



Tel: +9180-2287 4039
+9180-2235 4085
Fax : +9180-2228 5591
e-mail : com-hfws@karnataka.gov.in

COMMISSIONERATE Health & Family Welfare Services

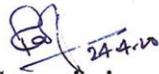
No: SSU/COVID-19/07/2020-21

Date: 24.04.2020

CIRCULAR

The Standard Operating Procedure (SOP) of Containment zone activities including micro plan formats have been shared from Government of India. Certain state specific actions have been incorporated and Guidelines have been clarified for effective implementation in districts.

For controlling the further spread of COVID-19, it is very important for districts to implement containment zone actions strictly for every positive confirmed case.


Commissioner
H&FWS, Bengaluru

Copy for necessary action:

1. DC/CEO/SP's of all districts.
2. DS/DHO/RCHO/DSO's of all districts.

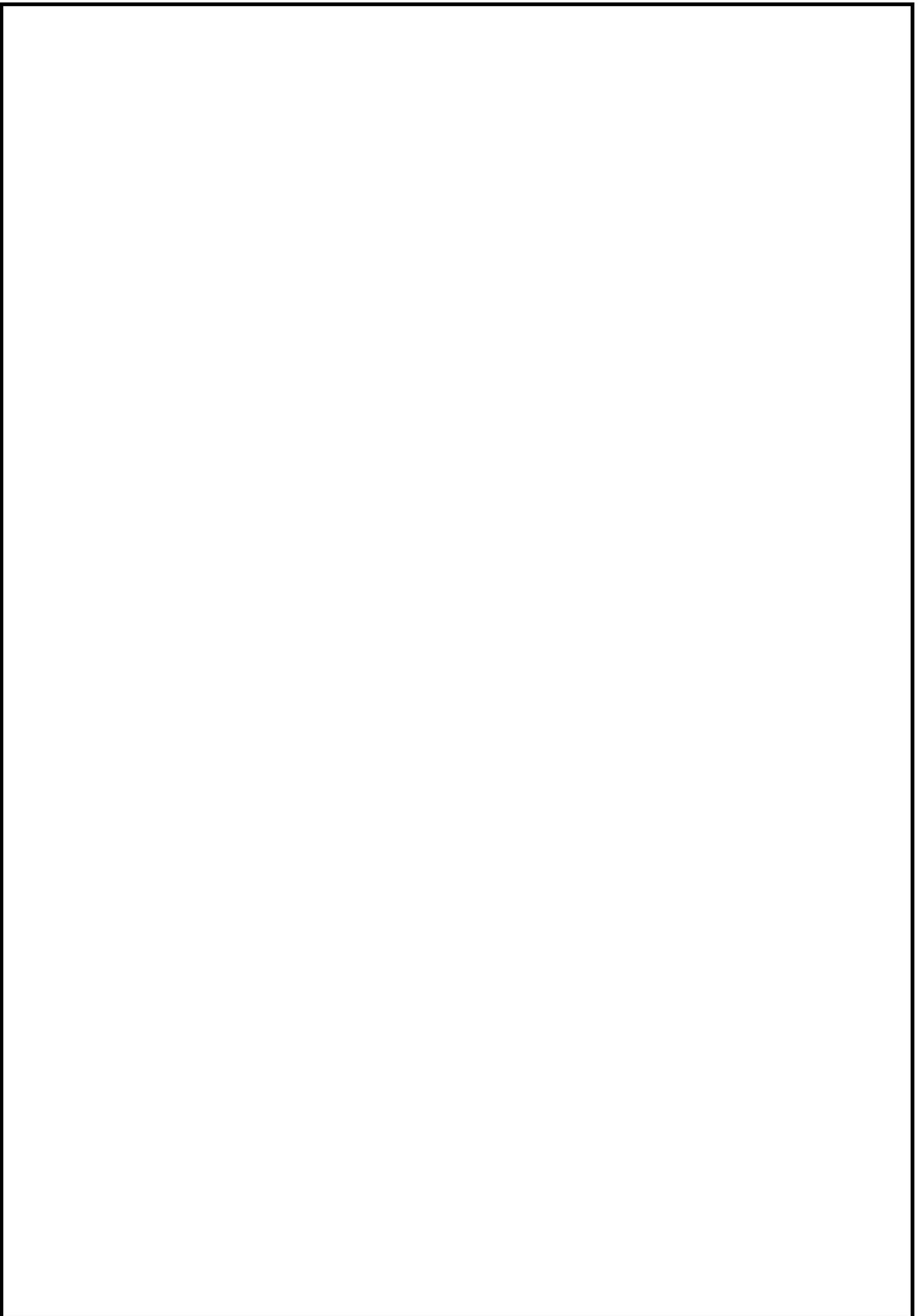
Copy for information:

1. Additional Chief Secretary, GoK, H&FW, Bengaluru.
2. OSD, SSU Covid-19.
3. Mission Director, NHM, Bengaluru.
4. Director, H&FWS, Bengaluru.
5. Project Director, RCH, Bengaluru.
6. Project Director, IDSP, Bengaluru.
7. Joint Director, CMD, Bengaluru.
8. Office Copy.



Containment Plan for Novel Coronavirus Disease 2019 (COVID-19)

**Department of Health & Family Welfare Services
Government of Karnataka**



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 in China has now spread to over 200 countries/territories, with reports of local transmission happening in more than 160 of these countries/territories. As per WHO (as of 20th April, 2020), there has been a total of 23,56,414 confirmed cases and 1,60,120 deaths due to COVID-19 worldwide.

In India, as on 20th April, 2020, 18,601 confirmed cases (including 77 foreign nationals) and 590 deaths reported from 32 States/UTs. Large number of cases has been reported from Maharashtra, Delhi, Tamil Nadu, Madhya Pradesh, Rajasthan, Gujarat, Uttar Pradesh, Telangana, Andhra Pradesh, Kerala and Karnataka.

1.2. Risk Assessment

COVID-19 was declared a pandemic by WHO on 11th March, 2020. While earlier the focus of spread was centered on China, it has now shifted to Europe and North America. WHO has advised countries to take a whole-of-government, whole-of-society approach, built around a comprehensive strategy to prevent infections, save lives and minimize impact.

In India also, clusters have appeared in multiple States, particularly Maharashtra, Delhi, Tamil Nadu, Madhya Pradesh and Rajasthan. 408 districts are now reporting COVID-19 cases and the risk of further spread remains very high.

In Karnataka, as on 20th April 2020, 408 confirmed cases and 16 deaths have been reported from 20 districts. Large number of cases has been reported from BBMP, Bengaluru Urban, Mysuru, Belagavi, Vijayapura and Kalaburgi.

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 jump species to 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, 2012). The etiologic agent responsible for current outbreak of SARS-CoV-2 is a novel coronavirus 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 been 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.

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

As per guidelines of Government of India, Karnataka would be following a scenario based approach for the following possible scenarios:

- i. Travel related case reported in Karnataka
- ii. Local transmission of COVID-19
- iii. Large outbreaks amenable to containment
- iv. Wide-spread community Transmission of COVID-19 disease
- v. Karnataka becomes endemic for COVID-19

{Note: Guidelines will be issued at a later date for iv & v}

2.1. Strategic Approach for Scenario: “Travel related cases reported from Karnataka”

- (i) Inter-Ministerial coordination (Group of Ministers, Committee of Secretaries) and State-District co-ordination has been established.
- (ii) Early detection through universal screening of all International passengers at Points of Entries (PoEs).
- (iii) Surveillance and contact tracing for tracking travellers in the community who have travelled from affected countries.
- (iv) Early diagnosis through testing samples of suspect cases.
- (v) Buffer stock of Personal Protective Equipment (PPE) maintained.
- (vi) Risk communication for creating awareness among public to follow preventive public health measures.

Classification of International Passengers arriving at Point of Entry (Airport/Seaport):

A category Passengers: Passengers who are Symptomatic on arrival are isolated in hospital & samples sent for testing. If positive, shifted to a COVID Hospital & if Negative facility isolation for 14 days, with a repeat sample taken on the 12th day

B Category Passengers: Asymptomatic passengers over 60 year's age and/or with co-morbid conditions are kept in facility isolation for 14 days. Sample is tested on 12th day or immediately on onset of symptoms. If sample is tested negative, can be discharged on 14th day & followed up for next 14 days (Reporting period);

*Note: if any B category passenger in isolation facility becomes positive on the 12th day then-

- He/she will be shifted to designated COVID hospital.
- The contacts who stayed along with the positive case in the quarantine facility will be tested on the 12th day
- If tested negative, they will be sent for home quarantine and tested again on 12th day

C Category Passengers: Asymptomatic passengers less than 60 years & without any co-morbid conditions are home quarantined for 14 days. These passengers are stamped with indelible ink on the back of their palm & Home Quarantine Sticker is displayed outside their homes.

All these asymptomatic Passengers have to upload selfie on the quarantine app or report symptoms to the Helpline. The helpline should also make daily calls to these Passengers to identify the onset of symptoms at the earliest. After 14 days of home quarantine, they will be in the Reporting period for next 14 days.

2. 2. Local transmission of COVID-2019 disease

Local transmission will lead to clustering of cases in time and space, epidemiologically linked to a travel related case or a positive case that has links to a travel related case. The cluster containment strategy will be:

- Extensive contact tracing and active surveillance for ILI cases in containment zone
- Testing all suspect cases and high risk contacts
- Isolating all suspects / confirmed cases and providing medical care.
- Quarantining contacts
- Implementing social distancing measures
- Intensive risk communication

2.3 Large outbreaks amenable to containment

The strategy will remain the same as explained in para 2.2 as above but vary in extent depending upon spread and response to be mounted to contain it. Geographic quarantine and containment strategy will include:

- Defining area of operation and applying strict perimeter control
- Active search of cases, early isolation, contact listing and tracking, quarantine and follow up of contacts
- Testing all suspect cases, symptomatic contacts, asymptomatic direct and high-risk contacts of a confirmed case and SARI cases as per the guidelines issued from time to time.
- Clinical management based on risk profile
- Social distancing measures
- Administer HCQS in healthcare workers and contacts as per the defined protocol
- Create awareness on hand hygiene, respiratory etiquettes and sanitation Defining the area of operation

3. Scope of this Document

In alignment with strategic approach of Government of India, this document provides state specific guidelines and actions that need to be taken for containing a large outbreak. The actions for mitigation phase will be dealt separately under a mitigation plan.

4. Objective

The objective of this plan is to stop the chain of transmission thus reducing the morbidity and mortality due to COVID-19.

5. Containment for large outbreaks through geographic quarantine

5.1 Large outbreak

A large outbreak is defined as localized increase in the incidence of COVID-19 cases occurring within a defined geographic area e.g., in a village, town, or city. This could also imply progression of a small cluster, earlier noticed for which cluster management action is under implementation, into multiple clusters. The cases may or may not be epidemiologically linked. For operational purpose, a large outbreak is deemed to be present when there are 15 or more cases.

5.2 Geographic quarantine

Geographic quarantine (cordon sanitaire) strategy calls for **near absolute interruption of movement of people** to and from a relatively large defined geographic area where there is single large outbreak or multiple foci of local transmission of COVID-19. In simple terms, it is a barrier erected around the focus of infection.

Geographic quarantine shall be applicable to such areas reporting large outbreak and/or multiple clusters of COVID-19 spread over multiple talukas of one or more districts that are contiguous based on the distribution of cases and contacts

5.3 Containment of individual clusters within the geographically defined perimeter

The strategy is to contain multiple clusters noted within the outbreak zone. Cluster Containment Strategy would be to contain the disease within a defined geographic area by early detection of cases, 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, quarantine of contacts and risk communication to create awareness among public on preventive public health measures.

5.4 Evidence for implementing geographic quarantine

In 2009, during the H1N1 Influenza pandemic it was observed that well connected big cities with substantive population movement were reporting large number of cases, whereas rural areas and smaller towns with low population densities and relatively poor road/ rail/ airway connectivity were reporting only few cases.

The current geographic distribution of COVID-19 mimics the distribution of H1N1 Pandemic Influenza. This suggests that while the spread of COVID-19 in our population could be high, it's unlikely that it will be uniformly affecting all parts of the state. This calls for differential approach to different regions of the state, while mounting **strong efforts in Containment Zone**.

Large scale measures to contain COVID-19 over large territories have been tried in China. Mathematical modeling studies have suggested that containment might be possible especially when other public health interventions are combined with an effective social distancing strategy.

5.5 Factors affecting large outbreak cluster containment

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

- (i) Number and size of the cluster/s.
- (ii) Effectiveness of geographic quarantine.
- (iii) How efficiently the virus is transmitting in Indian population, taking into account environmental factors especially temperature and humidity.
- (iv) Public health response in terms of active case finding, testing of large number of cases, immediate isolation of suspect and confirmed cases and quarantine of contacts.
- (v) Geographical characteristics of the area (e.g. accessibility, natural boundaries)
- (vi) Population density and their movement (including migrant population).
- (vii) Ability to ensure basic infrastructure and essential services.

6. Action Plan for Geographic quarantine

6.1. Legal framework

The State Government/District administration should review the existing legal instruments that provide legal support to implement the containment plan. Some of the Acts/ Rules for consideration could be

- (i) Disaster Management Act (2005)
- (ii) Epidemic Act (1897)
- (iii) IPC and Cr.PC and
- (iv) State Specific Public Health Act.

The Home Ministry has delegated the powers under DM Act, 2005 [Section 10 sub-section 2 clauses (i) and (1)] to Secretary (Health and Family Welfare) to act in such a way to contain or control the outbreak. States may invoke the provisions under DM Act, 2005 or under the Epidemic Act, 1897 to delegate powers to identified authority to act in such a manner to control or contain the outbreak.

Indian Penal Code under sections 270 provides power to act against those indulging in spread of disease. Section 144 of the Code of Criminal Procedure, when invoked, prohibits gathering of people.

6.2 Institutional mechanisms and Inter-sectoral Co-ordination

6.1.1 At the State level

6.1.2 The 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.

Institutional arrangement at the District/ operational level

6.1.3 Deputy Commissioner/ Commissioner-BBMP would be the nodal person for all preparedness and response activities within his jurisdiction. Deputy Commissioner/ Commissioner-BBMP will hold regular meetings with health functionaries, Disaster Management Authority, Revenue, PWD, Forest, Education and Panchayati Raj/ Local Self Governance Departments where the containment plan will be finalized and operationalized. These officials will issue directions to their ground level staff in all aspects of preparedness, control and containment in accordance with the Containment Plan and Guidelines.

Deputy Commissioner/ Commissioner-BBMP would need to identify key issues (logistics, legal, technical and resources) and address them for implementing containment operations. He/she will keep ready all administrative orders for social distancing, restriction of rail/road/air transport, perimeter control and continuity of essential services.

In addition, a compendium of all the administrative orders required for enforcing the non-pharmaceutical interventions would be prepared well in advance and kept ready to be executed during response phase.

6.2. Trigger for Action

Epidemiological intelligence on increase in the incidence of a COVID-19 cases occurring within a defined geographic area will be trigger for action. This will be provided by IDSPs early warning and response (EWAR) system. Routine laboratory based surveillance of SARI (Severe Acute Respiratory Illness) cases and Influenza Like Illness (ILI) is another trigger for action.

6.3. Deployment of Rapid Response Teams (RRT)

State Surveillance Unit will deploy the State Rapid Response Team (RRT) to support and advice the District. The District will deploy its own District RRT and Taluka RRT

6.4. Identify area under geographic quarantine

6.4.1 Defining containment and buffer zones:

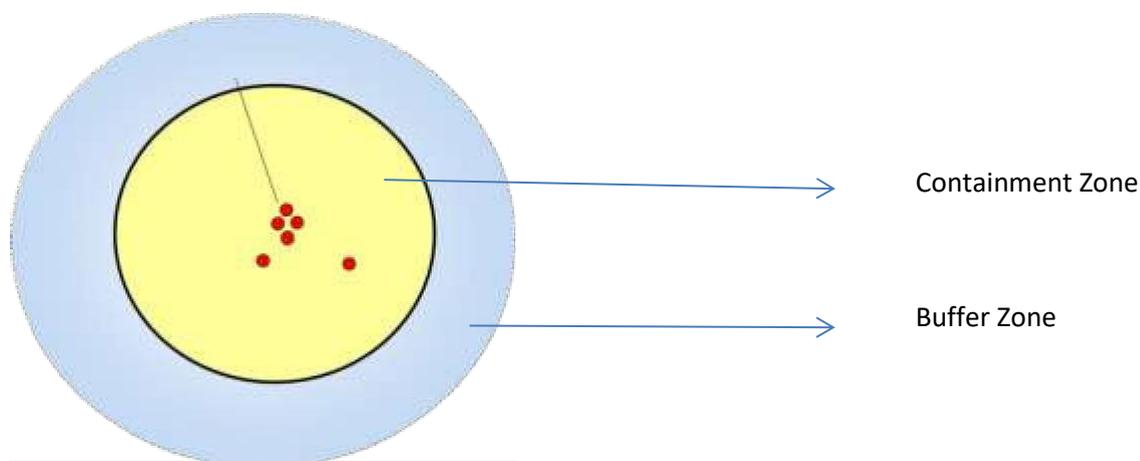
The area under geographic quarantine will be defined.

There shall be

- (i) **Containment zone, surrounded by**
- (ii) **Buffer zone**

Boundary for geographic quarantine may be defined based on :

- (i) Geospatial distribution of each cluster/positive case contained within,
- (ii) **Administrative unit/boundary** containing clusters/cases
- (iii) Feasibility to implement strict interruption of movement of people
- (iv) Joint assessment by District and Taluka RRTs



State Specific Demarcation of Containment and Buffer Zones: Karnataka

Containment Zone is a well-defined “area” around the residence/premises where a COVID – positive person resides/works and where the **most intensive measures** to prevent the spread of viral infection need to be implemented.

The “area” remains a containment zone till

- No new COVID-19 case is reported within 28 days of the last positive case of that area OR
- less than 10 primary and secondary contacts remain under active home quarantine in the containment Zone

Containment zone:

1. **For an Apartment Complex:** The particular tower/block which has the residence of the COVID positive person. In case of single block apartment, it would be entire apartment
2. **For an Independent House/Villa-** An area of 100 metres with road/physical perimeter all around the house of COVID positive person
3. **For a Slum Area:** (notified or otherwise)- An Area of 100 metres around the house with road /physical perimeter which has the residence of COVID positive person
4. **For a Rural Area:** the complete habitation where the COVID positive person resides or a smaller contiguous area as deemed necessary

BBMP commissioner / Deputy Commissioner of the district will delineate the area as defined above by identifying roads or other features for clear geographical segregation

Considerations:

- Even a single positive confirmed case should be considered for notifying a containment zone
- The containment zone will be decided by the BBMP Commissioner/ Deputy Commissioner of the district based on the extent of cases or contacts listed and mapped by them
- BBMP Commissioner/ Deputy Commissioner will identify physical features like road, parks etc. to delineate the containment zone and notify that within 8 hours of detection of COVID positive case
- Health screening to be done in the containment zone along with complete ban on movement of people except Government officials providing essential services like Medical, food, water, sanitation etc.

- Enhanced of testing as per protocol for all cases of ILI (Influenza Like Illness) in the containment zone
- Each surveillance team to be assigned around 50-100 houses
- For all individuals in containment zone
 - Daily health screening for Influenza like illness (ILIs)
 - Testing for all ILIs through **mobile sample collection** unit with a lab technician (one mobile sample collection unit may cover multiple containment zones as per feasibility)

6.4.2. Buffer Zone

- Buffer Zone is a well-defined area around the containment zone
- **Buffer zone**
 - **An area in radius of 5 km for urban**
 - **An area in radius of 7 Km for rural**
 - Passive surveillance should be carried out in buffer zone specially for ILIs / SARI
- **All the houses in buffer zone to be visited once in 3 days by surveillance teams for screening**
- ILIs cases identified during house to house survey should be referred to Fever Clinic for triage and testing
- If buffer zone of a containment zone falls into other district/state, Deputy Commissioner/BBMP-Commissioner should inform respective Deputy Commissioner of other district/state through mail and telephone with copy to state surveillance unit

6.4.3 Perimeter

Perimeter of the geographically quarantined 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 7.4.

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
- The District administration will post signs and create awareness informing public about the perimeter control
- Enforce social distancing and usage of masks in public places. Enhance IEC activities
- Health workers posted at the exit point will perform screening (e.g. interview travelers, record the place and duration of intended visit and keep complete record of intended place of stay)

- **Thermal screening, IEC shall be carried out at all entry and exit points.**
- Details of all persons moving out of perimeter zone for essential/ emergency services will be recorded
- Those entering such geographically quarantined areas shall be **given a chemo-prophylactic dose of hydroxy-chloroquine**
- All vehicles moving in & out of the perimeter control will be **decontaminated with sodium hypochlorite (1%) solution**
- **Appropriate logistics and protective gear including gloves, masks, hand sanitizers and PPEs, if required should be provided by the BBMP/Deputy Commissioner of district in order that the teams can effectively perform their responsibilities.**
 - N-95 masks for teams in Containment Zone
 - Triple Layered masks for teams in Buffer Zone
 - Prophylactic HCQS for all teams within containment zone
 - PPE for Medical examination of suspects and sample collection centres
 - Thermal scanners at entry/exit points
 - Reporting formats etc.
 - Availability of 1% of sodium hypochlorite solution
- All vehicular movement, movement of public transport and personnel movement will be stopped. All roads including rural roads connecting the containment zone will be guarded by Police. For personnel and vehicles requiring regular movement, a pass/ID card may be issued with details recorded and communicated
- Details of all persons moving out of perimeter zone for essential/ emergency services will be recorded and they will be followed up

SOP for Staff involved in Containment Zone Activities

- Survey teams visiting the containment zone for daily survey can be allowed to go home. They should follow all protocols of using N95 Masks. They should be on HCQS chemoprophylaxis under medical supervision
- Pourakarmikas (Cleaning personnel) working in containment zone may be allowed to go home after work every day. They should follow strict precautions like wearing Face shield, N-95 mask, Gloves, head cap & Gum shoes while working in the containment zone. Face shield and Gum shoes should be disinfected with 1% hypochlorite solution after every use & left in the Incident Commanders Office. N-95 masks, headcap and gloves should be disposed properly as per guidelines. They should be on HCQS chemoprophylaxis under medical supervision. Duty clothes should washed with detergent and hot water every day.

- For Vehicle drivers of utilities for containment zone: Driver & should wear face cover/ mask and use hand sanitizer regularly. Person involved in handling and delivering utilities at the entry/exit points should wear Triple layer mask.
- If any medical professionals (both public and private) are residing within the notified containment zone, they should be allowed to serve their essential duties provided they are not listed as contacts for the positive confirmed case
- Police personnel posted for duty in containment zone can be permitted to go home after shifts. They have to use proper Face shield, N-95 masks and gloves. They should be on HCQS chemoprophylaxis under medical supervision. Duty uniform should be washed with detergent and hot water every day.
- Doctor posted for containment zone can be stationed at control room formed for the zone with incident Commander. Three batches of Staff nurses along with ASHA/ANM can be posted at entry/exit point for screening throughout the day. Should take precautions and use proper PPE (Face shield, N-95 masks and gloves)
- In case of Medical emergency persons are allowed to leave the containment zone, taking proper precautions & requisite authorization.

6.4.4 Activities in Containment and Buffer zones

| Containment Zone | Buffer Zone |
|--|---|
| <p data-bbox="145 1240 810 1279">Defined area around epi-center (Positive case)</p> <ul data-bbox="205 1317 783 1581" style="list-style-type: none"> • Strict Perimeter control • Entry & Exit Point Screening • Daily House to House Survey • Active search for cases • Testing of all ILI cases as per guidelines • Emphasis on Vulnerable Groups identification and follow-up | <p data-bbox="815 1240 1437 1279">Defined area around the containment Zone</p> <ul data-bbox="876 1317 1422 1581" style="list-style-type: none"> • No perimeter control • Daily House to house survey • Active search for cases • ILI/SARI Surveillance. ILI cases to be referred to fever clinics • Emphasis on Vulnerable Groups identification and follow-up |

Standard Operating procedure in BBMP and urban areas

1. Incident commander – Crisis Management Team

Once a Containment Zone is declared by the BBMP/Deputy Commissioner, the BBMP/Deputy Commissioner should appoint an Incident Commander for each Containment zone who will be responsible for the overall management of the Containment Zone and Buffer Zone surrounding it. In cases of non-BBMP areas, the Deputy Commissioner should appoint an Incident Commander for each Containment Zone.

The Incident Commander in the BBMP area should be a senior officer of BBMP exclusively appointed for this purpose. In case of non-BBMP urban areas, the Deputy Commissioner can appoint a taluk level/district level officer as the Incident Commander for each containment zones.

All decisions relating to management of the Containment Zone is the responsibility of the Incident Commander, including determining the exact boundaries under guidance of the BBMP Commissioner/ Deputy Commissioner of the district. Day to day management would be the prerogative of the Incident Commander, subject to directions of the Government. The boundaries of the Containment Zone must be clearly demarcated and the main entry and exit points to the Containment Zone need to be identified.

An Incident Command Centre would need to be established in the vicinity of the Containment Zone from which the Incident Commander will operate. The Incident Command Centre shall have a centralized control room under the supervision of the Incident Commander with police, municipal and health authority representatives assigned to the control room. It should be a 24x7 centre with basic amenities for the personnel manning it. BBMP/municipality should provide all facilities for the smooth operation of the command centre.

Special teams to implement the activities in containment zone need to be formed. Mobile teams to enforce the lockdown in the Containment Zone have to be put in place by the Incident Commander. An assessment of persons in the Containment Zone requiring special needs (pregnancies, cardiac patients etc) would need to be undertaken with the help of local associations in order to cater to their needs in times of emergency. The Joint Commissioner of the respective BBMP Zones/Chief Officer of the urban municipality should provide all assistance/support to the Incident Commander for smooth discharge of her/his duties, including deputing staff for all departments as required.

2. Complete seal down – Role of Police

The Containment Zone would have to be cordoned off by permanent barricading to all its entrances by the Police. No person should come out of their houses for any purpose unless any emergency. There would be only one entry and exit for each Containment Zone. No private vehicular traffic would be allowed inside or outside the Containment Zone. It would be the responsibility of the police to ensure that there is complete sealing of the area.

Further, complete curfew management would need to be undertaken by the Police. Essential services and medical emergencies would need to be allowed by the Police with issuance of emergency passes. Use of technology to enforce the seal down would be required. Drones could be effectively used in the Containment Zones to ensure a total lockdown.

3. Health Department – Responsibilities

State Health Department and urban body health officials shall jointly undertake surveillance and preventive activities. Health out-post to be established in such a zone with a doctor and sufficient field staff do contact tracing daily apart from an intensive IEC campaign.

Contact tracing and tracking as per protocol needs to be undertaken. Immediate shifting of low risk (primary) contacts to institutional quarantine and subjecting low risk (secondary) contacts to home quarantine needs to be done. It is noticeable that in slum areas due to paucity of space, effective home quarantine cannot be followed for low risk contacts also. Therefore, such contacts also will be shifted to institutional quarantine for slum areas. The Health team will be responsible for the testing of high risk and low risk contacts by drawing swab samples as per protocol. Rapid anti-body tests to rule out any community spread need to be undertaken when deemed fit by BBMP Commissioner/DC of the district.

Survey of vulnerable population like elderly (>60 years), pregnant women, co-morbidities including diabetes mellitus, hypertension, renal disorders, immunodeficiency etc for early identification of ILI. Health profiling of entire population to find Influenza like Infections (ILIs) cases or any symptoms resembling COVID-19 and treating them should be undertaken on priority. The team would need to advise the strictest form of social distancing in such area under the guidance of the Incident Commander. The Health Department would facilitate or provide masks and other materials that help in the quarantine and social distancing measures.

The health-related activities will be undertaken under the overall supervision of the Incident Commander.

4. Responsibility of Municipal Authorities

The BBMP/Municipal Authorities would be responsible for maintaining overall sanitation in the Containment Zone. Daily solid waste management (including bio medical waste) as well as spraying of disinfectants should be undertaken in the Containment Zone. Adequate provision of drinking water in cases of shortage of water supply would need to be undertaken. This could also entail house to house provisioning of water in cases where there is a requirement. Food packets and ration to the needy should also be undertaken by the BBMP/municipal authorities as per the requirement. All municipal staff would be allowed in the Containment Zone with valid government identity cards for the above purposes.

5. Essential Supplies Management

Since the Containment Zone would be completely sealed down with no movement of people outside their houses even for basic necessities like groceries, meat, milk, LPG and medicines, the Police should provide for entry and exit passes for providers of such services to supply essential commodities/services within the Containment Zone. The local police station nearest to the Containment Zone should provide emergency services pass so that there could be uninterrupted supply of essential goods and services to the zone. All essential supply shops like groceries, meat, milk, medicines, LPG would be closed in the Containment Zone. Provision of ration by Fair Price Shops to the doorstep of the ration card holder would also need to be undertaken.

Standard Operating procedure in the rural areas

1. Incident Commander – Crisis Management Team

Once a Containment Zone is declared by the Deputy Commissioner, the Deputy Commissioner will appoint an Incident Commander for each Containment Zone responsible for the overall management of the Containment Zone and Buffer Zone surrounding it. The Deputy Commissioner should appoint an Incident Commander for each Containment Zone. The boundaries of the Containment Zone must be clearly demarcated and the main entry and exit points to the Containment Zone need to be identified. In case of a revenue village, the entire revenue habitation or a smaller contiguous part as determined would need to be cordoned off.

All decisions relating to management of the Containment Zone is the responsibility of the Incident Commander, including determining the exact boundaries under guidance of the Deputy Commissioner of the district. Day to day management would be the prerogative of the Incident Commander, subject to directions of the Deputy Commissioner. The boundaries of the Containment Zone must be clearly demarcated and the main entry and exit points to the Containment Zone need to be identified.

An Incident Command Centre would need to be established in the vicinity of the Containment Zone from which the Incident Commander will operate. The Incident Command Centre shall have a centralized control room under the supervision of the Incident Commander with police, panchayat and health department representatives assigned to the control room. The local panchayat officials should provide all assistance to the Incident Commander to perform his duties as per this circular.

2. Complete seal down – Role of Police

The declaration of the revenue habitation as a Containment Zone would not entail any person coming out of their house for any purpose. The entire habitation would have to be cordoned off by permanent barricading to all its entrances by the Police. There would be only one entry and exit to the entire habitation. No private vehicular traffic would be allowed inside or outside the Containment Zone. It would be responsibility of the police to ensure that there is complete sealing of the area.

3. Health Department - Responsibilities

The district health officials will be responsible for surveillance and preventive measures in the Containment Zone. A Health outpost is to be established in such a zone with a doctor and sufficient field staff to do house to house survey daily apart from an intensive IEC campaign. Contact tracing and tracking as per protocol needs to be undertaken. Immediate shifting of low risk (primary) contacts to institutional quarantine and subjecting low risk (secondary) contacts to home quarantine needs to be done. It is noticeable that in slum areas due to paucity of space, effective home quarantine cannot be followed for low risk contacts also. Therefore, such contacts also will be shifted to institutional quarantine for slum areas.

The Health team will be responsible for the testing of high risk and low risk contacts by drawing swab samples as per protocol. Rapid anti-body tests to rule out any community spread need to be undertaken when deemed fit by BBMP Commissioner/DC of the district. Health profiling of entire population to find Influenza like Infections (ILIs) or Severe Acute Respiratory Infection (SARI) cases or any symptoms resembling COVID-19 and treating them should be undertaken on priority. The team would need to advise the strictest form of social distancing in such area under the guidance of the Incident Commander. The Health Department would facilitate or provide masks and other materials that help in the quarantine and social distancing measures.

4. Responsibilities of the Gram Panchayat

The Gram Panchayat Authorities would be responsible for maintaining overall sanitation in the Containment Zone. Daily solid waste management as well as spraying of disinfectants should be undertaken in the Containment Zone. Adequate provision of drinking water in cases of shortage of water supply would need to be undertaken. This could also entail house to house provisioning of water in cases where there is a requirement. All panchayat staff would be allowed in the Containment Zone with valid government identity cards for the above purposes. Gram Panchayat should provide all facilities to set up and smooth operation of the command centre.

5. Essential supplies Management

Since the Containment Zone would be completely sealed down with no movement of people outside their houses allowed even for basic necessities like groceries, meat, milk and medicines, the police should provide for entry and exit passes for providers of such services to supply essential commodities/services within the Containment Zone. All essential supply shops like groceries, meat, medicines would be closed in the Containment Zone. Provision of ration by Fair Price Shops to the doorstep of the ration card holder would also need to be undertaken.

However, agricultural activity/operations should be allowed for asymptomatic and healthy persons to continue in the Containment Zone with necessary social distancing measures and compulsory wearing protective masks.

Buffer Zone Management:

1. The Incident Commander appointed for the Containment Zone will be given the responsibility of managing the Buffer Zone also. He can use the same set up to monitor it.
2. Partial Lockdown- Role of Police: The social distancing measures in the area around the Containment Zone with restricted movement of public needs to be ensured by the police. No public function or gathering should be allowed.
3. Health Department:
 - a. Active and effective surveillance by health staff to find ILI cases and refer them to Fever Clinic
 - b. Each surveillance team to cover minimum 50-100 houses each day and all houses to be covered in a day for health status.
 - c. Enforce social distancing and usage of masks in public places.

Appropriate protective gear including gloves, masks, hand sanitizers and PPEs, if required should be provided by the BBMP/Deputy Commissioner in order that the teams can effectively perform their responsibilities.

7. Surveillance

7.1. Surveillance in containment zone, including house-to-house visits, contact listing, tracking and follow up shall be carried out as detailed in Cluster Containment Plan. Contact tracing shall be as per state SOP on the same.

7.2. The Surveillance activities are to be undertaken both in the containment zone and buffer zones:

- Active case search will be done through house-to-house visit. For such purpose, a designated surveillance team will visit on an average 50-100 households
- The surveillance would be done by JHAs, ASHAs and field officers from other departments like education, ULD, Panchayat etc
- Additional workforce can also be drawn from Red Cross, NSS, NYK, & Ayush students, nursing colleges etc.
- The surveillance workers (COVID Warriors) will interview the households through a questionnaire regarding
 - (i) signs, symptoms
 - (ii) travel history
 - (iii) history of contact with a confirmed/suspect COVID-19 case
 - (iv) Number of elderly in the household
 - (v) Number of persons with co-morbidity
- Teams for house to house survey in containment and buffer zones should be different from contact tracing teams. Both teams should share data on additional contacts found during house to house survey
- They will also inform their supervisory officers of cases detected and contacts listed during the day. They will also compile and collate daily reports.
- They will ensure that the mobile sample collection units collect sample from ILI cases
- They will follow up with on the vulnerable groups

7.3. Passive Surveillance and Surveillance of Vulnerable Groups

- Passive surveillance shall be enhanced throughout the district from all government and private health facilities. Reports should be obtained on a daily basis on the number of ILI and SARI cases admitted/diagnosed and treated along with the name and phone number of the patient
- Reports should be obtained on a daily basis from the pharmacies on the dispensation of fever/ cough and cold remedies dispensed along with the name and contact number of the patient

ILI and SARI Surveillance (in all the districts)

- ILI and SARI surveillance should be strengthened in the entire district
- **All cases of SARI in the district** should be immediately notified for COVID-19 testing
- **All cases of ILI in the containment zone** areas should be tested for COVID-19
- All cases of ILI from other areas should be referred to Fever Clinics for further assessment
- Also, Universal survey should be done in all the districts to identify houses with elderly persons (aged above 60 days) with co-morbidities. These houses should be followed-up by concerned ASHA/JHA/health supervisors every 3 days in districts with COVID positive cases and every week in districts with no COVID positive cases
- As a matter of abundant caution all cases of ILI should be advised strict home quarantine for 14 days

Case Definitions:

- **Influenza Like Illness (ILI) case definition:**
 - An acute respiratory infection with
 - a) measured fever of $\geq 38\text{ C}^\circ$
 - b) and cough
 - c) With onset within the last 10 days
- **Severe Acute Respiratory Infection (SARI) case definition:**
 - An acute respiratory infection with:
 - a) history of fever or measured fever of $\geq 38\text{ C}$
 - b) and cough
 - c) with onset within the last 10 days
 - d) and requires hospitalization (Difficulty in breathing)

Surveillance among Vulnerable Groups :

- **In all Areas (Within and outside containment zones)**
 - Persons more than 60 years Age
 - Pregnant Women
 - Diabetes Mellitus
 - Hypertension
 - Tuberculosis
 - Cancers
 - Dialysis
 - Stroke
 - HIV Positive
 - Organ transplant
 - Primary Immunodeficiency disorders (PID) and Other Immunocompromised

- **Surveillance teams should be formed by drawing staff from other departments not involved in containment zone (Education, WCD, RDPR, ULB, other departments and Nursing colleges)**
 - Do house-to house survey - follow up health condition of all such persons in their areas
 - **JHA/ASHA/Health Supervisors should plan to visit houses where elderly persons with co-morbidities are residing and follow up every 3 days**
- **If any ILI/SARI Symptoms among vulnerable among**
 - Immediately inform concerned medical officer
 - Arrange Ambulance and refer to nearest fever clinic
- **Collect phone numbers of such persons and share with state for mobile SMS follow-up**

7.2 **Precise mapping** of the Containment and Buffer Zones shall be carried out.

- Map should show clear boundaries and depict the entry/exit points and major landmarks
- Containment and buffer zone boundaries should be depicted

| Containment Zone | Buffer Zone | Rest of the area in COVID districts | Rest of the area in Non -COVID districts |
|--|--|---|---|
| -Intense Surveillance -Once a day House to house survey - Mobile sample collection teams with Lab technicians / suspect taken to nearest sample collection centre to collect samples of all ILI cases in BBMP/Urban areas - One mobile team can cater to many containment zones | -Once in 3 days House to house survey -All ILI cases are referred to fever clinics and sample collection after triage | -Vulnerable group* covered once in 3 days and remaining covered once in a week. -Any ILI case to be immediately referred to PHC. -All patients with COVID like symptoms will be referred to fever clinics from PHC and sample collection after triage | -All persons covered once in 7 days. -Any symptomatic patient to be immediately referred to PHC. -All patients with COVID like symptoms will be referred to fever clinics from PHC and sample collection after triage |

District Command system (DC of District/BBMP Commissioner)

- An Incident Commander should be notified for each Containment Zone by DC and review:
 - Constitution of teams for Surveillance (active & passive)
 - Field operations by Paramedics, JHAs, AWWs, and support staff from other departments

1) Daily house to house visits to:

- Search clinically suspect (ILI) cases.
- Identify contacts of confirmed and suspect cases – provide masks
- Surveillance of Vulnerable groups
- Maintain line list of suspect/ confirmed cases and contacts
- Monitor contacts daily
- Inform Supervisory Medical Officer about suspect cases and their contacts
- Create awareness among community

II) Medical Examination and Sample Collection

III) Counsel individuals to take precautions to avoid contact with those with Symptoms suggestive of COVID-19

IV) Ensure that contacts on facility/ home quarantine use 3 layered surgical masks at all times. Educate them on proper use and disposal of masks.

8. Laboratory support

8.1 Designated laboratories

The identified ICMR-VRDL network laboratories and designated private laboratories 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) shall also be engaged to collect/ 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 as designated from the state depending upon geographic proximity.

ICMR testing protocol shall be followed. All test results should be available within 12-24 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

A. Indications for RT-PCR (Throat swab + Nasal Swab):

- All symptomatic individuals who have undertaken international travel in the last 14 days
- All primary contacts (direct and high-risk contacts) of Confirmed cases
 - If symptomatic – Test immediately
 - If Asymptomatic - should be tested once on Day 12 of quarantine
- All Secondary contacts of Confirmed cases
 - If symptomatic – Test immediately
 - If Asymptomatic - should be tested once on Day 12 of quarantine
- All symptomatic health care workers
- All hospitalized patients with Severe Acute Respiratory Illness (fever AND cough and/or shortness of breath)
- ILI patients in containment zone
- ILI Patients in whom Rapid test is negative and clinician warrants RT-PCR, test can be done
- All symptomatic police personnel involved in quarantine/ isolation/ surveillance, activities of suspect/confirmed COVID-19 cases in the state.

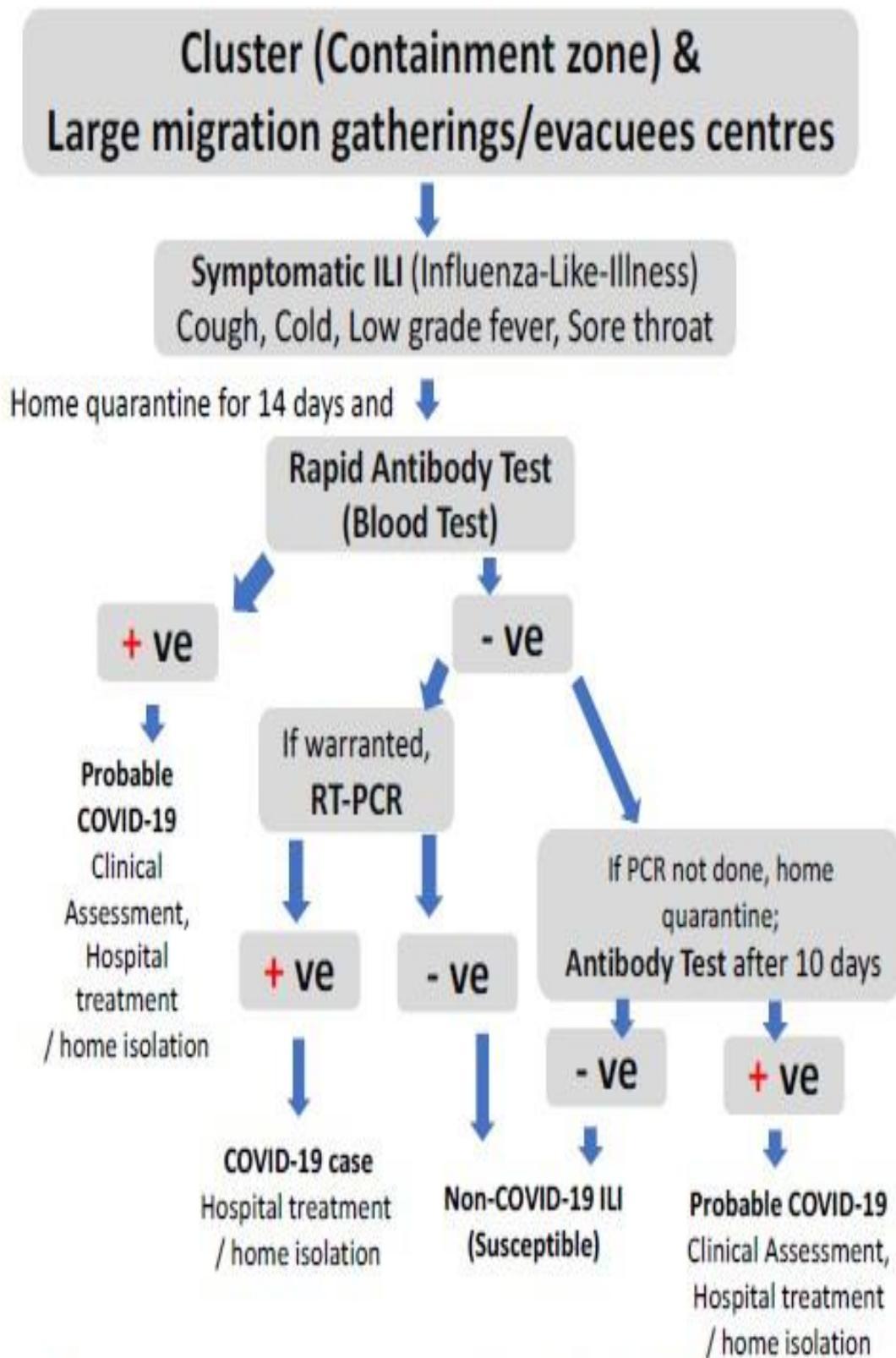
B. Indications for Rapid Antibody based Blood Test:

Symptomatic Influenza Like illness-ILI (Cough, Cold, low grade fever, sore throat)

- Patients coming to designated Fever clinics
- Patients identified during house-to-house survey in buffer zone
- Patients in large migratory gatherings/shelters
- Above patients in whom first Rapid test has come negative and RT-PCR not done, Repeat Rapid test 10 days after first Rapid test

STRATEGY FOR USE OF RAPID ANTIBODY BASED BLOOD TEST

(4 April, 2020)



If symptoms worsen, refer to designated COVID-19 hospitals

9. Hospital care

All suspect/confirmed COVID-19 cases will be hospitalized and kept in isolation in dedicated COVID-19 hospitals/hospital blocks. Persons testing positive for COVID-19 will remain hospitalized till such time as two of their samples are tested negative (14 days after collection of first sample positive for COVID-19) as per discharge policy. Advice 14 days of home quarantine followed by 14 days of reporting period after discharge. About 15% of the patients are likely to require hospitalization, and an additional 5 % will requires ventilator management.

A three tier arrangement for managing suspect/ confirmed cases will be implemented to decrease burden on the COVID Block/ hospital.

- (i) The mild and very mild cases will be kept in COVID Care Centers which essentially are temporary makeshift hospital facilities made by converting hotels/ hostel/ guest houses/ stadiums near a COVID-19 hospital. The existing quarantine facility may also be converted. This will be identified near an existing COVID hospital/ COVID block
- (ii) Dedicated COVID Health Centers would be identified in existing hospitals. These centers will have isolation beds with oxygen support for managing moderate cases, which require monitoring of their clinical status (patients with radiological evidence of pneumonia)
- (iii) Severe cases requiring critical care/intensive care will be managed in Dedicated COVID Hospitals. Some of the severe cases may progress to respiratory failure and /or 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 plan.

In every hospital, fever clinic with triage, holding areas, sampling stations and individual doctor's chambers where patients with fever/cough/breathing difficulty will be attended

9.1 Surge capacity

Based on the risk assessment, if the situation so warrants (if data suggests 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 identified for temporary hospitals will be operationalized.

Surge capacity will also need enhancement in terms of laboratory testing capacity.

9.2 Pre-hospital care (ambulance facility)

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

For any further guidance Standard Operating Procedure (SOP) for transporting a suspect/confirmed case of COVID-19 may be referred;

(Available at: <https://ncdc.gov.in/WriteReadData/1892s/66149969001580629188.pdf>)

9.3 Infection Prevention Control Practices

Health care associated infections among attending healthcare personnel are well documented in the current COVID-19 outbreak. There shall be strict adherence to Infection prevention control (IPC) practices in all health facilities. IPC committees would be formed (if not already 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 where aerosolisation is anticipated, 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 commonly touched surfaces with sodium hypochlorite solution.

Detailed guidelines available MoHFW's website on

- (i) Infection prevention and control in healthcare facilities,
 - (ii) Rational use of Personal Protective Equipment,
- may be referred to.

All healthcare workers must be advised to self-monitor their health and report any breach in IPC practices or occurrence of any illness.

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.

Doctors managing severe COVID cases may contact RGICD, Bangalore. (Helpline– 9745697456/ 080-46848600) or through tele-medicine network to seek guidance for management of severe cases.

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 based on consecutive two samples taken 24 hours apart tested negative (14 days after collection of first sample positive for COVID-19) and the patient is free from symptoms. After discharge, patient should be advised home quarantined for 14 days followed by self-reporting for next 14 days.

11. Psychosocial support

Quarantine, isolation and being affected by a new disease, all can be very stressful for those involved and for their family members. Social distancing measures that force one to stay at home and resulting social isolation can be frustrating. This apart, the healthcare workers working under the fear of an unknown disease, under stressful and demanding situations, impact their mental well-being. A guidance note on dealing with various mental issues is available at:

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

The National Institute of Mental Health and Neuro Sciences (NIMHANS) will be the nodal agency to plan and execute psycho-social support. NIHMANS will prepare a Psycho-Social Support plan and implement the same in the COVID affected areas.

12. Pharmaceutical interventions

As of now there is no approved specific drug or vaccine for cure or prevention of COVID-19.

However Hydroxychloroquine has been recommended as chemoprophylaxis drug for use by asymptomatic healthcare workers managing COVID-19 cases and contacts of confirmed COVID-19 cases under medical supervision

Advisory issued by ICMR in this regard is available at:

<https://www.mohfw.gov.in/pdf/AdvisoryontheuseofHydroxychloroquinasprophylaxisforSARSCoV2infection.pdf>).

Contacts and healthcare workers receiving Hydroxychloroquine as chemoprophylaxis will be informed to report any untoward health event to nearest health facility

In addition, a combination of Hydroxychloroquine and Azithromycin has been advocated for use in severe cases of COVID-19 under medical supervision.

(Guideline on clinical management protocol of COVID-19 is available at:

<https://www.mohfw.gov.in/pdf/RevisedNationalClinicalManagementGuidelineforCOVID1931032020.pdf>)

13. 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

13.1. Preventive public health measures

There will be intensive social mobilization among the population in geographic quarantine zone for adoption of community-wide practice of frequent washing of hands and respiratory etiquettes. The community will also be encouraged to self-monitor their health and report to the ASHA/Anganwadi worker visiting home or to nearest health facility.

13.2. Quarantine and isolation

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

13.2.1. 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 home quarantine/facility quarantine of contacts of suspect /confirmed cases. The guideline on home quarantine is available on the website of MOHFW which provides detailed guidance on home quarantine.

The contacts advised quarantine will undergo risk profiling. Those above age of 60 or with co- morbidities will be shifted to designated quarantine facility. This will help identify early development of symptoms among them, their testing and shifting to isolation facility

13.2.2. 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.

In resource constrained settings, all positive COVID-19 cases can be cohorted in a ward with good ventilation. All suspect cases could also be cohorted in a separate ward. However, under no circumstances these cases should be mixed up.

The COVID Care Centers/Dedicated COVID Centers and Dedicated COVID Hospitals will all have separate facilities to keep suspect and confirmed cases.

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.

13.3 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:

13.3.1 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.

13.3.2 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 as the area is declared to be free of COVID-19.

13.3.3. 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.

13.3.4. Cancellation of public transport (bus/rail)

There will be prohibition for persons entering the geographic quarantine and on persons exiting the geographic quarantine 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 the 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.

14. Material Logistics

14.1. 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">• 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 performing interventional lifesaving maneuvers.• Those working in laboratories or collecting sample |
| 2 | N-95 Mask and gloves | <ul style="list-style-type: none">• Supervisory doctors verifying a suspect case• Doctors/nurses attending patients in Screening fever clinics/ respiratory clinics / primary health care facilities |
| 3 | Triple Layer Surgical mask | <ul style="list-style-type: none">• 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 |

The district administration has to ensure adequate stock of Personal Protective Equipment (PPE). The quantity required for a containment operation will depend upon the size and extent of the cluster and the time required for containing it. Districts will also ensure that the PPE are being used in accordance with the guidelines on rational use of PPE.

14.2. 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.

14.3. Stay arrangements for the field staff

The staff can be go home after survey activities each day. They should take proper precautions while within containment zone and use proper PPE. They should report their medical condition regularly to the incident commander and be on HCQS chemoprophylaxis under medical supervision.

14.4 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.

15. Risk communication

15.1 Risk communication material

Risk communication materials [comprising: (i) posters and pamphlets (ii) audio only material (i) AV films (prepared by State IEC Division)] will be prepared and kept ready for targeted roll out in the entire geographic quarantine zone.

15.2 Communication channels

15.2.1 Interpersonal communication

During house to house surveillance, JHA, ASHAs/ other community health workers will interact with the community for:

- (i) reporting symptomatic cases
- (ii) contact tracing
- (iii) information on preventive public health measures.

15.2.2 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.

15.2.3 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.

15.2.4 Media Management

At the District level, only Deputy Commissioner or his/her nominee will 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 including social media.

16. Information Management

16.1 Control room at State & District Headquarters

A Control Room (if not already in place) shall be set up at District headquarters. This shall be manned by District Surveillance Officer under which data managers (deployed from IDSP/ NHM) responsible for collecting, collating and analyzing data from field and health facilities.

Micro-plan for containment zone should be prepared. Daily situation reports shall be sent to state government without fail.

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

- No of containment zones identified in district
- Total number of families surveyed
- Total number of suspect cases
- Total number of samples collected
- Total number of confirmed cases
- Total number of critical cases on ventilator
- Total number recovered and discharged
- Total number of deaths
- Total number of contacts under surveillance
- Total number of PPEs and other logistics.
- Taluka / District level consolidation of field data – Active surveillance
- Data from Govt and Private health facility from containment and buffer zones
- Daily report of cluster containment

16.2 Control Room in the geographic quarantine zone

A Control Room shall be set up inside the geographic quarantine 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.

16.3 Alerting the neighboring Districts/States

The Control Room at State Government Headquarters 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.

17. Capacity building

It is expected that in such circumstances, large human resource requirement will be there to manage: (i) Field activities including surveillance, (ii) Clinical care at hospitals, (iii) laboratory testing and (iv) support staff to provide support services.

17.1 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 and health service providers

17.2 Target trainee population

Various sections of healthcare workforce (including specialist doctors, medical officers, nurses, JHAs, BHEOs, 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.

Prepare Training plan and calendar for undertaking training of non-health workers (including trainee JHA), volunteers from Red Cross, Civil Defence, NCC, NSS, Nehru Yuvak Kendra volunteers, Panchayati Raj functionaries on community surveillance (self- protection, brief questionnaire interview and reporting to supervisors).

Train all available clinical resources (respiratory physicians, anaesthetists, intensivists, MBBS doctors who have handled ventilators, including DNB and MD students) on clinical and ventilator management.

The training resources available at IGOT platform of GoI and Jagruti Karnataka Youtube channel of Government of Karnataka may be utilized.

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

17.3 Replication of training in other Districts

The district administration will ensure that unaffected districts/ talukas 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.

18. Financing of containment operations

The fund requirement would be estimated taking into account the scale of operations and SDRF funds can be used as per notification issued by Ministry of Home Affairs. the Deputy Commissioner/ Commissioner-BBMP from. NHM flexi-fund can also be used as per notification issued by Ministry of Home Affairs.

19. Scaling down of operations

The operations will be scaled down if no secondary laboratory confirmed COVID-19 case is reported from the geographic quarantine zone **for at least four weeks after the last confirmed test** has been isolated and all his contacts have been followed up for 28 days. A containment operation shall be deemed to be over 28 days from the date the last case in the containment zone tests negative.

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.

Model Micro-Plan for Containment Zone- Karnataka

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

Location of Positive Confirmed Case/s:

PHC/UPHC/ Planning Unit:.....

Taluka:

District:

Micro-plan for Containing Local Outbreak of COVID-19

Geographic Location: _____

Village/ Municipality/ Corporation: _____

PHC/ Planning unit: _____

Taluka: _____

District: _____

1. Objective of the micro-plan

- To contain the outbreak of COVID-19 in defined geographic area
- One micro-plan to be prepared for each case/cluster

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/ Taluka:

No of Municipalities/ Corporations:

Block/Taluka Details

Name of Block/Taluka:

Population:

Number of Villages:

3. Mapping the affected area

The containment zone will be decided by the District RRT based on the extent of cases/contacts listed and mapped by them.

(Draft notification is enclosed)

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

Name of the epi-centre: Municipality ward/ village:

Population in Containment Zone:

Number of houses in containment zone:

3.2 Buffer Zone – As per Cluster Containment Plan

Number of Municipalities /village

Panchayats:

Number of Villages/ Wards in Buffer Zone:

Population in Buffer Zone:

Number of houses in Buffer zone

3.3 The containment zone will be divided into Areas/Sectors **with 100 houses each** (50-60 houses in difficult areas). The Areas/ sectors will facilitate all activities for containment as described in the ensuing sections/ paragraphs.

Note: If Pulse polio micro-plan is readily available, one team day can be considered as one area/sector and teams planned accordingly

Every confirmed case has to be considered as an epicenter and micro-plan activities will be done as described above.

Divide the village/ward into Areas/ sectors. List them with name (of village/ward) and identified nodal officer.

Listing of Areas/Sectors (Annexure 4)

| Name of Village/ Ward | Area/ Sector | Name of Area/ Sector (First house-Last house) | Team Members | Contact number | Supervisor with contact Number (1 per 3 -5 teams) |
|-----------------------|--------------|---|--------------|----------------|---|
| | A | | 1 2 | | |
| | B | | 1 2 | | |
| | C | | 1 2 | | |
| | D | | 1 2 | | |

4. Human Resource

4.1. Administrative and Technical Personnel

The Deputy Commissioner/ Commissioner-BBMP will be Nodal person for cluster containment in their respective districts.

An incident commander can be notified for each containment zone

| S. No | Name | Designation | Contact Number (O) | Mobile |
|-------|------|-------------------------|--------------------|--------|
| 1 | | DC/Commissioner-BBMP | | |
| 2 | | CEO-ZP | | |
| 3 | | DHO | | |
| 4 | | DSO/ Programme Officers | | |
| 5 | | Epidemiologist | | |
| 6 | | THO | | |
| 7 | | DHEO/ Health Supervisor | | |

District RRT

| S. No. | Name | Designation | Contact Number (O) | Mobile |
|--------|------|-------------|--------------------|--------|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |

4.2. Human Resource for operations / field activities

4.2.1 Responsibilities assigned to various functionaries

4.2.1.1 Survey teams: JHA / ASHA/ Anganwadi worker/ Field personnel from other departments*:

4.2.1.1.1. Daily house to house visit to:

- (i) Search clinically suspect cases (ILI)
- (ii) Identify contacts of confirmed and suspect cases
- (iii) Maintain line list of suspect/ confirmed cases and contacts
- (iv) Monitor contacts daily
- (v) Inform Medical Officer about suspect cases and their contacts
- (vi) Identify elderly (above 60 years age) with co-morbidity and follow-up
- (vii) Create awareness among community about disease prevention, home quarantine, common signs and symptoms, hand hygiene, cough etiquette, social distancing and need for reporting suspect cases by distributing 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/facility 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 JHA/ASHA/AWWs, 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. Senior Health Assistant (Male/Female)

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

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

4.2.1.3. Block Health Education Officer(BHEO) 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
- Media tracking

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 (Medical Officer/ Taluka Health 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
- 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 (JHA/ ASHA/Anganwadi Worker) will be able to visit 100 houses in a day (50-60 in difficult areas).

Human resources for containment survey should be mobilized from all the line departments through orders from Deputy Commissioner/ Commissioner-BBMP

A supervisory Medical Officer shall be deployed for supervision

4.2.2 Human Resource requirement for field operations

- Should be planned as per area of containment zone and number of HR required

5. Components of Micro-plan

5.1 Surveillance

5.1.1. Active Surveillance

5.1.1.1. Constituting Teams for Health Surveillance:

Each health worker/ Field Surveyor would cover 50 houses in the sector assigned to them. They should visit same assigned 50 houses every day for 14 days. The listing of municipality wards/ villages allocated to surveillance teams, their names, name of supervisors for each team and their contact number should be done.

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/ JHA/ASHA/Anganwadi Worker and field surveyors from other departments

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

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

5.1.1.3. Role of Supervisory Medical Officer/ Senior Health Assistant/ LHV

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

He / she will visit any suspect case brought to his/ her notice by the JHA/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, ILI and SARI to the identified supervisory officer for that sector. Suspect COVID-19 cases reported by health facilities should be noted in proforma.

6 Logistics

6.1 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 within 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 double layered Bag (yellow).

7. Communication

DHEO/ BHEO / or any other designated communication staff will be allocated the work of public education outreach on COVID-19. Public information education and communication campaign will be held in the community.

The sector wise allocation of BHEO with 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.

8.. Data Management

The DSU/ Control Room will have data managers (deployed from IDSP/ NHM) responsible for collecting, collating and analyzing data from field and health facilities. 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 ILI Cases in Containment Zone
No. of SARI cases in containment Zone
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:

Disinfection of Areas visited by COVID Positive Case

- After contact tracing and complete movement history, all places visited by COVID positive case within last 14 days should be disinfected including home, workplace, hospital, Quarantine Facility, car, bus, train compartment, school etc.
- For Disinfection:
 - 1% Hypochlorite Solution
 - Readily available solution in market or prepare every 24 hours with bleaching powder (320 grams of bleaching powder in 10 litres water or 1 kg bleaching powder in 30 litres of water)
 - Can be used for bus stands, railway stations, buses, trains, vehicles, malls, cinema theatres, marriage halls, office spaces etc
 - Can be used for cleaning floors and surfaces
 - OR
 - Lysol Spray (Lysol IP: 50% Cresol and 50% Liquid Soap)
 - 2.5% Lysol (1 litre Lysol in 19 litres water) for bus stands, railway stations, buses, trains, vehicles, malls, cinema theatres, marriage halls, office spaces etc)
 - 5% Lysol (1 litre Lysol in 9 litres water) for Hospitals, Clinics and Ambulances

QUESTIONNAIRE

- a) House Number, Name of Head of Family and contact number
- b) Number of members in the family
- c) Number of members aged more than 60 years in family
- d) Number of members in family with co-morbidity (Hypertension, Diabetes, Asthma, Bronchitis, Tuberculosis, Cancer, HIV, Organ Transplant, Kidney disease or any other ailment)
- e) Any pregnant woman in the family
- f) Any person in family has fever (>38 degrees C/100.4F), Cough within last 10 days
- g) Do you or any family members have any history of contact with the Person Tested Positive?
- h) If yes, provide details? Date, Duration and Nature of Interaction
- i) Persons you met after your contact with the Person Tested Positive? Provide Details Name, Age, Address, Date, Duration & Nature of Interaction (List them)

IMPORTANT POINTS FOR TEAM

- Health Officials must inform the jurisdictional Police Officer about the visit of the Team.
- Wear N95 Mask, Use Sanitizer and carry Official Identity Card and show the ID to the Primary Contact.
- Maintain distance of 2 Meters/ 6 Feet from any person
- Questions must be preferably asked outside the house instead of going inside their house
- Team members should be given chemoprophylaxis of Hydroxychloroquine under medical supervision as per guidelines

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

1. No of containment zones identified
2. No of administrative and technical personnel in containment zone (Annexure -1)
3. Details of District RRT (Annexure- 2)
4. Human resource requirement for field operations (Annexure-3)
5. Total number of families surveyed
6. Total number of suspect cases (Annexure 5 A)
7. Total number of samples collected (Annexure 8)
8. Total number of confirmed cases
9. Total number of critical cases on ventilator
10. Total number recovered and discharged
11. Total number of deaths
12. Total number of contacts under surveillance (Annexure 1,Format 2)
13. Total number of PPEs and other logistics. (Annexure 6)
14. Taluka / District level consolidation of field data – Active surveillance (annexure 7)
15. Data from Govt and Private health facility from containment and buffer zones(annexure -8)
16. Daily report of cluster containment (annexure -9)


Commissioner,

Health & Family Welfare Services

Circulars



GOVERNMENT OF KARNATAKA

No. HFW 109 ACS 2020

Karnataka Government Secretariat
Vikasa Soudha,
Bengaluru, dated: 17-04-2020

CIRCULAR

Sub: Definition of Containment Zone, Cluster and their management
S.O.P. reg.

Ref: Circular no. HFW 100 ACS 2020 dated: 11.04.2020.

This office has issued a Circular cited at reference above defining hotspot, containment zone and cluster. However, after detailed deliberations and careful consideration, it is felt that the definitions need modification for easier implementation of various lockdown measures and Covid-19 virus control strategies. **Therefore, the Circular cited above is withdrawn.**

I. Following are the **revised definitions** along with the detailed strategies for their management.

1. Containment Zone:

Containment Zone is a well-defined "area" around the residence of a novel Coronavirus – positive person where the most intensive measures to prevent the spread of viral infection need to be implemented. The "area" remains a Containment Zone till

- i. no new Covid-19 case is reported within 28 days of the last positive case of that area or
- ii. less than 10 primary and secondary contacts remain under active home quarantine (as earlier defined) in the Containment Zone.

The 'area' is defined as follows.

- a) For an **apartment complex** - the particular tower/block which has the residence of Covid – positive person. In case of single block apartments, it would be the entire apartment.
- b) For an **independent house/Villa**, an area of 100 metres with road / physical perimeter all around the house of Covid – positive person.
- c) For a **slum area** (notified or otherwise) an area of 100 metres around the house with road / physical perimeter which has the residence of Covid positive person.
- d) For a **rural area**, the complete habitation where the Covid - positive person resides or a smaller contiguous area as deemed necessary.

BBMP Commissioner/Deputy Commissioner of the district will delineate the "area" as defined above by identifying roads or other features for clear geographical segregation.

2. Buffer Zone:

Buffer Zone will be an area in a radius of 5 km for urban and 7 km for rural areas around the Containment Zone. Active surveillance and social distancing measures should be in place in the Buffer Zone to avoid spread of Covid-19 infection.

There will be an Intensive Buffer Zone of 1 km radius wherein house to house screening should be done.

When a Containment Zone turns normal due to non-reporting of any new Covid-19 case in that Containment Zone within 28 days of the declaration of that area as a Containment Zone or less than 10 contacts remaining under active home quarantine (as earlier defined) in the Containment Zone, the Buffer Zone shall turn into a normal zone.

3. Cluster:

Cluster refers to an aggregation of Covid – positive cases grouped together which are epidemiologically linked. The cases should be linked to a particular Covid – positive person wherein many such cases have occurred in a small area.



to a particular Covid – positive person wherein many such cases have occurred in a small area.

II. Standard Operating procedure in BBMP and urban areas

1. Incident Commander – Crisis Management Team

Once a Containment Zone is declared by the BBMP, the Commissioner should appoint an Executive Magistrate or a Class I officer entrusted with magisterial powers as Incident Commander for each Containment who will be responsible for the overall management of the Containment and Buffer Zone surrounding it. In cases of non-BBMP areas, the Deputy Commissioner should appoint an Incident Commander for each Containment Zone and Buffer Zone as above. The SOP that is being designed for the Containment Zone will be replicated in the Cluster.

The Incident Commander in the BBMP area should be a senior or Junior Class-I officer of BBMP entrusted with Magisterial powers exclusively appointed for this purpose. In case of non-BBMP urban areas, the Deputy Commissioner can appoint a taluk level/district level officer as the Incident Commander for one or more Containment Zone.

All decisions relating to management of the Containment Zone is the responsibility of the Incident Commander, including determining the exact boundaries under guidance of the BBMP Commissioner/ Deputy Commissioner of the district. Day to day management would be the prerogative of the Incident Commander, subject to directions of the Government. The boundaries of the Containment Zone must be clearly demarcated and the main entry and exit points to the Containment Zone need to be identified.

An Incident Command Centre would need to be established in the vicinity of the Containment Zone from which the Incident Commander will operate. The Incident Command Centre shall have a centralized control room under the supervision of the Incident Commander with police, municipal and health authority representatives assigned to the control room. It should be a 24x7 centre with basic amenities for the personnel manning it. BBMP/municipality should provide all facilities for the smooth operation of the command centre.

Special teams to implement the containment in the Containment Zone need to be formed. Mobile teams to enforce the lockdown in the Containment Zone have to be put in place by the Incident Commander. An assessment of persons in the Containment Zone requiring special needs (pregnancies, cardiac patients etc) would need to be undertaken with the help of local associations in order to cater to their needs in times of emergency. The Joint Commissioner of the respective BBMP Zones/Chief Officer of the urban municipality should provide all assistance/support to the Incident Commander for smooth discharge of her/his duties, including deputing staff as required.

2. Complete seal down – Role of Police

The Containment Zone would have to be cordoned off by hard barricading of all its entrances by the Police. The Containment Zone would not entail any person coming out of the Containment Zone for any purpose. There would be only one entry and exit for each Containment Zone. No private vehicular traffic would be allowed inside or outside the Containment Zone area. It would be the responsibility of the police to ensure that there is complete sealing of the area.

Further, complete curfew management would need to be undertaken by the Police. Essential services and medical emergencies would need to be allowed by the Police with issuance of emergency passes. Use of technology to enforce the seal down would be required. Drones could be effectively used in the Containment Zones to ensure a total lockdown.

3. Health Department – Responsibilities

State Health Department and urban body health officials shall jointly undertake surveillance and preventive activities. Health outpost to be established in such a Containment Zone with a doctor and sufficient field staff to do health screening twice a day apart from an intensive IEC campaign.

Contact tracing and tracking as per protocol needs to be undertaken. Immediate shifting of high risk (primary) contacts to

institutional quarantine and subjecting low risk (secondary) contacts to home quarantine needs to be done. In slum areas due to paucity of space, effective home quarantine cannot be followed for low risk contacts also. Therefore, such contacts also may be shifted to institutional quarantine for slum areas. The Health team will be responsible for the testing of high risk and low risk contacts by drawing swab samples as per protocol. Rapid anti-body tests to rule out any community spread need to be undertaken when deemed fit by BBMP Commissioner/DC of the district.

Health profiling of entire population to find Influenza like Infections (ILIs) or Severe Acute Respiratory Infection (SARI) cases or any symptoms resembling COVID-19 and treating them should be undertaken on priority. The team would need to advise the strictest form of social distancing in such area under the guidance of the Incident Commander. The Health Department would facilitate or provide masks and other materials that help in the quarantine and social distancing measures.

The health-related activities will be undertaken under the overall supervision of the Incident Commander.

4. Responsibility of Municipal Authorities

The BBMP/Municipal Authorities would be responsible for maintaining overall sanitation in the Containment Zone. Daily solid waste management (including bio medical waste) as well as spraying of disinfectants should be undertaken in the Containment Zone. Adequate provision of drinking water in cases of shortage of water supply would need to be undertaken. This could also entail house to house provisioning of essential supplies, services and water. Food packets and ration to the needy should also be undertaken by the BBMP/municipal authorities as per the requirement. All municipal staff would be allowed in the Containment Zone with valid municipal / government identity cards for the above purposes.

MU

5. Essential Supplies Management

Since the Containment Zone area would be completely sealed down with no movement of people outside their houses even for basic necessities like groceries, meat, milk, LPG and medicines, the Police should provide for entry and exit passes for providers of such services to supply essential commodities/services within the Containment Zone. The local police station nearest to the Containment Zone should provide emergency services passes so that there could be uninterrupted supply of essential goods and services to the Containment Zone. All essential supply shops like groceries, meat, milk, medicines, LPG would be closed in the Containment Zone. Provision of ration by Fair Price Shops to the doorstep of the ration card holder would also need to be undertaken.

III. Standard Operating procedure in the rural areas

1. Incident Commander – Crisis Management Team

Once a Containment Zone is declared by the Deputy Commissioner, the Deputy Commissioner will appoint an EXECUTIVE Magistrate as Incident Commander for each Containment Zone responsible for the overall management of the Containment Zone and Buffer Zone surrounding it. The Deputy Commissioner should appoint an Incident Commander for each Containment Zone. The boundaries of the Containment Zone must be clearly demarcated and the main entry and exit points to the Containment Zone need to be identified. In case of a villogo, the entire habitation or a smaller contiguous part as determined would need to be cordoned off.

All decisions relating to management of the Containment Zone is the responsibility of the Incident Commander, including determining the exact boundaries under guidance of the Deputy Commissioner of the district. Day to day management would be the prerogative of the Incident Commander, subject to directions of the Deputy Commissioner.

An Incident Command Centre would need to be established in the vicinity of the Containment Zone from which the Incident Commander will operate. The Incident Command Centre shall have a centralized control room under the supervision of the Incident Commander with police,

6 JMS

panchayat and health department representatives assigned to the control room. The PDO and local panchayat officials should provide all assistance to the Incident Commander to perform his duties as per this circular.

2. Complete seal down – Role of Police

The declaration of the habitation as a Containment Zone would not entail any person coming out of their house for any purpose. The entire habitation would have to be cordoned off by hard barricading to all its entrances by the Police. There would be only one entry and exit to the entire habitation. No private vehicular traffic would be allowed inside or outside the Containment Zone area. It would be responsibility of the police to ensure that there is complete sealing of the area.

3. Health Department - Responsibilities

The district health officials will be responsible for surveillance and preventive measures in the Containment Zone. A Health outpost is to be established in such a zone with a doctor and sufficient field staff to do health screening twice a day apart from an intensive IEC campaign.

Contact tracing and tracking as per protocol needs to be undertaken. Immediate shifting of high risk (primary) contacts to institutional quarantine and subjecting low risk (secondary) contacts to home quarantine needs to be done. In densely populated areas due to paucity of space, effective home quarantine cannot be followed for low risk contacts also. Therefore, such contacts also may be shifted to institutional quarantine for densely populated areas.

The Health team will be responsible for the testing of high and low risk contacts by drawing swab samples as per protocol. Rapid antibody tests to rule out any community spread need to be undertaken when deemed fit by DC of the district. Health profiling of entire population to find Influenza like Infections (ILIs) or Severe Acute Respiratory Infection (SARI) cases or any symptoms resembling COVID-19 and treating them should be undertaken on priority. The team would need to advise the strictest form of social distancing in such area under the guidance of the Incident Commander. The Health Department would

facilitate or provide masks and other materials that help in the quarantine and social distancing measures.

4. Responsibilities of the Gram Panchayat

The Gram Panchayat Authorities would be responsible for maintaining overall sanitation in the Containment Zone area. Daily solid waste management as well as spraying of disinfectants should be undertaken in the Containment Zone area. Adequate provision of drinking water in cases of shortage of water supply would need to be undertaken. This could also entail house to house provisioning of essential supplies and services. All panchayat staff would be allowed in the Containment Zone with valid government panchayat identity cards for the above purposes. Gram Panchayat should provide all facilities to set up and smooth operation of the command centre.

5. Essential supplies Management

Since the Containment Zone area would be completely sealed down with no movement of people outside their houses allowed even for basic necessities like groceries, meat, milk and medicines, the police should provide for entry and exit passes for providers of such services to supply essential commodities/services within the Containment Zone. All essential supply shops like groceries, meat, medicines would be closed in the Containment Zone. Provision of ration by Fair Price Shops to the doorstep of the ration card holder would also need to be undertaken.

However, agricultural activity/operations should be allowed for asymptomatic and healthy persons to continue in the Containment Zone area with necessary social distancing measures and compulsory wearing of protective masks.

IV. Buffer Zone Management:

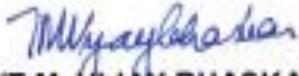
1. **The Incident Commander** appointed for the Containment Zone will be given the responsibility of managing the Buffer Zone also. He can use the same set up to monitor it.

2. **Partial Lockdown- Role of Police:** The social distancing measures in the area around the Containment Zone with restricted movement of public needs to be ensured by the police. No public function or gathering should be allowed.

3. Health Department:

- a. Active and effective surveillance by health staff to find ILIs & SARI cases and refer them to Fever Clinic or Isolation hospital as the case may be.
- b. Each surveillance team to cover minimum 50 houses each day and all houses to be covered in a day for health status.
- c. Enforce social distancing and usage of masks in public places.

Appropriate protective gear including gloves, masks and hand sanitizers (PPEs, if required as per HFW guidelines) should be provided by the BBMP/Deputy Commissioner in order that the teams can effectively perform their responsibilities.


(T.M. VIJAY BHASKAR)
Chief Secretary to
Government of Karnataka

To:

- 1) Commissioner, BBMP
- 2) All Deputy Commissioners
- 3) Commissioner, HFWS
- 4) Mission Director, NHM
- 5) Director, HFWS
- 6) Director, Medical Education.



ಕರ್ನಾಟಕ ಸರ್ಕಾರ

ಸಂಖ್ಯೆ : ಆಕುತ 113 ಅಮುಕಾ 2020

ಕರ್ನಾಟಕ ಸರ್ಕಾರದ ಸಚಿವಾಲಯ,
ವಿಶಾಸನೌಧ,
ಬೆಂಗಳೂರು, ದಿನಾಂಕ: 17-04-2020

ಸುತ್ತೋಲೆ

ರಾಜ್ಯದಲ್ಲಿ ಕೋರೋನಾ ವೈರಸ್ ಪ್ರಕರಣಗಳ ಸಂಖ್ಯೆ ಹೆಚ್ಚುತ್ತಿರುವ ಹಿನ್ನೆಲೆಯಲ್ಲಿ, ಐ.ಸಿ.ಎಂ.ಆರ್. ಶಿಫಾರಸ್ಸುಗಳ ಪ್ರಕಾರ, ಅಧಿಕ ಆಪಾಯವಿರುವ ಜನರಿಗೆ ಪ್ರತಿಬಂಧಕ ಔಷಧಿಯಾಗಿ ಹೈಡ್ರೋಕ್ಲೋರೋಕ್ವಿನ್ (Hydroxychloroquine) ನೀಡಬಹುದಾಗಿದೆ.

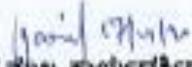
ಈ ಕೆಳಕಂಡ ವರ್ಗದವರಿಗೆ ಹೈಡ್ರೋಕ್ಲೋರೋಕ್ವಿನ್ (HCQ) ಮಾತ್ರಿಗಳನ್ನು ಆದ್ಯತೆಯ ಮೇರೆಗೆ ನೀಡಬೇಕಾದ ಅಗತ್ಯವಿದೆ.

1. ಆಸ್ಪತ್ರೆಗಳಲ್ಲಿ ಕಾರ್ಯನಿರ್ವಹಿಸುವ ವೈದ್ಯಕೀಯ ಮತ್ತು ಆರೆ ವೈದ್ಯಕೀಯ ಸಿಬ್ಬಂದಿ ವರ್ಗದವರಿಗೆ.
2. ಕೋವಿಡ್-19 ತಪಾಸಣೆಗಾಗಿ ಮನೆ-ಮನೆಗಳಿಗೆ ಭೇಟಿ ನೀಡುತ್ತಿರುವವರು ಕಣ್ಣವಲೂ ತಂಡಗಳಲ್ಲಿ ಕೆಲಸ ಮಾಡುತ್ತಿರುವ ಇಲಾಖಾ ಅಧಿಕಾರಿಗಳು ಹಾಗೂ ಸಿಬ್ಬಂದಿ ವರ್ಗದವರು.
3. ಕೋವಿಡ್-19 ದೃಢಪಟ್ಟ ವ್ಯಕ್ತಿಗಳೊಂದಿಗೆ ಸಂಪರ್ಕ ಹೊಂದಿರುವವರಿಗೆ.
4. ರೋಗನಿರೋಧಕ ಕ್ರಮವಾಗಿ ನಿಯಂತ್ರಿತ ವಲಯದಲ್ಲಿ (Containment Zone) ಕೆಲಸ ಮಾಡುವವರಿಗೆ.
5. ಆರೋಗ್ಯ ಇಲಾಖೆಯಲ್ಲಿ ಕೆಲಸ ಮಾಡುವ ಎಲ್ಲಾ ಅಧಿಕಾರಿಗಳಿಗೆ.
6. ವೈದ್ಯಕೀಯ ಶಿಕ್ಷಣ ಇಲಾಖೆಯ ಅಡಿಯಲ್ಲಿ ಬರುವ ವೈದ್ಯಕೀಯ ಕಾಲೇಜುಗಳಲ್ಲಿ ಕೋವಿಡ್-19 ಸಂಬಂಧ ಕರ್ತವ್ಯ ನಿರ್ವಹಿಸುತ್ತಿರುವ ಸಿಬ್ಬಂದಿ ವರ್ಗದವರು.
7. ಅಂಬುಲೆನ್ಸ್ ವಾಹನಗಳಲ್ಲಿ ಕೋವಿಡ್-19 ಸಂಬಂಧ ಕರ್ತವ್ಯ ನಿರ್ವಹಿಸುತ್ತಿರುವ ಸಿಬ್ಬಂದಿ ವರ್ಗದವರು.
8. ಪೊಲೀಸ್ ಇಲಾಖೆ ಹಾಗೂ ಇತರೆ ಯಾವುದೇ ಇಲಾಖೆಯಿಂದ ಕೋವಿಡ್-19 ಸಂಬಂಧ ಕರ್ತವ್ಯ ನಿರ್ವಹಿಸುತ್ತಿರುವ ಸಿಬ್ಬಂದಿ ವರ್ಗದವರು.
9. ಕೋವಿಡ್-19 ಸಂಬಂಧ ಕೆಲಸ ನಿರ್ವಹಿಸುತ್ತಿರುವ ಖಾಸಗಿ ವೈದ್ಯಕೀಯ ವೃಂದ.

ಹಿರಿಯ ನಾಗರಿಕರು, ಈ ಹಿಂವಯೇ ಹೈಡ್ರೋಕ್ವಿನ್ ಸಮರ್ಪಣೆಯ ಬಳಲುತ್ತಿರುವವರು, ಬಹುಶಃ ಕೋರತೆ ಹೊಂದಿರುವವರು ಮತ್ತು 4-ಅಮಿನೋಕ್ವಿನ್ಲೋಲಿನ್ ಇದಕ್ಕೆ ಅತಿಸಂವೇದಿಯಾಗಿರುವ (Hypersensitivity) ವ್ಯಕ್ತಿಗಳು ಮತ್ತು ಇತರೆ ದೀರ್ಘಕಾಲಿಕ ಖಾಯಿಲೆಗಳಿಂದ ಬಳಲುತ್ತಿರುವ ವ್ಯಕ್ತಿಗಳು ವೈದ್ಯಕೀಯ ತಪಾಸಣೆ ಹಾಗೂ ತಜ್ಞರ ಸೂಕ್ತ ಸಲಹೆಯೊಂದಿಗೆ ಹೈಡ್ರೋಕ್ಲೋರೋಕ್ವಿನ್ (Hydroxychloroquine-HCQ) ಮಾತ್ರಿಗಳನ್ನು ಪ್ರತಿಬಂಧಕ (Prophylaxis) ಔಷಧಿಯಾಗಿ ಪಡೆಯಬಹುದಾಗಿದೆ. 15 ವರ್ಷಕ್ಕಿಂತ ಕೆಳಗಿನ ವಯಸ್ಸಿನ ಮಕ್ಕಳಿಗೆ ಈ ಔಷಧಿಯನ್ನು ಶಿಫಾರಸ್ಸು ಮಾಡಬಾರದು.

ಹೈಡ್ರೋಕ್ಲೋರೋಕ್ವಿನ್ (HCQ) ಮಾತ್ರಿ ಔಷಧಿಯ ಪ್ರಮಾಣ ಮತ್ತು ಪಕಿತೆಯ ಅವಧಿಯನ್ನು ಈ ಕೆಳಕಂಡಂತೆ ವಿವರಿಸಲಾಗಿದೆ.

| ಅರ್ಜಿ ಪತ್ರಿಕೆಗಳು | ಪ್ರವೇಶಿಸಿದ ಕೋರೋನಾ ವಾಕ್ಯ ಮತ್ತು ಪ್ರಮಾಣ (ದೋಷಿಣ) |
|--|--|
| ಕೋವಿಡ್-19 ಕಂಠಿತ ಅಥವಾ ಖಚಿತವಾಗಿ ಪ್ರಕರಣಗಳ ಸಂದರ್ಭದಲ್ಲಿ ಸಕ್ರಿಯವಾಗಿ ಕೊಡಗಿನಿಸಿಕೊಂಡಿರುವ ದೋಷಿಣಗಳ ಅಲ್ಲದೆ ಇತರ ಅದೋಷಿಣ ಸೇವಾ ಸಿಬ್ಬಂದಿ ಮತ್ತು ಕೋವಿಡ್-19 ನಿರಂತರಿತ ವಲಯದಲ್ಲಿ ಅಪರನಿರೀಕ್ಷಿಸುವವರು. | ದೋಷಿಣ ದಿನ : 400 mg ದಿನಕ್ಕೆ ಎರಡು ಬಾರಿ ಮುಂದಿನ 7 ವಾರಗಳು 400 mg ವಾರಕ್ಕೆ ಒಂದು ಬಾರಿ ಅಪಾರದೋಷಿಣ ಸೇವೆ |
| ಮರಣದಲ್ಲಿ ಇರುವ ಪ್ರವೇಶಾಲಯದಿಂದ ಖಚಿತವಾಗಿ ಕೋವಿಡ್-19 ಪ್ರಕರಣಗಳ ಸಂವರ್ತನ ಕೊಂಡಿರದ ದೋಷಿಣಗಳ ಅಲ್ಲದವರು. | ದೋಷಿಣ ದಿನ : 400 mg ದಿನಕ್ಕೆ ಎರಡು ಬಾರಿ ಮುಂದಿನ 3 ವಾರಗಳು 400 mg ವಾರಕ್ಕೆ ಒಂದು ಬಾರಿ ಅಪಾರದೋಷಿಣ ಸೇವೆ |


 ಅಪರ ಮೈತ್ಯ ಕಾರ್ಯದರ್ಶಿಗಳು,

ಅದೋಷಿಣ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆ.

ಎನ್, ಕೆಎ, ಭೂಮಿ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆ.

ಪುಟ:

- 1) ಭೂಮಿ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆ
- 2) ನಿರಂತರಿತ, ಭೂಮಿ ಮತ್ತು ಕುಟುಂಬ ಕಲ್ಯಾಣ ಇಲಾಖೆ

DRAFT NOTIFICATION FOR CONTAINMENT ZONE

NOTIFICATION OF CONTAINMENT ZONE
NUMBER < > FOR < > DISTRICT

In view of power delegated to Chairperson, < > District Disaster Management Authority under National Disaster Management Act' (NDMA) 2005 by G.O. No. RD 157 TNR 2020 and in exercise of the powers conferred under section 26, 30 and 34 of NDMA' 2005,

and

Under relevant paras of notification issued under Epidemic Disease Act' 1897 by State Government,
and

As per definition of Containment Zone vide G.O. No. HFW 109 ACS 2020 dated 17.04.2020, I hereby declare the following area as an Active Containment Zone for Patient no. < >, who is Covid-19 positive from midnight of

The entire area bound by following boundaries.

East.....

West.....

North.....

South.....

No of residential houses =

No. of Shops/Offices =

Total Population =Further, Buffer Zone will be an area of km around this containment zone bound by:

East:

West:

North:

South:

The rough sketch of both Containment and Buffer Zone is attached with this notification.

For effective implementation of Covid-19 virus control measures, <Name> <Designation> is appointed as Incident Commander who will be overall in-charge of Containment Zone. The Incident Commander will take necessary actions as specified in containment zone notification referred above.

Signature

Microplan for COVID-19 Containment Zone Karnataka

PHC/ Planning Unit _____

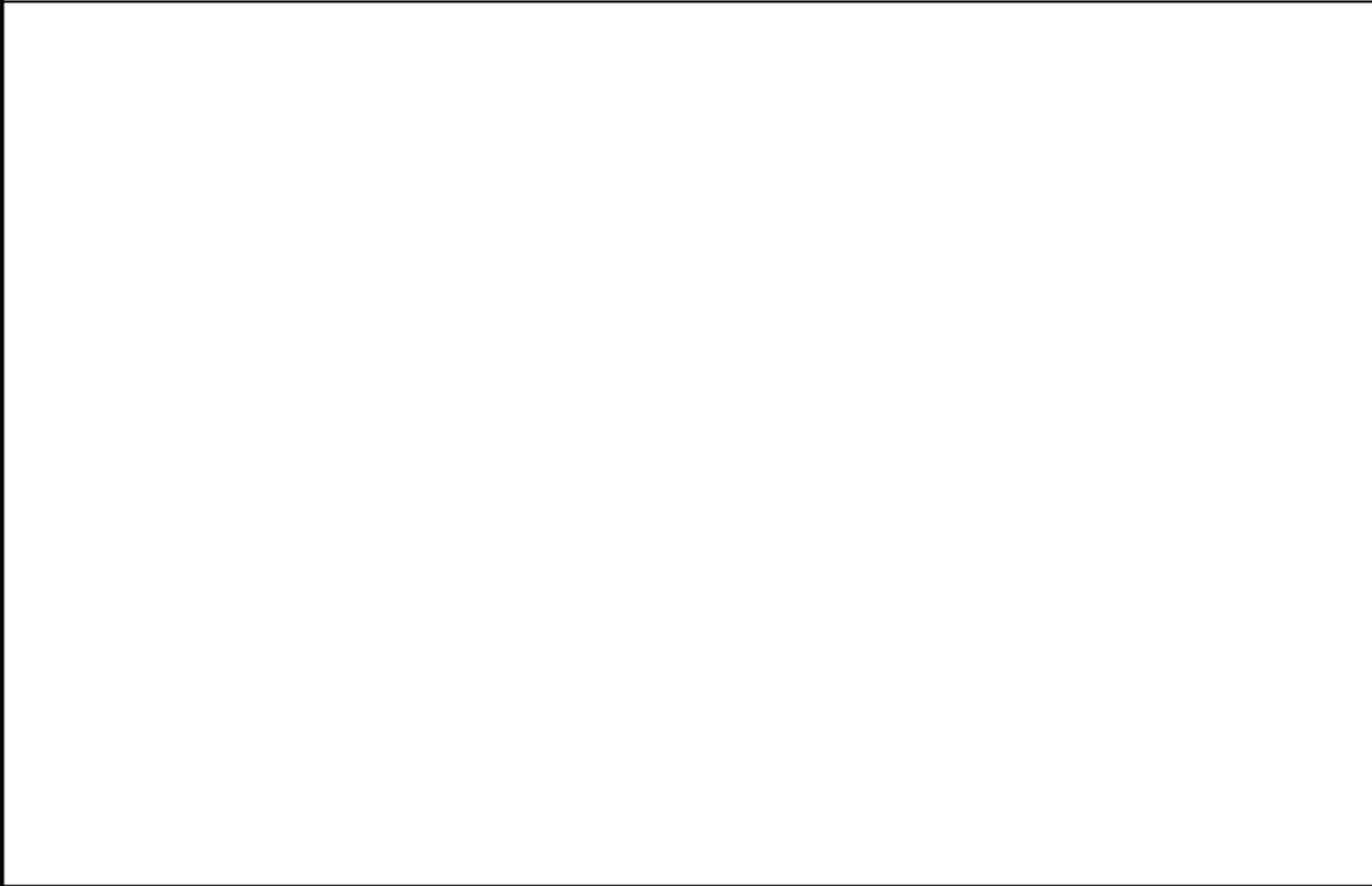
TALUKA _____

DISTRICT _____

Postive Case Number/s and Cluster Number: _____

(As Assigned from State)

Name of the Disitric: _____ Taluka: _____ PHC/ Planning unit: _____

| Map Showing Containment Zone and Buffer Zone in relation to Postive Confirmed case/s | LEGEND |
|--|---|
|  | SUB CENTRE  |
| | VILLAGES HQ  |
| | ROAD  |
| | RAILWAY LINE  |
| | RIVER  |
| | LAKE / POND  |
| | School  |
| | Religious place  |
| Total Population taken for Containment Zone: Signature of MO | Total Population taken for Buffer Zone: |

Annexure-1: Human Resource

1.1 Administrative and Technical Personnel

| <i>SLNo</i> | <i>Name</i> | <i>Designation</i> | <i>Contact Details (Mobile)</i> |
|--------------------|--------------------|--|--|
| 1 | | Deputy Commissioner or his assignee | |
| 2 | | State/District RRT | |
| 3 | | DHO/DSO | |
| 4 | | Medical Officer | |
| 5 | | Senior Health Assistant | |
| 6 | | Other Department Nodal Staff as per requirement | |
| 7 | | DHEO and other communication staff | |
| 8 | | Municipal/ village Panchayat staff Civil society | |
| 9 | | THO/ Nodal Programme Officer | |

Note : Deputy Commissioner / District Collector is the Nodal Person for the cluster containment at Districts

Annexure-2 District Rapid Response Team Members

| <i>Sl.No</i> | <i>Name</i> | <i>Designation</i> | <i>Contact Details (Mobile)</i> |
|---------------------|--------------------|---------------------------|--|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |
| 11 | | | |
| 12 | | | |

Annexure-3 Human Resource Requirements for Field Operations

| <i>Sl.No</i> | <i>Designation of Staff</i> | <i>Nature of work assigned</i> | <i>Total Number of Personnel Required for containment Operation</i> | <i>Number To be Mobilized from within the Taluka</i> | <i>Number Mobilized from other Talukas</i> |
|--------------|--|----------------------------------|---|--|--|
| 1 | Taluka Health officer | <i>Plan, Operate , Strategic</i> | | | |
| 2 | Programme Officer (District Nodal Officer) | <i>Supervision</i> | | | |
| 3 | Medical Officers | <i>Field Supervision</i> | | | |
| 4 | LHV/ Senior Health Assistant/ HI | <i>Field Supervision</i> | | | |
| 5 | IHA / ASHA / AWW | <i>Field Survey</i> | | | |
| 6 | Volunteers and personnel from other Departments | <i>Field Survey</i> | | | |
| 7 | Block Extension Educator / Other IEC Staff | <i>IEC/ RCC</i> | | | |
| 8 | Municipal / Village Panchayat Staff / Civil Society Volunteers | <i>Community Mobilization</i> | | | |
| 9 | Others (as per Requirement) | | | | |

Annexure-4 : Survey Teams Planning Format-19 CONTAINMENT ZONE - KARNATAKA

1. House to House Survey Teams Planning for Containment Zone and Buffer Zone

1. 1 Listing of Areas/ Sectors

| <i>Area/ Sector</i> | <i>Name of the Area/ Sector (50-100 ouses each)</i> | <i>Name of Surveyors (2 per Team)</i> | <i>Designation and contact number</i> | <i>Supervisor (one per 3-5 Teams)</i> | <i>Designation & Contact Details</i> |
|-------------------------|---|---|---|---|--|
| A | | 1 2 | | | |
| B | | 1 2 | | | |
| C | | 1 2 | | | |
| D | | 1 2 | | | |
| E | | 1 2 | | | |
| F | | 1 2 | | | |
| G | | 1 2 | | | |
| H | | 1 2 | | | |
| I | | 1 2 | | | |

Annexure-5A. Symptomatic Case (Influenza like Illness-ILI) reporting and Follow-up

| Sl. No. | Survey House No. | Patient's name & Address | Phone Number | History of contact with a lab confirmed case | Sex | Age | Fever | Cough | Difficulty in breathing | Date of onset of first symptom |
|---------|------------------|--------------------------|--------------|--|-----------|-----------|-------|-------|-------------------------|--------------------------------|
| | | | | | | (Yr / Mo) | | | | |
| 1 | | | | Y / N / Not known | M / F / O | __ / __ | Y / N | Y / N | Y / N | __ / __ / __ |
| 2 | | | | Y / N / Not known | M / F / O | __ / __ | Y / N | Y / N | Y / N | __ / __ / __ |
| 3 | | | | Y / N / Not known | M / F / O | __ / __ | Y / N | Y / N | Y / N | __ / __ / __ |
| 4 | | | | Y / N / Not known | M / F / O | __ / __ | Y / N | Y / N | Y / N | __ / __ / __ |
| 5 | | | | Y / N / Not known | M / F / O | __ / __ | Y / N | Y / N | Y / N | __ / __ / __ |
| 6 | | | | Y / N / Not known | M / F / O | __ / __ | Y / N | Y / N | Y / N | __ / __ / __ |
| 7 | | | | Y / N / Not known | M / F / O | __ / __ | Y / N | Y / N | Y / N | __ / __ / __ |
| 8 | | | | Y / N / Not known | M / F / O | __ / __ | Y / N | Y / N | Y / N | __ / __ / __ |
| 9 | | | | Y / N / Not known | M / F / O | __ / __ | Y / N | Y / N | Y / N | __ / __ / __ |
| 10 | | | | Y / N / Not known | M / F / O | __ / __ | Y / N | Y / N | Y / N | __ / __ / __ |

Influenza Like Illness (ILI) case Definition: Fever (> 38^o C) and cough within last 10 days

Format For Case-Wise Contact Listing And Follow - Up (CONFIDENTIAL) Annexure1, Format-2

DATE: _____

| Patient No (Confirmed COVID19) | Age (yrs) | Sex (M/F) | Address | District | Date of Symptom Onset | Any other information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|-----------------------------------|----------------------------|----------------------|---------|-----------|-----------------------|-----------------------|----------|--------------|--------------------------------------|----------------------------|--|-------------------------|--|--------------------------|---------------------------------|----------------------------------|--|------------------------|----------------------|------------------------|--------------------------------|----------------|------------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|------------------|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Contact Information and follow up | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sl. No. | Date of Contact (Exposure) | Location of Exposure | Name | Age (yrs) | Sex (M/F) | Address | District | Phone Number | Type of Contact: Primary / Secondary | Contact number of Neighbor | Relation to positive case [co-traveller, health worker, community, household (relation), others] | Country of visit if any | Date of arrival from affected country, if applicable | Observation started from | Co-morbid conditions (if any)** | Vulnerable section*** (Yes / No) | Isolated (Home/ Hospital/ others) specify the name | Sample taken Yes or no | Date of sample taken | Result-Pos/Neg/Pending | Name of Lab, where sample sent | Date of Result | Date of Stamping | Day of follow - up (Put a 'X' if the contact has no symptom and put a '✓' if the contact has one of the following symptoms* listed below) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | Quarantine period | | | | | | | | | | | | | | Reporting period | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 |

*ILI symptoms like Fever / Cough or Difficulty in breathing

** Co-morbid conditions - HTN, DM, Chronic Kidney Disease.

***Vulnerable section: Secondary contact living in small overcrowded area, slums, migrants, etc. who are vulnerable to be infected.

MICRO PLAN FOR CONTAINMENT OF LOCAL OUTBREAK - COVID -19

Annexure-7 (ACTIVE SURVEILLANCE)

PHC/ Containment Zone level Compilation Format

(Same Format can be used for Compilation at Taluka or District)

| | | |
|---------------------------------|---|------------------------------------|
| District, Taluka | : | |
| Area, Sector | : | |
| Village allocated: | : | |
| Name of the field worker | : | Phone: <input type="text"/> |
| Name of the Supervisor | : | Phone: <input type="text"/> |
| Name of the PHC doctor | : | Phone: <input type="text"/> |

Data compilation tool at field level (Field Level Data Compilation Sheet)

| S.No | Name of Village/ Urban Area/ PHC | Total Houses Surveyed | Total Population Surveyed/ Screened | Total number of Elderly (>60 years) | Total number of Elderly with Co- morbidity | Total number of Primary (High Risk) Contacts | Total number of Secondary (Low Risk) Contacts | Total Number of Contacts under Home Quarantine | No. of ILI cases identified | Total no of suspects tested | | Total no of positives | | Total no of patients admitted |
|--------------|--|--------------------------|--|--|--|--|---|---|--------------------------------|-----------------------------|---------------------------|-----------------------|---------------------------|-------------------------------------|
| | | | | | | | | | | RT-PCR | Rapid Antibody Test | RT-PCR | Rapid Antibody Test | |
| 1 | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | | | |
| Total | | | | | | | | | | | | | | |

Prevent other information

Total Population in containment Zone:

Total Villages, Wards:

Total number of Village Panchayat/ Municipalities:

| Sl. No. | Date | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 | Day 8 | Day 9 | Day 10 | Day 11 | Day 12 | Day 13 | Day 14 | Day 15 | Day 16 | Day 17 | Day 18 | Day 19 | Day 20 | Day 21 | Day 22 | Day 23 | Day 24 | Day 25 | Day 26 | Day 27 | Day 28 | Rev |
|---------|-------------------------------------|-------|------------|-------|------------|-------|------------|-------|------------|-------|------------|--------|------------|--------|------------|--------|------------|--------|------------|--------|------------|--------|------------|--------|------------|--------|------------|--------|------------|-----|
| | | Today | Cumulative | Today | Cumulative | Today | Cumulative | Today | Cumulative | Today | Cumulative | Today | Cumulative | Today | Cumulative | Today | Cumulative | Today | Cumulative | Today | Cumulative | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 | Population Surveyed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1A | In Containment Zone | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1B | In Buffer Zone | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 | Houses Visited | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2A | In Containment Zone | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2B | In Buffer Zone | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 | Morbidity Data | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3A | Total ILI Cases Identified | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3B | Total SARI Cases reported | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3C | Total suspected Covid Identified | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4 | Number of samples Collected | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4A | For RT-PCR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4B | For Rapid Antibody Test | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5 | Results | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5A | Positive by RT-PCR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5B | Positive by Rapid Antibody Test | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6 | Admission Details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6A | To COVID Care Centre(CCC) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6B | Dedicated COVID Health Centre(DCHC) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6C | Dedicated COVID Hospital (DCH) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7 | Number of IEC Activities held | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Note : Daily Report should be monitored by 11.00 Am daily

| | | | |
|--|--|--|--|
| Signature of the District Surveillance Officer | | Signature of the Reporting Medical officer | |
| Contact Details | | Contact Details | |