

सर्वोच्च प्राथमिकता / समयबद्ध  
संख्या ७१५ / पाँच-५-२०२०

प्रेषक,

अमित मोहन प्रसाद,  
प्रमुख सचिव,  
उत्तर प्रदेश शासन।

सेवा में,

समस्त जिलाधिकारी,  
उत्तर प्रदेश

चिकित्सा अनुभाग-५

लखनऊ: दिनांक : ०६ अप्रैल, २०२०

विषय:- जनपद स्तर पर कोविड-१९ हेतु आकस्मिक योजना का प्रारूप (Template) का निर्धारण।

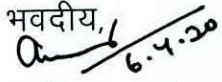
महोदय,

उपर्युक्त विषयक संयुक्त सचिव, स्वास्थ्य एवं परिवार कल्याण मंत्रालय, भारत सरकार, नई दिल्ली के पत्र संख्या-डी-३२०२०/५/२००९- ई०एम०आर० पार्ट-दो दिनांक ०४.०४.२०२० (प्रति संलग्न) का कृपया अवलोकन करें जिसके माध्यम से स्वास्थ्य मंत्रालय, भारत सरकार द्वारा Large outbreaks amenable for containment of COVID-19 का प्रारूप उपलब्ध कराया गया है। इस आधार पर प्रत्येक जनपद में District Level Crisis Management Plan for Covid-19 तैयार किया जाना है।

अतएव इस सम्बन्ध में भारत सरकार द्वारा उपलब्ध करायी गयी चेकलिस्ट की प्रति संलग्न कर प्रेषित करते हुये मुझे यह कहने का निदेश हुआ है कि कृपया Large outbreaks amenable for containment of COVID-19 के प्रारूप के अनुसार अपने जनपद में District Level Crisis Management Plan for Covid-19 को क्रियान्वित किया जाना सुनिश्चित करें।

मुझे यह भी कहने का निदेश हुआ है कि उक्त योजना को अन्तिम रूप देते हुये कृत कार्यवाही की सूचना/ आख्या diradmncamp@gmail.com पर प्रत्येक दशा में ०२ दिन के अन्दर उपलब्ध कराया जाना सुनिश्चित करें।

संलग्नक: यथोक्त।

भवदीय,  
  
(अमित मोहन प्रसाद)  
प्रमुख सचिव

संख्या एवं दिनांक तदैव

प्रतिलिपि – निम्नलिखित को सूचनार्थ एवं आवश्यक कार्यवाही हेतु प्रेषित:-

1. संयुक्त सचिव, स्वास्थ्य एवं परिवार कल्याण मंत्रालय, भारत सरकार नई दिल्ली, को उनके पत्रसंख्या- डी- 32020 / 5/2009-ई0एम0आर0 पार्ट-दो दिनांक 04.04.2020 के क्रम में सूचनार्थ प्रेषित।
2. समस्त मण्डलायुक्त, उत्तर प्रदेश।
3. महानिदेशक, चिकित्सा एवं स्वास्थ्य सेवाए, उत्तर प्रदेश।
4. मिशन निदेशक, राष्ट्रीय स्वास्थ्य मिशन, उत्तर प्रदेश।
5. निदेशक संचारी/निदेशक (प्रशासन) चिकित्सा एवं स्वास्थ्य सेवाए, उत्तर प्रदेश।
6. समस्त मुख्य चिकित्सा अधिकारी, उत्तर प्रदेश।
7. गार्ड फाइल।

आज्ञा से,  
  
(शत्रुंजय कुमार सिंह)  
विशेष सचिव

  
06/04/2020



## COVID-19 - DO letter conveying containment plans, microplan and checklist

From : writeto dr yogesh &lt;writeto.dr.yogesh@gmail.com&gt;

Sat, Apr 04, 2020 12:37 PM

Subject : COVID-19 - DO letter conveying containment plans, microplan and checklist

5 attachments

To : cs-ap <cs@ap.gov.in>, cs-arunachal@nic.in, Kumar Sanjay Krishna IAS <cs-assam@nic.in>, Chief Secretary Bihar <cs-bihar@nic.in>, Chief Secretary Office <csoffice.cg@gov.in>, vivekdhand@nic.in, chiefsecretary@gujarat.gov.in, Chief Secretary <cs-goa@nic.in>, Keshni Anand Arora <cs@hry.nic.in>, Shri Anil Kumar Khachi <cs-hp@nic.in>, cs-jandk <cs-jandk@nic.in>, Shri Sukhdev Singh <cs-jharkhand@nic.in>, cs@karnataka.gov.in, Chief Secretary, Government of Kerala <chiefsecy@kerala.gov.in>, cs <cs@mp.nic.in>, cs-madhyapradesh <cs-madhyapradesh@nic.in>, cs@maharashtra.gov.in, cs-anipur@nic.in, cs miz <cs\_miz@rediffmail.com>, Chief Secretary Nagaland <csngl@nic.in>, Chief Secretary Odisha <csori@nic.in>, Chief Secretary, Punjab <cs@punjabmail.gov.in>, cs-rajasthan <cs-rajasthan@nic.in>, Prakash <cs-skm@hub.nic.in>, chief secretary <cs-uttaranchal@nic.in>, chiefsecyuk@gmail.com, cs@tn.gov.in, Chief Secretary <cs@telangana.gov.in>, cs-tripura <cs-tripura@nic.in>, CHIEF SECRETARY GoUP <csup@nic.in>, chiefsec@wb.gov.in, Shri Vijay Kumar Dev <csdelhi@nic.in>, Farooq Khan <lk-admin@nic.in>, Praful Patel <administrator-dd@gov.in>, Chief Secretary Andamans <cs-andaman@nic.in>, Chief Secretary CS, Puducherry <cs.pon@nic.in>

Cc : Dr K S Jawahar Reddy I A S <prlsecy\_hmfw@ap.gov.in>, samirsinha69@gmail.com, samirsinha@gov.in, principalsecyhealth@gmail.com, arunachalhome@gmail.com, secretaryani106@gmail.com, healthbih <healthbih@nic.in>, secretaryhealthcg@gmail.com, Arun Kumar Gupta <hs-chd@nic.in>, Pooja Jain <secy-edu-dnh@gov.in>, Secretary Education <secy-edu-dd@nic.in>, Mrs. Padmini Singla <pshealth@nic.in>, Secretary Education <secedu-sect.goa@nic.in>, cohealth@gujarat.gov.in, Ram Dass Dhiman <healthsecy-hp@nic.in>, acshealth2019@gmail.com, hlthdept fdi <hlthdept.fdi@gmail.com>, admsecyhealthjk@gmail.com, prs-hfw@karnataka.gov.in, Prl Secy Health <secy.hlth@kerala.gov.in>, Dr S Sundaravadivelu IAS <secy-home@gov.in>, Principal Secretary, Health & Family Welfare <pshealth@mp.gov.in>, psec pubhealth <psec.pubhealth@maharashtra.gov.in>, acs pubhealth <acs.pubhealth@maharashtra.gov.in>, V. Mang <mang@nic.in>, comsecymiz@gmail.com, ramkeeias@hotmail.com, Secretary H and FW Deptt Odisha <orhealth@nic.in>, Anurag Agarwal <pshfw@punjab.gov.in>, Secretary to Government Government of Puducherry <secyfin.pon@nic.in>, phsrajasthan@gmail.com, healthsecyskm@yahoo.com, hfwsec@gmail.com, secytrpfc18@gmail.com, psecup health <psecup.health@gmail.com>, secynkja@gmail.com, prin secy wbhealth <prin.sec.ybhealth@gmail.com>, Vivek Kumar <secy.hfw-wb@gov.in>, mdrhmap@gmail.com, chwhyd@yahoo.com, mdrhmasm@gmail.com, MD NHM AR.P <md-ar-nrh@nic.in>, ss mduthm <ss.mduthm@gmail.com>, ed shsb <ed\_shsb@yahoo.co.in>, mdrhmcg@yahoo.co.in, nrhmchd@gmail.com, nrhmdnh@gmail.com, md-dnn-dd@nic.in, S.M. Ali <mddshm.delhi@gov.in>, specialsechealth@gmail.com, mdrh@gujarat.gov.in, Mission Director, NRHM-HP <md-hp-nrh@nic.in>, nrhmjharkhand16@gmail.com, mdrh@gujarat.gov.in, mdrh@gujarat.gov.in, mdrh@gujarat.gov.in, md-nhm@karnataka.gov.in, arogyakeralam@gmail.com, smdrh@gmail.com, rchlakshadweep@gmail.com, missiondirectormp@gmail.com, Mission Director NHM <mdnhm@mp.gov.in>, mdrh@mumbai <mdnrh.mumbai@gmail.com>, nrhmmegh@gmail.com, dhsmi@rediffmail.com, amanwarr@gmail.com, nrhmmizoram@yahoo.com, nrhmmizoram@gmail.com, nrhmnagaland@gmail.com, drkevi med <drkevi.med@gmail.com>, Mission Director, NRHM Orissa <missiondirector@nic.in>, nrhmpunjab@gmail.com, mdrhmpunjab@gmail.com, Mission Director, Puducherry <md-pdy-nrh@nic.in>, nrhmpundicherry@yahoo.co.in, MD NRHM, Rajasthan <md-nrh-rj@nic.in>, mdrhmsikkim@gmail.com, mdrhmts@gmail.com, chfw ts <chfw.ts@gmail.com>, NRHM TN <rhcpcni@tn.nic.in>, aditimb1802@gmail.com, ed@sifpsa.org, mdupnrh@gmail.com, mdrhnm@gmail.com, mdrh@wbhealth.gov.in, Principal Secretary, HM & FW <prlsecy\_hmfw@telangana.gov.in>, phs@rajasthan.gov.in, Cabinet Secretariat <cabinet@nic.in>, PK Mishra <pkmishra.pmo@gov.in>, alav <alav@ias.nic.in>, lavagarwal@hotmail.com, diremr@gmail.com, Sanjeeva Kumar <ash-mohfw@nic.in>

Respected Sir/Madam,

Please find attached DO letter from Sh. Lav Agarwal, Jt. Secretary, MoHFW, GoI conveying:

1. Cluster Containment Plan for COVID 19
2. Model Microplan for containment of local transmission of COVID 19
3. Containment plan for Large outbreaks of COVID 19
4. Template for District Contingency Plan for COVID 19

Regards

Dr. Yogesh, M.D.  
Chief Medical Officer,  
EMR Division, Dte. GHS  
Min. of Health & FW  
Tel: 011-23063205

21/4/20  
06/4/2020

- DO letter conveying containment plans, microplan and checklist.pdf  
76 KB
- 1. Cluster Containment plan.pdf  
2 MB
- 2. Model Microplan for containment of local transmission of COVID19.pdf  
982 KB
- 3. Containment Plan for Large Outbreaks of COVID-19 (Final).docx  
199 KB
- 4. Template for District Contingency Plan for COVID 19.doc  
30 KB



No. 2090/MS/GI/2020



LAV AGARWAL, IAS  
Joint Secretary

Tel. : 011-23061195  
T/Fax : 011-23061842  
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भारत सरकार  
स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
निर्माण भवन, नई दिल्ली - 110011  
GOVERNMENT OF INDIA  
MINISTRY OF HEALTH & FAMILY WELFARE  
NIRMAN BHAVAN, NEW DELHI - 110011

DO. No. D.32020/5/2009-EMRPartII(PartII)  
Dated the 4<sup>th</sup> April, 2020

Respected Madam/Sir,

The management of novel corona virus disease (COVID-19) has entered into a crucial phase. There are clusters of cases reported from many states. About 90 such districts are identified having high case also and this number is increasing with time.

In this regard, we had circulated the **Cluster Containment Plan on 2<sup>nd</sup> March, 2020** (copy attached) to State Health Secretaries and to State Surveillance Officers. We had also provided a **model micro-plan (copy attached)** for cluster containment to State Surveillance Officers, which is also available on the website of Ministry of Health and Family Welfare.

Ministry has prepared a plan for **Large outbreaks amenable for containment of COVID19 (copy attached)** which is also available on the website of Ministry of Health and Family Welfare. Large numbers of cases reported in few districts are amenable to containment and we request you to follow the proposed action plan for undertaking the containment measures.

It is also important that each district shall have a District Level Crisis Management Plan for COVID19. Please find attached herewith a checklist for the same. It is requested that each district use this checklist as a normative guidance to prepare a comprehensive and detailed plan of action for COVID19 management duly ensuring that required resources are in place for such an operation.

The plans as mentioned above are available at MoHFW's website [www.mohfw.gov.in](http://www.mohfw.gov.in). It is requested that the same may be disseminated to all relevant field functionaries and their orientation taken up for effective implementation.

Urgent

सुधित

Dr. Anil Kumar

Yours sincerely

April

(Lav Agarwal)

प्र. स. स्वास्थ्य / With sincere regards,

चि. शि.

उ. प्र. के स्वास्थ्य विभाग

4.4.20

(राजेन्द्र कुमार तिवारी)

मुख्य सचिव

उत्तर प्रदेश शासन

Chief Secretaries of all States

1. Additional Chief Secretary/Principal Secretary/Secretary (Health) of all States
2. MD, NHM of all States/UTs

Copy for kind information:

1. O/o Cab Secretary, Rashtrapati Bhawan, New Delhi
2. O/o PS to Hon'ble Prime Minister, PMO, South Block, New Delhi
3. O/o Advisor to PM (AS), PMO, South Block, New Delhi

4/4/2020  
(अमित मोहन प्रसाद)  
प्रमुख सचिव  
प्र. स. स्वास्थ्य एवं परिवार कल्याण विभाग  
उत्तर प्रदेश शासन

VSK/MS

4/4/2020



## Template for District Contingency Plan for COVID – 19

### **1. Background**

### **2. Rationale / Need of Plan**

- a. **Alignment with Central and State Containment Plans**

### **3. District Profile**

- a. Demographic Profile – Map – Political and Resource Maps
- b. Administrative profile – Administrative Reporting
- c. Occupational Profile

### **4. Risk Assessment**

- a. Epidemiology & Definitions (Novel Corona Virus, COVID 19, Incubation Period, Mode of Transmission, Sign and Symptoms, Suspect Case, Confirmed Case, Contact – High Risk & Low Risk)
- b. Public Health Profile of the District
  - i. Data of other illnesses, preferably for last three years:
    - 1. Infectious Diseases (e.g. Dengue, Malaria, SARI, ILI etc.)
    - 2. Non-infectious Diseases (e.g. Cardiovascular, renal diseases etc.)
- c. Current Situation:
  - i. Population density of different blocks
  - ii. Urban Centres
  - iii. COVID affected people (tested positive)
  - iv. No. of persons Quarantined
  - v. No. of persons in Isolation
  - vi. Tests done
  - vii. People under Surveillance
  - viii. People under Hospitalisation
  - ix. People with the history of foreign travel
  - x. Labs for testing
  - xi. Quarantine facilities, both institutional and home quarantine

- xii. Isolation facilities
- xiii. Treatment facilities
- xiv. Protection of the frontline workers
- d. No. of people returned from foreign countries, after 1<sup>st</sup> March and follow up with them regarding their health status
- e. No. of Migrant labours / other professionals returned after 1<sup>st</sup> Mar
- f. Vulnerable Clusters and planning for them
- g. Vulnerable Groups (aged, pregnant women, people living in aged homes etc., sanitation workers etc.) and planning for them

#### **5. Institutional Arrangements for COVID – 19**

- a. District Health EOC & Helpline
- b. Line Departments with specific Responsibilities and Formation of Task Forces
- c. NGO coordination cell
- d. Other Stakeholders and their responsibility

#### **6. Infrastructure**

- a. Health Facilities in District
  - i. Hospitals – Govt. / Private / Nursing Homes / Clinics / PHCs / CHCs
  - ii. Hospital and critical care facility, ICUs etc. – Number of beds needed, available, gap, plan to meet the demand
  - iii. Health Personnel in the District: Doctors in govt, private, Ayurvedic doctors, Retired Doctors, veterinary doctors, Nurses in govt and private, Paramedical staff, health workers
  - iv. Drugs Stock
  - v. Testing Facilities - Testing facility – demand, availability and gap<sup>1</sup>



- vi. Isolation and Quarantine Facilities - Quarantine facility, isolation facility – demand, availability from various sources both private and public, gap and plan to meet the gap
- vii. Medical Colleges (Allopathic, Homeopathic, Ayurvedic, Siddha etc.)
- viii. Resources available in the neighbouring district in case the local capacity is overwhelmed

## **7. Prevention and Mitigation Measures**

- a. Rail/Road/Air Network/sea port (Points of Entry/Exit) and Measures at entry/exit points
- b. Manpower Mobilization: Demand, availability from different sources, Gap and plan to meet the gap (Doctors, Nurses, Paramedical staff, others)
- c. Resource Mobilization (PPEs, Ventilators, Masks, Gloves, Oxygen Cylinders etc.)- Demand, availability from various sources, gap and plan to meet the gap
- d. Cleaning and disinfection of public places undertaken
- e. Planning for other natural & human induced disasters in coming months while COVID – 19 is continuing

## **8. Preparedness & Response**

- a. Actions taken for COVID 19 (Pharmaceutical and Non-Pharmaceutical Interventions)
  - i. Before Lockdown
  - ii. During lockdown
    - 1. Current Implementation of Lockdown measures-compliance to various government directives and instruction
    - 2. Identification of areas for selective lockdown based on risk and existing cases, and vulnerabilities
    - 3. Maintenance of essential services in such areas, taking care of vulnerable, feeding the poor etc.

- iii. Actions to be taken after lockdown (Partial or phase wise lifting / total lifting of lockdown)
  - iv. Psycho-social support and counselling to infected, in quarantine, isolation and even medical personnel engaged in treating the infected
  - v. Rapid response teams at the district level with clear mandate on what they need to do within four to six hours in different scenarios, e.g. (i) in cases where more patients come in for hospitalisation beyond the normal capacity of the hospital; where to take the additional patients ? Which is the nearest contingency hospital planned ? (ii) in case any particular locality has to be fully sealed ?
- b. Compliance to Directions from Central / State Governments
  - c. SOPs – For Pharma & Non-Pharma interventions

#### **9. IEC/Awareness/Involvement of NGOs & CSOs**

- a. NGO/civil society engagement- Identification of NGOs, their geographical area of operation, expertise, experience, capacity, their training needs and allocation of work
- b. Capacity building and training for various cadres, volunteers, NGOs etc.

#### **10. Budgetary Provisions**

##### **Annexures:**

- A. Important Contact Details
- B. Sample IEC Materials for use by NGOs/CSOs/other agencies
- C. Checklist of Emergency Support Functions
- D. Protocol for sample collection and testing
- E. Other relevant advisories from Central and State Governments

**Check List - Department's role as lead/support agency against Emergency Support Functions) (Tick ✓ and elaborate on ticked items)**



S. No.	Emergency Support Functions	Lead (L) / Support (S) Agency (Tick $\checkmark$ and mark L or S)	
		Lead Agency	Support Agency
1			
2			
3			
4			
5			

Note: Coastal states which are prone to cyclones, and States which are prone to heat wave and the States prone to floods should evaluate the medical facilities located for COVID 19 from the hazard, risk and vulnerability perspective and consider risk informed planning so that the facilities are not affected by natural disaster impacts.



# **Containment Plan**

**Novel Coronavirus Disease 2019**

**(COVID 19)**

**Ministry of Health & Family Welfare  
Government of India**



# **1. INTRODUCTION**

## **1.1 Background**

On 31<sup>st</sup> 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 7<sup>th</sup> 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 26<sup>th</sup> 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 26<sup>th</sup> 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 26<sup>th</sup> February, 2020) it is very high for China and high at regional and global levels. WHO on 30<sup>th</sup> 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 within 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.

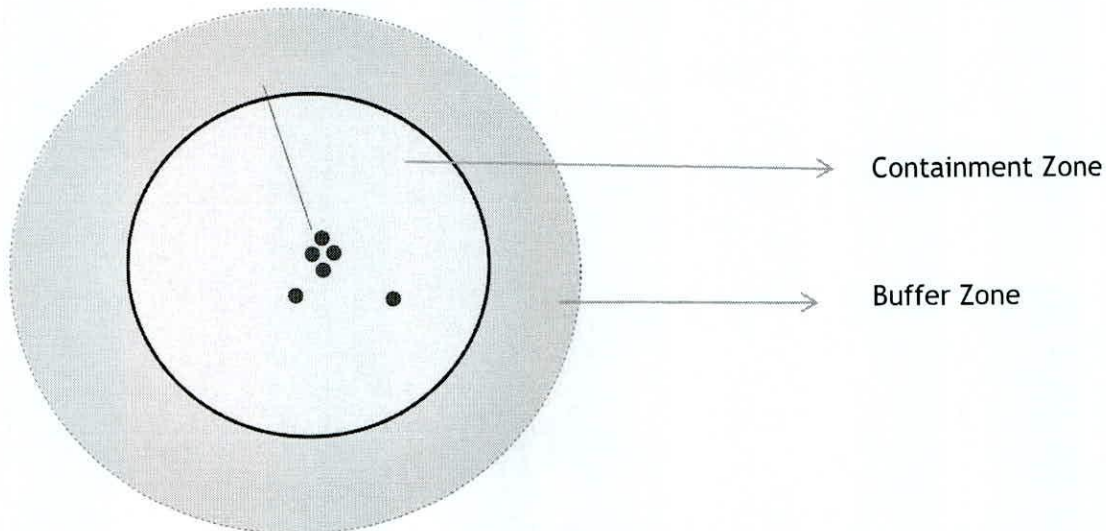


Table 1: Scenarios for determining containment and buffer zones

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 taxis.

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 )	<ul style="list-style-type: none"><li>• Doctors and nurses attending to patients in isolation, ICU/ critical care facilities of hospitals in the containment zone.</li><li>• Para-medical staff in the back cabin of ambulance.</li><li>• Auxillary/ support staff involved in disinfection vehicles/ ambulances and surface cleaning of hospital floors and other surfaces</li></ul>
2	N-95 Mask and gloves	<ul style="list-style-type: none"><li>• Supervisory doctors verifying a suspect case</li><li>• Persons collecting samples.</li><li>• Doctors/nurses attending patients in primary health care facilities</li></ul>
3	Triple Layer Surgical mask	<ul style="list-style-type: none"><li>• To be used by Field workers doing surveillance work</li><li>• Staff providing essential services.</li><li>• Suspect cases and care giver / by stander of the suspect case</li><li>• Security staff.</li><li>• Ambulance drivers</li><li>• Residents permitted to go out for essential services .</li></ul>

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 within 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.

**Model Micro-Plan**

**Micro Plan for Containing Local Transmission of  
Coronavirus Disease (COVID-19)**

Epicentre -----  
----- Block, ----- District,  
----- State



## Micro-plan for Containing Local Outbreak of COVID-19

**Geographic Location:** -----Municipality, ----- Block, ----- District, ----- State

1. Objective of the micro-plan

To contain the outbreak of COVID-19 in defined geographic area

2. **Demographic details (for each district coming under containment and buffer zones separately, as defined in Section 3)**

District details

District area:  
District Population:  
No of Blocks:  
No of Municipalities:

Block Details

Name of Block:  
Population:  
Number of Villages:

3. **Mapping the affected area**

**The containment zone will be decided by the RRT based on the extent of cases/contacts listed and mapped by them.** However if contact listing/ mapping is taking time (>12-24 hours), then on arbitrary basis demarcate an area of 3 Kms radius around the epicenter (the residence of the positive case). This area of 3 km radius will be the containment zone. **If required, based on the mapping of contacts and cases, the containment zone will be refined.**

A buffer zone of an additional 5 Kms radius (7 Kms in rural areas)/administrative boundary of including neighboring districts/per-urban zone shall also be identified, as detailed in the cluster containment plan.

3.1 Affected area (Containment Zone – As per Cluster Containment Plan)

Name of the epicentre: Municipality ward/ village:  
Number of affected Municipalities /villages:  
Number of Villages/ Wards in Containment Zone:  
Number of houses in containment zone:  
Population in Containment Zone:

**State RRT**

S. No.	Name	Designation	Contact Number (O)	Mobile
1				
2				
3				

**District RRT**

S. No.	Name	Designation	Contact Number (O)	Mobile
1				
2				
3				

**4.2. Human Resource for operations / field activities****4.2.1 Responsibilities assigned to various functionaries****4.2.1.1 ASHA/ ANM/ Anganwadi worker\*:****4.2.1.1.1. Daily house to house visit to:**

- (i) Search clinically suspect cases.
- (ii) Identify contacts of confirmed and suspect cases
- (iii) Maintain line list of suspect/ confirmed cases and contacts
- (iv) Monitor contacts daily
- (v) Inform Supervisory Medical Officer about suspect cases and their contacts
- (vi) Create awareness among community about disease prevention, home quarantine, common signs and symptoms and need for reporting suspect cases by distributing fliers, pamphlets and also by inter-personal communication.

4.2.1.1.2. Counsel individuals to take precautions to avoid contact with those with symptoms suggestive of COVID-19.

4.2.1.1.3. Ensure that contacts are on home quarantine use 3 layered surgical masks at all times. Educate them on proper use and disposal of masks. The team will also educate the family members about precautions to be taken while taking care of persons under home quarantine.

\* If there is human resource constraint to engage as many ASHA/AWW/ANMs, then Indian Red Cross society/NDRF/Civil Defence/NSS/NCC volunteers available in the district shall be engaged after proper briefing on roles and responsibilities and infection, prevention and control practices.



#### 4.2.1.2. LHV/ MPWMW

- Supervisory duty at the village/ block covering the epicenter.
- Daily visit to allocated sectors to oversee and cross-check the activities of ASHA/Anganwadi workers/ ANM.

Report on real time basis, any person reporting of symptoms of COVID-19.

#### 4.2.1.3. Block Extension Educator and other communication staff

- Public information education and communication campaign targeting schools, colleges, work place, self-help groups, religious leaders, teachers, postman etc.
- Arrangement of miking.

#### 4.2.1.4. Municipal/ village Panchayat staff / Civil society volunteers

- Create awareness in the community
- Encouraging community to follow frequent hand wash, respiratory etiquettes, self-monitoring of health and reporting to the health workers about persons in their vicinity having cough, fever, breathing difficulty.

#### 4.2.1.5. Supervisory Officer

- Supervises the field work
- Verifies suspect case as per case definition.
- Arranging shifting of suspect case to health facility.
- Random Check of persons under home quarantine.
- Submit daily report to control room

#### 4.2.1.6 Block NHM Manager/ any other designate of DM

- Information management with in the containment zone
- Contingency funding of the containment operations
- Managing finances.

#### **4.2.2. Norms for deployment of human resource:**

A health care worker (ANM/ ASHA/Anganwadi Worker) will be able to visit 50 houses in a day (30 in difficult areas).

A supervisory Medical Officer shall be deployed to cover 1000 population.

#### 4.2.2 Human Resource requirement for field operations

S. No.	Designation of staff	Nature of work assigned	No. of personnel deployed for containment operation	Mobilized from within the District	Mobilized from adjoining District
1.	District Collector or his assignee	Incident Command			
2	Central/ State RRT	Planning and operations			
3	Sector Medical Officers	Supervisory			
4	LHV	Intermediate Supervisory			
5	ANM/ ASHA/ Anganwadi Worker	Field work			
6	Block Extension Educator and other communication staff	IEC			
7	Municipal/ village Panchayat staff Civil society volunteers	Community mobilization			
8	NHM -District/ Block Manager	Logistics Information Management Financial management			

### 5. Components of Micro-plan

#### 5.1 Surveillance

##### 5.1.1. Active Surveillance

##### 5.1.1.1. Constituting Teams for Human Health Surveillance:

Each health worker would cover 50 houses in the sector assigned to them. The listing of municipality wards/ villages allocated to surveillance teams, their names, name of supervisors for each team and their contact number is at **Annexure-I**

##### 5.1.1.2. Assigning Tasks to the Teams

The Medical Officer in-charge will assign tasks as listed in para 4.2.1 to the Supervisory Officer/ANM/ASHA/Anganwadi Worker.



During the course of their house to house visit, the ANM/ASHA/Anganwadi Worker will identify suspect case, if any, as per case definition. The name, age, sex, and the address of such persons to be recorded on proforma at **Annexure-II**. The Health worker will counsel household members to take basic precautions to avoid direct contact with a suspect case. He / she will provide a mask to the (i) suspect case (till such time he/she is examined by the supervisory officer).

The concerned ANM/ASHA/Anganwadi Worker will immediately inform his/her supervisory officer about the suspect case.

### 5.1.1.3. Role of Supervisory Medical Officer/ LHV

The door to door surveillance will be supervised by Medical Officers/ LHV assigned sectors within the defined surveillance zone. He/she will also collect data from the health workers under him/ her, collate and provide the cumulative data to the control room by 4.00 P.M.

He / she will visit any suspect case brought to his/ her notice by the ANM/ASHA/Anganwadi Worker during their daily house to house visit. He/ she will immediately call for the ambulance and ensure transfer of the patient to identified hospital after ensuring on the basic precautions. Details of the registration number of the ambulance, shifting time to the hospital and contact number will be kept and conveyed to the Control Room.

Name of the patient being shifted	Age	Sex	Ambulance No.	Name of the driver/ Paramedic	Contact number	Time of Shifting

### 5.1.2. Passive Surveillance

All health facilities in the containment and buffer zones will be listed. All such facilities both in Government and Private sector (including clinic) shall report clinically suspect cases of COVID-19 to the identified supervisory officer for that sector. Proforma for reporting suspect COVID-19 cases by health facilities is at **Annexure-III**.

## 6 Contact Tracing

The contacts of the laboratory confirmed cases/ suspect cases of COVID-19 will be line-listed. 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.

These contacts will be tracked by assigned ANM/ASHA/Anganwadi Worker of that sector and kept under home quarantine for 14 days. They will be monitored for clinically compatible signs and symptoms of COVID-19 for 28 days in total. If the residential address of the contact is beyond the containment zone or in adjoining district / State, the district IDSP will inform the concerned District IDSP.

Detail guidance for contact tracing, quarantine and isolation is given at **Annexure –IV**. Proforma for line listing of contacts is at **Annexure-V**.

### 7. Laboratory Support

The microbiologist in the Central/State RRT will be responsible for managing laboratory Support. He/ She will identify nearest VRDL network laboratory for logistic support for sample collection, packaging and transportation. The doctors manning the isolation facility will be trained by the RRT and they shall be responsible for sample collection, packaging and transportation. The sample collection proforma to be attached with the samples is at **Annexure-VI**.

Name of the VRDL Laboratory	Name of Nodal person	Contact number

### 8. Identified Health Facility

8.1. The Physician in the RRT will visit the nearby hospitals and identify the nearest hospital best suited for isolation and tertiary care/ medical college best suited for Ventilator management/ critical care management/ Salvage therapy (ECMO).

Name of the identified health facility	Name and Contact details of MS	Name and contact details of Nodal officer	Contact details of Emergency

The details of the identified facilities will be informed to all the Supervisory Officers by the NHM District/ Block manager.

All suspect cases of COVID-19 will be admitted to the above identified health facility. The Supervisory Medical Officer, in whose Jurisdiction the case is reported,



shall ensure his/ her hospitalization. The hospital will be informed in advance about the referral case.

Reporting format for health facilities identified for isolation/critical care management of COVID-19 cases is at **Annexure III**.

### 8.2. Ambulance facility

There will be earmarked ambulance for the transfer of patients. The drivers will be trained in infection prevention and control practices and also in disinfection of ambulance after transporting suspect cases. Drivers of these ambulances will be provided with appropriate PPE depending on the risk assessment conducted by district/RRT epidemiologist.

Date	Shift	Name of the driver	Name of the Paramedic	Contact numbers (Driver and Paramedic)
	8:00 AM – 2:00 PM			
	2:00 PM – 8:00 PM			
	8:00 PM – 8:00 AM			

### 8.3 Hospital infection prevention and Control

The Microbiologist in the RRT will train the health workers on infection prevention control practices prior to their field assignment. They will also train the identified field functionaries on donning and doffing of PPE. The PPEs are to worn as per the risk assessment for various categories of personnel.

S. No	Name of the item	Remarks
1	Full complement of PPE (N 95 Mask, Gloves, Goggles, coveralls, headgear, foot wear)	To be used by: <ul style="list-style-type: none"> <li>• Doctors attending to patients in health facilities in the containment zone and referral hospital for isolation/ critical care, where aerosolization can occur (like intubation, non-invasive ventilation, tracheostomy, and manual ventilation before intubation, suction etc.)</li> <li>• Doctors collecting samples.</li> <li>• EMTs attending patient in ambulances</li> <li>• Staff in the laboratories</li> </ul>
2	N-95 Mask and gloves	<ul style="list-style-type: none"> <li>• To be used by supervisory doctors verifying a suspect case</li> </ul>

		<ul style="list-style-type: none"> <li>Doctors/nurses attending patients in screening clinics/OPD</li> </ul>
3	N-95 mask, gloves	<ul style="list-style-type: none"> <li>Sanitary workers involved in sanitation and disinfection activities for COVID-19 cases</li> </ul>
4	Triple Layer medical mask/ examination gloves	<p>To be used by:</p> <ul style="list-style-type: none"> <li>field workers,</li> <li>suspect cases and</li> <li>care giver / by stander of the suspect case</li> <li>Ambulance drivers.</li> <li>All functionaries at the perimeter control.</li> </ul>

## 10. Logistics

### 10.1. PPE

All PPE will be used rationally. RRT members will train the identified field functionaries on donning and doffing of PPE. The PPEs are to worn as per the risk assessment for various category of personnel.

The following daily log on PPE will be maintained:

S. No.	Name of the item	Opening balance for the day	Nos. used with in the day	Closing balance	Remarks
1	PPE Kits				
2	N-95 Mask				
3	Triple Layer Surgical mask				
4	Gloves				
5	Biohazard bags				

All PPEs to be disposed of in a Biohazard Bag (yellow). The outer surface will be disinfected using 1% Sodium Hypochlorite spray.

## 11. Communication

Block Extension Educator / or any other designated communication staff will be allocated the work of public education outreach on COVID-19. Public information education and communication campaign shall target schools, colleges and work place within the



containment zone. The key messages (including that used for Inter-personal Communication) have already been conveyed to the States.

The sector wise allocation of BEE their name and contact no. will be listed. Municipal/ Village Panchayat Officers will be allocated sectors with in the surveillance zone for encouraging and participating in public awareness campaigns and participation. The rostering of staff for public education outreach is at **Annexure-VIII**.

## 12. Data Management

The Control Room will have data managers (deployed from IDSP/ NHM) responsible for collecting, collating and analyzing data from field and health facilities. They will work in 3 shifts. Data Collection tools will form **Annexure-IX** of this document. Output variables to be generated at micro level on daily basis;

- No. of Suspect case of COVID-19
- No. of laboratory confirmed case
- No. of deaths
- No. of contacts line listed:
- No. of contacts tracked:
- No. of contacts currently under surveillance:
- No. of contacts which have exited the follow up period of 28 days:

## 13. Control Room

The following details will be provided under this head:  
 Nodal Officer with contact number:  
 Control Room Number:

## 14. Office orders (indicative)

Orders on notification.  
 Order for taking services of personnel

## 15. Budgeting (indicative)

S.no	Item	Unit cost	Total cost	
1.	Transportation			
	No. of vehicles hired			
	POL expenditure for Office vehicles/ ambulances			
2.	Communication			
	Cost of printing posters			
	Hiring personnel for display of posters			

	Cost of hiring vehicles for miking			
	Advertisement cost : local dailies cable network local TV channels SMS			
3	Logistics			
	Three layered surgical mask			
	N 95 mask			
	PPE			
4	Contingency Expenditure			



**Annexures**

<b>Annexure No.</b>	<b>Subject</b>
<b>I</b>	Containment zone: Identified Sectors for surveillance
<b>II</b>	Data collection tool at field level Data collection tool at field level (Field Level Data Compilation Sheet)
<b>III</b>	Daily Line listing of Patients detected at health facilities
<b>IV</b>	Recommended guidance for contact tracing, quarantine and isolation for Coronavirus Disease (COVID-19)
<b>V</b>	Line listing of Contacts
<b>VI</b>	Sample collection proforma to be attached with the samples
<b>VII</b>	Transportation arrangement for containment Operation
<b>VIII</b>	Identified Sectors for Public Education Outreach and rostering of identified communication staff
<b>IX</b>	Daily report of COVID-19 Outbreak

**Annexure-I**

Containment zone: Identified Sectors for surveillance

Sector	Name of Municipal ward/ village	Name of ANM/ASHA/Anganwadi Worker	Contact Number	Name of Supervisory Officer	Contact Number



**Annexure-II**

**Data collection tool at field level  
(Line listing of suspect cases)**

State & District :  
 Sector :  
 Village allocated: :  
 Name of the field worker : Phone:  
 Name of the Supervisor : Phone:  
 Name of the PHC doctor : Phone:

S.No	Name of patient	Age	Sex	Address	c/o Fever, Cough, Difficulty in breathing	Remarks

**Data collection tool at field level (Field Level Data Compilation Sheet)**

S. No.	Name of village	Total population surveyed	M	F	No. of Suspect cases identified	Total number of contacts put under home quarantine	Remarks
<b>Total</b>							