

## 5. India affected: Operational Framework for Response

---

The response would be centered on the strategic approach discussed in section-2. Containment of small geographic clustering would only be attempted if the virus is found not transmitting efficiently in our population. Otherwise, mitigation measures would be followed that includes (i) Early detection of cases and their management, (ii) Implementing pharmaceutical (individual case management / vaccination) and non pharmaceutical interventions and (iii) risk communication campaign.

If the infection becomes rampant, non pharmaceutical interventions at individual and community level (especially social distancing measures) would be centre stage, large number of cases need to be triaged and managed at home or hospital and continuity of hospital services ensured.

### 5.1 Central Government

The NDMA and NCMC would review the situation and give directions for the line ministries to role out the action plan. The Inter Ministerial Task Force would review the policy related issues and Joint Monitoring Group, the technical issues. The JMG would review the situation on daily basis. EMR division would be the central coordinating unit in MOHFW. The control room in EMR division (011-23061469) would work on 24x7 basis. The Regional Offices of Health and Family Welfare would liaison with the State Governments for all related matters.

The Emergency Support Function (ESF) plan of the Ministry of Health and Family Welfare would be activated (**Annexure-VI**).

MOHFW would provide the updated guidelines to the states which would also be posted on its website ([www.mohfw.nic.in](http://www.mohfw.nic.in)). The surveillance would be enhanced to detect clusters through the IDSP. The clinical samples would be tested in identified central laboratories. Medical Practitioners and general public would be encouraged to report cases to the toll free number 1075 or to the outbreak Monitoring Cell of NICD at 011-23093401.

Important contact numbers of the MOHFW are given at **Annexure-VII**

MOHFW would conduct exit screening in all international airports, port and border check points. NICD would be the nodal agency for outbreak investigations. It would depute Central Rapid Response Team to investigate outbreak and assist the State for institution of public health measures. The role and responsibility of the Central RRT is at **Annexure- VIII**.

The point at which entry screening needs to be stopped depends on extent of spread in India. Extensive spread (multiple clusters, containment ruled out and mitigation measures opted) is an indication for stopping entry screening and to consider the exit screening option.

MOHFW would evaluate the stockpile of drugs and consumables and provide the necessary logistic support to the States. The risk communication material would be rolled out for print and visual media and would also be made available to the State in vernacular languages. The outbreak monitoring cell of NICD would monitor the outbreak situation.

IHR focal point would notify the case(s) to WHO under the International Health Regulations. ICMR would begin the work on developing candidate vaccine strain. MOHFW would monitor the situation and review the policy and strategy based on WHO advisory and country's own assessment.

## **5.2 The State Government**

The Chief Minister would convene a meeting of the State Disaster Management Authority to review the response for the pandemic in health sector and sectors other than health. The action plan would be reviewed, gaps identified and filled.

The Chief Secretary would convene a meeting of Secretaries of health, revenue, home, finance, panchayat raj / local self governance, public works transport and review the requirements in each sector. The State would identify the extent of cluster formation, the morbidity and mortality. The capacity of the district(s) to contain/ control the outbreak would be assessed and additional support provided. If required, the centre would be requested for assistance. The State RRTs would be deployed. If the disease gets widespread, then mitigation measures including social distancing measures would be enforced. IEC campaign would focus on simple public health measures to prevent the disease (hand washing, cough etiquettes, staying away at least arms length from an affected person) and flu wise campaign (report to authorities about illness and seek treatment).

If the infection becomes overwhelming with severe morbidity / mortality, Chief Secretary would review the situation for continuity of essential services in the State. The crisis management plan of NDMA would be activated. The individual sectors would be monitored for continuity of operations.

Daily updates / press releases would be issued. The identified spokesperson would brief the media.

The contact numbers of State Nodal Officers are at **Annexure-IX**.

## **5.3 District Administration**

District Collector will hold meeting (s) in their respective districts with SP, CMO, Revenue, PWD, Forest, Education and Panchayati Raj/ Local Self Governance Departments where the

District Action Plan would be reviewed and activated. The support required from the State Government would be listed out.

District Collector will also convene a meeting of Zilla Parishads and who in turn would organize meeting of Panchayat Samitis and Gram Panchayats to spread awareness and involve the PRIs in control and containment operations, especially in enforcing the social distancing measures and if required, enforcing quarantine and restricting the movement of population.

On receipt of information of a cluster, District CMO/ District Hospital would be alerted. The district RRT would be deployed. The district RRT would be reinforced with State RRT and if required the Central RRT. The RRT would be responsible for the outbreak investigations and instituting public health measures.

The strategy to be adopted depends on a number of technical parameters (such as epidemiological, Virological and clinical) and administrative parameters (availability of oseltamivir, geographic terrain, supply chain, human resource etc). The feasibility would be high if there is a single cluster within defined natural boundaries. Another indicator is the reproductive number; if one person infects two persons in 3 days (15 cases in 10 days) containment may be possible. If the spread is more than this, containment is less likely. District Collector would be informed of this by the Central / State RRT.

If the decision of the RRT is to contain the cluster, then cluster containment plan would be put into action. The operating procedure for the cluster containment is at **Annexure-X**. District Collector would need to identify key issues (logistics, legal, technical and resources) and address them for implementing containment operations.

If containment is not feasible due to efficient human to human transmission resulting in rapid spread and multiple clusters, social distancing measures (closure of schools, colleges, markets, cinemas and other places of public congregation) need to be enforced on a wider scale and movement of population restricted.

District Collector would roll out a district media plan for ensuring risk communication to the community to allay fears; disseminating public health messages through local channels, miking, distribution of the fliers / leaflets etc. This includes messages on cough etiquettes, hand washing, keeping arms length from others, self reporting of illness and seek treatment if complaining of influenza like illness.

At the grass root level, a micro-plan would be conceived specific to the actions listed above that would have the approval of District Collector. A model micro plan is at **Annexure-XI**.

If the outbreak is severe enough to affect the functioning of the district, the plan of NDMA would be enforced for maintaining essential services and continuity of operations.

District Collector would review situation on daily basis by meeting with all stake holders. The monitoring would reflect preparing and disseminate daily summary report on the operations.

Finally he/she would monitor the expenditure and seek financial support, if required from the State/ Centre.

## **5.4 Components of response plan**

### **5.4.1 Entry Screening**

The entry screening would be done at the international airports, ports and border check points. Guidelines would be issued to the airlines (**Annexure-II**) through Ministry of Civil Aviation. A standard operating procedure would be followed for entry screening (**Annexure-III**). A person conforming to the case definition (**Annexure-XII**) would be isolated at the airport quarantine centre and then transferred to the identified isolation facility. It would be ensured that standard infection control practices would be followed.

### **5.4.2 Exit Screening**

If India get affected and if there are large number of countries not yet having secondary spread of Influenza A H1N1, then Government of India could consider exit screening of its passengers. Standard operating procedure would remain as per Annexure-III, the only difference being the health screening counters would be placed before the check-in counters.

### **1.1..3 Surveillance**

#### **5.4.3.1. Event based surveillance**

IDSP would be reporting cluster of ILI/SARI through its existing routine reporting system. The medical professionals will be encouraged, through press advertisements by MOHFW, to report such clusters seen during their practice to IDSP. The district and state units will inform the events to central unit. Even nil events would be reported.

#### **5.4.3.3. Outbreak investigation**

NICD would be the nodal agency for outbreak investigations. The outbreak monitoring cell of NICD would monitor the situation. If required, Central Rapid Response Teams would be deputed to assist the State in outbreak investigations and containment operations. The laboratories of the Central Government would provide laboratory support. Initially in phase five, a number of samples needed to be tested. As one moves into phase 6, the testing would be limited for the purpose of studying further change in the characteristics of the virus.

#### **5.4.3.2. Active surveillance**

If the decision of the health department is for cluster containment, then in the specified geographic region active house to house surveillance would be done as per the standard operating procedure at Annexure-X. A set of data collection tools is at **Annexure-XIII**.

#### 5.4.3.3. Contact tracing

During cluster containment, efforts will be to trace all contact and put them on home quarantine and provide chemoprophylaxis. If the infection is wide spread, contact tracing would not be attempted. The guidelines for contact tracing are at **Annexure- XIV**.

#### 5.4.3.4. Passive surveillance

If the disease spreads fast among the communities, then the hospitals and health units treating cases would report the morbidity and mortality. A set of reporting format is at **Annexure-XV**.

### 1.1.4 Laboratory Support.

The laboratory support would be provided by NIV, Pune and NICD, Delhi. If required the standby laboratories at NICED, Kolkata and RMRC, Dibrugarh would be put into operation. The contact details of the identified laboratories are at **Annexure XVI**. The samples would be collected, stored and transported as per the guidelines at **Annexure-XVII**.

With widespread disease, samples would be collected only from a few to study further change in the viral characteristics.

### 1.1.5 Pre Hospital care

If the infection is widespread, the trained volunteers from Government / private / NGO sector would triage the cases. The 'CRB' screening tool would be applied. The CRB screening tool for the community health workers is at **Annexure- XVIII**. The patients requiring hospital care would be referred. Others would be provided home care. The guidelines for providing home care are at **Annexure-XIX**. If the disease is wide spread, the state / district authorities may consider setting up fever clinics at the village / sub centre level where paracetamol / pheneramine maleate etc would be made available.

### 1.1.6 Hospital care

For all 21 international airports and the checkpoints, the identified isolation facility would be functional. During the initial clustering, if cluster containment is decided, then health facility identified with in or near to the containment zone would be activated. If the infection is widespread, then all health facilities in the community (PHC, CHC), District and Sub-District Hospitals, medical colleges, private nursing homes and hospitals would activate its disaster plan.

Hospitals would implement actions for increasing the surge capacity depending upon the prevailing morbidity and mortality and the Central / State Guidelines.

If the rapid assessment indicates that the outbreak would overwhelm the existing facilities, then temporary hospitals identified during preparedness would be set up. Orders will be issued for private hospitals to accept cases. The hospitals under the administrative control of Ministry of Defence, Labour, Railways etc will also be used.

Absenteeism among hospital staff will be monitored. All leave would be cancelled. Reserve personnel could be employed to fill the gap.

The clinical management would be as per the protocol decided by MOHFW. The clinical management protocol is at **Annexure XX**. Patient care checklist is at **Annexure XXI**.

**Initially oseltamivir is recommended to be given to all suspect cases and to provide chemoprophylaxis to immediate family and social contacts. Once the infection gets widespread but with less severity, then oseltamivir need to be provided only to those developing lower respiratory tract infection.**

#### **5.4.7. Dead body handling & disposal**

In the unfortunate event of mass deaths due to influenza, the district administration would issue orders for mass burial / cremation (depending upon the religious sensitivity) especially when hospitals are flooded with unclaimed bodies. Temporary mortuaries would be established by all hospitals having to deal with large number of dead bodies.

Those hospital functionaries handling dead bodies should wear full complement of PPE. The social gathering for funerals and social customs of giving bath to the body etc should be discouraged.

#### **5.4.8 Infection Control Practices**

##### **5.4.8.1. Infection control practices at Individual and community level**

At the individual level, hand washing (especially after touching nose or mouth), staying at least arms length away from those having cough and sneeze and applying a handkerchief or tissue paper over mouth while you cough, would be followed. Visit especially to crowded places would be restricted.

##### **5.4.8.2. Infection Control Practices in Health Care Settings**

All health care facilities would follow strict infection control practices and hospital waste would be disposed of in accordance with the hospital waste management rules. All health care personnel should follow frequent hand wash. The commonly touched surfaces would be cleaned every day with sodium hypochlorite/ house hold bleach or quaternary ammonium compounds.

During initial clustering, the patients would be managed in isolation facilities. With substantial spread, patients may have to be cohorted in general wards, with beds separated at least one metre distance apart.

The use of personal protection equipments would be as per risk profiling. The risk profile would be reviewed depending upon the severity of the disease. PPE would be disposed of either by incineration (major institutions) or be burning or land fills (peripheral institutions).

The infection control guidelines are at **Annexure XXII**. The operating procedure for use of PPE is at Annexure- **XXIII**.

### **5.4.9 Pharmaceutical interventions**

#### 5.4.9.1 Drugs

The dosage schedule for oseltamivir chemoprophylaxis and treatment would be as given in para 4.2.5. If the decision is for cluster containment, oseltamivir would be moved to the affected area for providing mass chemoprophylaxis. The micro plan would specify the modality of distribution. At least 90 per cent of the population in the defined geographical limit of 0-5 km radius needs to be covered.

#### 5.4.9.2 Vaccine

If the vaccine is available, then the priority groups (Health care workers, persons at extremes of age, those with co-morbid conditions, those providing essential services and those providing law and order) would be vaccinated. The existing framework available under National Immunization Programme would be put to use. If vaccines are available in plenty, (unlikely scenario) then the entire population would be vaccinated.

### **5.4.10. Non-pharmaceutical interventions**

#### 5.4.10.1. Community wide quarantine

Attempt would be made to stamp out the initial cluster (s) provided they are amenable to containment. In such situation, the micro plan would be operationalized. Law and order and strict perimeter control enforced, essential services are maintained and is sustained by other pharmaceutical and non-pharmaceutical interventions.

#### 5.4.10.2. Home quarantine

Contacts of cases would be placed under home quarantine for a period of seven days. They would be self monitoring their health and reporting to the identified health authorities. Public would be made aware of the need to self quarantine through well managed risk communication strategy.

#### 5.4.10.3. Isolation

Initially, patients would be isolated in identified facilities. With widespread infection, mild cases would be managed at home.

#### 5.4.10.4. Social distancing measures

If the infection is widespread, then schools and colleges would be closed. Mass gatherings such as festivals; sporting, religious and political events would be prohibited. Funerals gatherings, in particular, needs to be discouraged. General public entry to airports and railway stations etc would be restricted. Public transportation would also be restricted.

In a worst case scenario, business work place, market closure and weekly markets would also be closed. Enough security personnel would be posted to maintain law and order.

The duration of such action cannot be pre decided, but may have to be 4-6 weeks.

#### **5.4.11. Risk communication**

The communication need to be specific to the situation. Even a few deaths in the initial clusters will create large scale panic. The communication would re-enforce actions to alleviate the fear among public. It would also be direct for the community to report immediately when they start showing symptoms. The non-pharmaceutical interventions also need to be supported by a media campaign. At the grass root level, there would be social mobilization to sustain positive health seeking behavior.

Effective risk communication, supported by confidence in government authorities and the reliability of their information, may help mitigate some of the social and economic disruption attributed to the pandemic.

#### **5.4.12. Psycho social issues**

The guidelines issued by NDMA would be followed. The nodal institution, National Institute of Mental Health and Neuro Sciences, Bangalore along with other Central and State institutions will spear head the nation wide campaign for community based interventions.

#### **5.4.13. Monitoring and Documentation**

The situation would be monitored on day to day basis. The EMR division of the MOHFW would put up daily status reports. The recommendations of the Joint Monitoring Group and the decisions of IMTF would be documented. Data collected during the pandemic would be an important tool for decision making during and after the pandemic. At the end of the pandemic, the actions taken by the government and its impact would be reviewed and documented.

#### **5.4.14. Media Briefing**

The Press Information Bureau would ensure press releases and arrange for media briefing. the identified authority would only brief the media.

#### **1.1.15. Maintenance of essential services**

When the pandemic is at its peak, there would be work absenteeism from all services including health. Even the essential services would be crippled. The crisis management plan of the NDMA would be followed for continuity of operations required to maintain essential services.