and provide the daily and cumulative data to the control room by 4.00 P.M. daily.

7.1.4 Passive Surveillance

All health facilities in the containment zone will be listed as a part of mapping exercise. All such facilities both in Government and private sector (including clinics) shall report clinically suspect cases of COVID-19 on real time basis (including 'Nil' reports) to the control room at the district level.

7.1.5. Contact Tracing

The contacts of the laboratory confirmed case/ suspect case of COVID-19 will be line-listed and tracked and kept under surveillance at home for 28 days (by the designated field worker). The Supervisory officer in whose jurisdiction, the laboratory confirmed case/ suspect case falls shall inform the Control Room about all the contacts and their residential addresses. The control room will in turn inform the supervisory officers of concerned sectors for surveillance of the contacts. If the residential address of the contact is beyond the allotted sector, the district IDSP will inform the concerned Supervisory officer/concerned District IDSP/State IDSP.

7.2. Surveillance in Buffer zone

The surveillance activities to be followed in the buffer zone are as follows:

i. Review of ILI/SARI cases reported in the last 14 days by the District Health Officials to identify any missed case of COVID-19 in the community.
ii. Enhanced passive surveillance for ILI and SARI cases in the buffer zone through the existing Integrated Disease Surveillance Programme.
iii. In case of any identified case of ILI/SARI, sample should be collected and sent to the designated laboratories for testing COVID-19.

All health facilities in the buffer zone will be listed as a part of mapping exercise. All such facilities both in Government and private sector (including clinics) shall report clinically suspect cases of COVID-19 on real time basis (including 'Nil' reports) to the control room at the district level. Measures such as personal hygiene, hand hygiene, social distancing to be enhanced through enhanced IEC activities in the buffer zone.

7.3. Perimeter Control

The perimeter control will ensure that there is no unchecked outward movement of population from the containment zone except for maintaining essential services (including medical emergencies) and government business continuity. It will also limit unchecked influx of population into the containment zone. The authorities at these entry points will be required to inform the incoming travelers about precautions to be taken and will also provide such travelers with an information pamphlet and mask.

All vehicular movement, movement of public transport and personnel movement will be restricted. All roads including rural roads connecting the containment zone will be guarded by police.

The District administration will post signs and create awareness informing public about the perimeter control. Health workers posted at the exit point will perform screening (e.g. interview travelers, measure temperature, record the place and duration of intended visit and keep complete record of intended place of stay).

Details of all persons moving out of perimeter zone for essential/ emergency services will be recorded and they will be followed up through IDSP. All vehicles moving out of the perimeter control will be decontaminated with sodium hypochlorite (1%) solution.

8. LABORATORY SUPPORT

8.1 Designated laboratories

The identified VRDL network laboratory, nearest to the affected area, will be further strengthened to test samples. The other available govt. laboratories and private laboratories (BSL 2 following BSL 3 precautions) if required, shall also be engaged to test samples, after ensuring quality assurance by ICMR/VRDL network. If the number of samples exceeds its surge capacity, samples will be shipped to other nearby laboratories or to NCDC, Delhi or NIV, Pune or to other ICMR lab networks depending upon geographic proximity.

All test results should be available within 12 hours of sampling. ICMR along with the State Government will ensure that there are designated agencies for sample transportation to identified laboratories. The contact number of such courier agencies shall be a part of the micro-plan.

The designated laboratory will provide daily update (daily and cumulative) to District, State and Central Control Rooms on:

i. No. of samples received
ii. No. of samples tested
iii. No. of samples under testing

iv. No. of positive samples

8.2 Testing criteria

All suspect cases conforming to the case definition will be tested. The testing of suspect cases in the containment and buffer zones will continue till 14 days from the date, the last confirmed case is declared negative by laboratory test.

9. HOSPITAL CARE

All suspect cases detected in the containment/buffer zones (till a diagnosis is made), will be hospitalized and kept in isolation in a designated facility till such time they are tested negative. Persons testing positive for COVID-19 will remain to be hospitalized till such time 2 of their samples are tested negative as per MoHFW's discharge policy. About 15% of the patients are likely to develop pneumonia, 5 % of whom requires ventilator management. Hence dedicated Intensive care beds need to be identified earmarked. Some among them may progress to multi organ failure and hence critical care facility/ dialysis facility/ and Salvage therapy [Extra Corporeal Membrane Oxygenator (ECMO)] facility for managing the respiratory/renal complications/ multi-organ failure shall be required. If such facilities are not available in the containment zone, nearest tertiary care facility in Government / private sector needs to be identified, that becomes a part of the micro-plan.

9.1 Surge capacity

Based on the risk assessment, if the situation so warrants (data suggested an exponential rise in the number of cases), the surge capacity of the identified hospitals will be enhanced, private hospitals will be roped in and sites for temporary hospitals identified and it's logistic requirements shall be worked out.

9.2 Pre-hospital care (ambulance facility)

Ambulances need to be in place for transportation of suspect/confirmed cases. Such ambulances shall be manned by personnel adequately trained in infection prevention control, use of PPE and protocol that needs to be followed for disinfection of ambulances (by 1% sodium hypochlorite solution using knapsack sprayers).

9.3 Infection Prevention Control Practices

Nosocomial infection in fellow patients and attending healthcare personnel are well documented in the current COVID-19 outbreak as well. There shall be strict adherence to Infection prevention control practices in all health facilities. IPC committees would be formed (if not already in place) with the mandate to ensure that all healthcare personnel are well aware of IPC practices and suitable arrangements for requisite PPE and other logistic (hand sanitizer, soap, water etc.) are in place. The designated hospitals will ensure that all healthcare staff is trained in washing of hands, respiratory etiquettes, donning/doffing & proper disposal of PPEs and bio-medical waste management.

At all times doctors, nurses and para-medics working in the clinical areas will wear three layered surgical mask and gloves. The medical personnel working in isolation and critical care facilities will wear full complement of PPE (including N95 masks).

The support staff engaged in cleaning and disinfection will also wear full complement of PPE. Environmental cleaning should be done twice daily and consist of damp dusting and floor mopping with Lysol or other phenolic disinfectants and cleaning of surfaces with sodium hypochlorite solution. Detailed guidelines available on MoHFW's website may be followed.

10. CLINICAL MANAGEMENT

10.1. Clinical Management

The hospitalized cases may require symptomatic treatment for fever. Paracetamol is the drug of choice. Suspect cases with co-morbid conditions, if any, will require appropriate management of co-morbid conditions.

For patients with severe acute respiratory illness (SARI), having respiratory distress may require, pulse oxymetry, oxygen therapy, non-invasive and invasive ventilator therapy. Detailed guidelines available on MoHFW's website and updated from time to time, may be followed.

10.2. Discharge Policy

Discharge policy for suspected cases of COVID-19 tested negative will be based on the clinical assessment of the treating physician. For those tested positive for COVID-19, their discharge from hospital will be governed by consecutive two samples tested negative and the patient is free from symptoms.

11. PHARMACEUTICAL INTERVENTIONS

As of now there is no approved drug or vaccine for treatment of COVID-19.

12. NON-PHARMACEUTICAL INTERVENTIONS

In the absence of proven drug or vaccine, non-pharmaceutical interventions will be the main stay for containment of COVID-19 cluster.

12.1. Preventive public health measures

There will be social mobilization among the population in containment and buffer zone for adoption of community-wide practice of frequent washing of hands and respiratory etiquettes in schools, colleges, work places and homes. The community will also be encouraged to self-

monitor their health and report to the visiting ASHA/Anganwadi worker or to nearest health facility.

12.2. Quarantine and isolation

Quarantine and Isolation are important mainstay of cluster containment. These measures help by breaking the chain of transmission in the community.

12.2.1. Quarantine

Quarantine refers to separation of individuals who are not yet ill but have been exposed to COVID-19 and therefore have a potential to become ill. There will be voluntary home quarantine of contacts of suspect /confirmed cases. The guideline on home quarantine available on the website of the Ministry provides detail guidance on home quarantine.

12.2.2. Isolation

Isolation refers to separation of individuals who are ill and suspected or confirmed of COVID-19. There are various modalities of isolating a patient. Ideally, patients can be isolated in individual isolation rooms or negative pressure rooms with 12 or more air-changes per hour.

In resource constrained settings, all positive COVID-19 cases can be cohorted in a ward with good ventilation. Similarly, all suspect cases should also be cohorted in a separate ward. However under no circumstances these cases should be mixed up. A minimum distance of 1 meter needs to be maintained between adjacent beds. All such patients need to wear a triple layer surgical mask at all times.

12.3 Social distancing measures

For the cluster containment, social distancing measures are key interventions to rapidly curtail the community transmission of COVID-19 by limiting interaction between infected persons and susceptible hosts. The following measures would be taken:

12.3.1 Closure of schools, colleges and work places

Administrative orders will be issued to close schools, colleges and work places in containment and buffer zones. Intensive risk communication campaign will be followed to encourage all persons to stay indoors for an initial period of 28 days, to be extended based on the risk assessment. Based on the risk assessment and indication of successful containment operations, an approach of staggered work and market hours may be put into practice.

12.3.2 Cancellation of mass gatherings

All mass gathering events and meetings in public or private places, in the containment and buffer zones shall be cancelled / banned till such time, the area is declared to be free of COVID-19 or the outbreak has increased to such scales to warrant mitigation measures instead of containment.

12.3.3. Advisory to avoid public places

The public in the containment and buffer zones will be advised to avoid public places and only if necessary for attending to essential services. The administration will ensure supply of enough triple layer masks to the households in the containment and buffer zones.

12.3.4. Cancellation of public transport (bus/rail)

There will be prohibition for persons entering the containment zone and on persons exiting the containment zone. To facilitate this, if there are major bus transit hubs or railway stations in the containment zone, the same would be made dysfunctional temporarily. Additionally, irrespective of fact that there is a rail/road transit hub, the perimeter control will take care of prohibiting people exiting the containment zone including those using private vehicles and taxies.

As a significant inconvenience is caused to the public by adopting these measures in the containment zone, State government would proactively engage the community and work with them to make them understand the benefits of such measures.

13. MATERIAL LOGISTICS

13.1. Personal Protective Equipment

The type of personal protective equipment for different categories of:

S. No.	Name of the item	Category of personnel
1	PPE Kit, N 95, Mask, Gloves, Goggles, cap and shoe cover)	• Doctors and nurses attending to patients in isolation, ICU/ critical care facilities of hospitals in the containment zone. • Para-medical staff in the back cabin of ambulance. • Auxillary/ support staff involved in disinfection vehicles/ ambulances and surface cleaning of hospital floors and other surfaces
2	N-95 Mask and gloves	• Supervisory doctors verifying a suspect case • Persons collecting samples. • Doctors/nurses attending patients in primary health care facilities
3	Triple Layer Surgical mask	• To be used by Field workers doing surveillance work • Staff providing essential services. • Suspect cases and care giver / by stander of the suspect case • Security staff. • Ambulance drivers • Residents permitted to go out for essential services .

The State Government has to ensure adequate stock of personal protective equipment. The quantity required for a containment operation will depend upon the size & extent of the cluster and the time required containing it. A containment of a cluster, lasting a month or two

in a population of 100,000 may require 20,00,000 triple layer masks; 2,00,000 gloves; 100,000 N-95 masks and about 50,000 PPE Kits. The foregoing number is to illustrate that State need to have a rate contract and assured supply for these items.

13.2. Transportation

A large number of vehicles will be required for mobilizing the surveillance and supervisory teams. The vehicles will be pooled from Government departments. The shortfall, if any, will be met by hiring of vehicles.

13.3. Stay arrangements for the field staff

The field staff brought in for the surveillance activities and that for providing perimeter control need to be accommodated with in the containment zone. Facilities such as schools, community buildings etc. will be identified for sheltering. Catering arrangement will need to be made at these locations.

13.4 Bio-medical waste management

A large quantity of bio-medical waste is expected to be generated from containment zone. Arrangement would also be required for such bio-medical waste (discarded PPEs etc.), preferably by utilizing the bio-medical waste management services at the designated hospital.

14. RISK COMMUNICATION

14.1 Risk communication material

Risk communication materials [comprising of (i) posters and pamphlets; (ii) audio only material; (iii) AV films] prepared by PIB/MoHFW will be prepared and kept ready for targeted roll out in the containment and buffer zones.

14.2 Communication channels

14.2.1 Interpersonal communication

During house to house surveillance, ASHAs/ other community health workers will interact with the community (i) for reporting symptomatic cases (ii) contact tracing (iii) information on preventive public health measures.

14.2.2 Mass communication

Awareness will be created among the community through miking, distribution of pamphlets, mass SMS and social media. Also use of radio and television (using local channels) will ensure penetration of health messages in the target community.

14.2.3 Dedicated helpline

A dedicated helpline number will be provided at the Control room (district headquarter) and its number will be widely circulated for providing general population with information on risks of COVID-19 transmission, the preventive measures required and the need for prompt reporting to health facilities, availability of essential services and administrative orders on perimeter control.

14.2.4 Media Management

At the Central level, only Secretary (H) or representative nominated by her shall address the media. There will be regular press briefings/ press releases to keep media updated on the developments and avoid stigmatization of affected communities. Every effort shall be made to address and dispel any misinformation circulating in media incl. social media.

At the State level, only Principal Secretary (H), his/her nominee will speak to the media.

15. INFORMATION MANAGEMENT

15.1 Control room at State & District Headquarters

A control room (if not already in place) shall be set up at State and District headquarters. This shall be manned by State and District Surveillance Officer (respectively) under which data managers (deployed from IDSP/ NHM) responsible for collecting, collating and analyzing data from field and health facilities. Daily situation reports will be put up.

The state will provide aggregate data on daily basis on the following (for the day and cumulative):

i. Total number of suspect cases
ii. Total number of confirmed cases
iii. Total number of critical cases on ventilator
iv. Total number of deaths
v. Total number of contacts under surveillance

15.2 Control room in the containment zone

A control room shall be set up inside the containment zone to facilitate collection, collation and dissemination of data from various field units to District and State control rooms. This shall be manned by an epidemiologist under which data managers (deployed from IDSP/ NHM) will be responsible for collecting, collating and analyzing data from field and health facilities.

This control room will provide daily input to the District control room for preparation of daily situation report.

15.3 Alerting the neighboring districts/States

The control room at State Government will alert all neighboring districts. There shall be enhanced surveillance in all such districts for detection of clustering of symptomatic illness. Awareness will be created in the community for them to report symptomatic cases/contacts.

Also suitable provisions shall be created for enhancing horizontal communication between adjacent districts, especially for contact tracing exercise and follow up of persons exiting the containment zone.

16. CAPACITY BUILDING

16.1 Training content

Trainings will be designed to suit requirement of each and every section of healthcare worker involved in the containment operations. These trainings for different target groups shall cover:

1. Field surveillance, contact tracing, data management and reporting
2. Surveillance at designated exit points from the containment zone
3. Sampling, packaging and shipment of specimen
4. Hospital infection prevention and control including use of appropriate PPEs and bio-medical waste management
5. Clinical care of suspect and confirmed cases including ventilator management, critical care management
6. Risk communication to general community

16.2 Target trainee population

Various sections of healthcare workforce (including specialist doctors, medical officers, nurses, ANMs, Block Extension Educators, MHWs, ASHAs) and workforce from non-health sector (security personnel, Anganwadi Workers, support staff etc.). Trainings will be tailored to requirements of each of these sections.

The training will be conducted by the RRT a day prior to containment operations are initiated.

16.3 Replication of training in other districts

The State Govt. will ensure that unaffected districts are also trained along the same lines so as to strengthen the core capacities of their RRTs, doctors, nurses, support staff and non-health field formations. These trainings should be accompanied with functional training exercises like mock-drills.

17. FINANCING OF CONTAINMENT OPERATIONS

The fund requirement would be estimated taking into account the inputs in the micro-plan and funds will be made available to the district collector from NHM flexi-fund.

17.1 Scaling down of operations

The operations will be scaled down if no secondary laboratory confirmed COVID-19 case is reported from the containment and buffer zones for at-least 4 weeks after the last confirmed test has been isolated and all his contacts have been followed up for 28 days. The containment operation shall be deemed to be over 28 days from the discharge of last confirmed case (following negative tests as per discharge policy) from the designated health facility i.e. when the follow up of hospital contacts will be complete.

The closing of the surveillance for the clusters could be independent of one another provided there is no geographic continuity between clusters. However the surveillance will continue for ILI/SARI.

However, if the containment plan is not able to contain the outbreak and large numbers of cases start appearing, then a decision will need to be taken by State administration to abandon the containment plan and start on mitigation activities.

18. IMPLEMENTATION OF THE MICRO-PLAN

Based on the above activities, the State/ District will prepare an event specific micro-plan and implement the containment operations.

Annexure-A

From

Mission Director, NHM
Bays No. 55-58, Paryatan Bhawan,
Sector-2, Panchkula,
Haryana.

To

All Civil Surgeon,
Haryana.

Memo No. NHM/HR/A2/2020/ 11268-89 Dated:- 04-04-2020

Subject:- Sanction of HR for containing and prevention of COVID- 19.

Reference on the subject cited above

Sanction of following staff is hereby granted as per the details given below:-

Sr. No	Name of Post	*ToRs*	No. of Post	Salary Per Month (In Rs)
1	Public Health Manager	• MD in CHA/Hospital Management/Community Medicine • Master /Diploma/Degree in CHA/Hospital Management/Community Medicine • MBA in Health Management • Master in Public Health	• 3 posts for HQ at Panchkula. • 3 posts for each districts (GH Panchkula, Gurugram & Faridabad). • 1 post for each districts (GH Ambala, Bhiwani, Charkhidadri , Fatehabad, Hisar,Jind, Jhajjar, Kaithal, Karnal, Kurukshetra, Mewat, Narnaul, Palwal, Panipat, Rewari, Rohtak, Sonipat, Sirsa, Yamunanagar).	80,000/-
2	Biologist	• Retired as Biologist from the Government Services	One post for each districts (22 districts in Haryana).	60,000/-
3	Health Inspector	• Retired as Health Inspector from the Government Services	One post for each districts (22 districts in Haryana.	40,000/-
4	Microbiologist	• MD in Microbiology	One post for each districts (22 districts in Haryana.	80,000/-

5	Data Entry Operator	• As per Service Bye Laws of NHM.	10 post for HQ at Panchkula	@Hartron Rate
6	Helper	• As per Service Bye Laws of NHM.	4 post for HQ at Panchkula	@D.C. Rate

The above staff may be hired on urgent basis by way of Walk –In- Interview initially upto 90 days, on Temporary Basis. The Staff is being sanctioned under Budget Head B.31.4 (temporary HR including incentive for community Health) as per GoI DO no. Z-18-10/NHM-1/Part dated 15-03-2020.

O/C for Mission Director
National Health Mission
Panchkula (Haryana)

Endst. No. NHM/HR/A2/2020/ 11290-11339 **Dated:-** 04-04-2020

A copy of the above is forwarded to the following for information and necessary action:-

1. Additional Chief Secretary to Govt. Haryana, Health Department, Haryana.
2. Director General Health Services, Sec-6, Panchkula, Haryana.
3. DFA, NHM Haryana, Panchkula, Haryana.
4. Director (IDSP) O/o DGHS, Haryana.
5. PS/MD, NHM Haryana, Panchkula, Haryana.
6. All DPMs/DAMs, NHM Haryana.

O/C for Mission Director
National Health Mission
Panchkula (Haryana)

Annexure-B

From

Director General Health Services,
Haryana, Panchkula.

To

All Civil Surgeons in the State

No. 32/3-IDSP-2020- 2081-2102 **Dated :** 13/04/2020

Subject : Regarding reconstitution of rapid Response Team at District level

In reference to the subject cited above.

It is to inform you that as per the directions issued vide letter No. 32/3/IDSP/20/2053-75 dated 10/04/20 you were requested to reconstitute your district RRTs by including public health professionals posted in your district. Further you were requested to coordinate with Medical College earmarked for your district vide letter No PCCM/20/357 dated 09-04-2020 to involve the experts/ professionals from these institutions to provide the technical guidance & support.

In this regard, as per the information received in this office reconstituted RRTs in the districts have already been involved in COVID management specially in implementation of containment plan. You are further requested that if there are further amendments in these RRTs, same may be intimated to the State HQ immediately.

You are further requested to send the all COVID related information / reports on time so that same may be apprised to higher authorities without any delay.

Encls As above

Director Health Services(IDSP)
O/o. Director General Health Services,
Haryana Panchkula

No. 32/3-IDSP-2020- 2103-05 **Dated :** 13/04/2020

A copy is forwarded to the followings for information please:

1. W/ ACS(H)
2. MD-NHM
3. Director,MER

Director Health Services(IDSP)
O/o. Director General Health Services,
Harvana Panchkula